Humana

Evidence of Coverage:

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of Humana Group Medicare Advantage PPO Plan

This document gives you the details about your Medicare and prescription drug coverage for this plan year. **This is an important legal document. Please keep it in a safe place.**

This plan, Humana Group Medicare Advantage PPO Plan, is offered by Humana Insurance Company, HumanaDental Insurance Company, Humana Insurance Company of New York, Humana Insurance of Puerto Rico, Inc., Emphesys Insurance Company and Humana Benefit Plan of Illinois, Inc. (When this *Evidence of Coverage* says "we," "us," or "our," it means Humana Insurance Company, HumanaDental Insurance Company, Humana Insurance Company of New York, Humana Insurance of Puerto Rico, Inc., Emphesys Insurance Company and Humana Benefit Plan of Illinois, Inc. When it says "plan" or "our plan," it means Humana Group Medicare Advantage PPO Plan.)

Out-of-network/non-contracted providers are under no obligation to treat plan members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call Customer Care (*phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet*) or see your Evidence of Coverage for more information, including cost-sharing that applies to out-of-network services.

This document is available for free in Spanish.

This information is available in a different format, including Braille, large print, and audio. Please call Customer Care (*phone numbers for Customer Care are located in Chapter 2, Section 1 of this document*) if you need plan information in another format.

Benefits, premiums and/or member copayments/coinsurance may change on the beginning of each plan year. The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. We will notify affected enrollees about changes at least 30 days in advance.

This document explains your benefits and rights. Use this document to understand about:

- Your plan premium and cost sharing;
- Your medical and prescription drug benefits;
- How to file a complaint if you are not satisfied with a service or treatment;
- How to contact us if you need further assistance; and,
- Other protections required by Medicare law.

2024 Evidence of Coverage

Table of Contents

CHAPTER 1:

Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in Humana Group Medicare Advantage PPO Plan, which is a Medicare PPO

You are covered by Medicare, and you have chosen to get your Medicare health care and your prescription drug coverage through our plan, Humana Group Medicare Advantage PPO Plan. We are required to cover all Part A and Part B services. However, cost sharing and provider access in this plan differ from Original Medicare.

Humana Group Medicare Advantage PPO Plan is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company.

Coverage under this Plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at: **www.irs.gov/Affordable-Care-Act/Individuals-and-Families** for more information.

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

This *Evidence of Coverage* document tells you how to get your medical care and prescription drugs. It explains your rights and responsibilities, what is covered, and what you pay as a member of the plan, and how to file a complaint if you are not satisfied with a decision or treatment.

The words coverage and covered services refer to the medical care and services and the prescription drugs available to you as a member of Humana Group Medicare Advantage PPO Plan.

It's important for you to learn what the plan's rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* booklet.

If you are confused or concerned or just have a question, please contact Customer Care.

Section 1.3 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how Humana Group Medicare Advantage PPO Plan covers your care. Other parts of this contract include your enrollment form, the *Prescription Drug Guide* (Formulary), and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called riders or amendments.

The contract is in effect for months in which you are enrolled in Humana Group Medicare Advantage PPO Plan coverage between January 1, 2024 and December 31, 2024.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of the Humana Group Medicare Advantage PPO Plan after December 31, 2024. We can also choose to stop offering the plan in your service area, after December 31, 2024.

Medicare (the Centers for Medicare & Medicaid Services) must approve Humana Group Medicare Advantage PPO Plan each year. You can continue each year to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

SECTION 2 What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

You are eligible for membership in our plan as long as:

- You have both Medicare Part A and Medicare Part B;
- -- *and* --You live in our geographic service area (Section 2.2 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.
- -- *and* -- You are a United States citizen or are lawfully present in the United States.

Section 2.2 Here is the plan service area for Humana Group Medicare Advantage PPO Plan

Humana Group Medicare Advantage PPO Plan is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area.

The service area is described below:

Where is Humana Group Medicare Advantage PPO Plan available?

Our service area includes specific counties within the United States, Puerto Rico and all other major US Territories.

The employer, union or trust determines where they are going to offer the plan.

If you plan to move out of the service area, you cannot remain a member of this plan. Please contact Customer Care to see if we have a plan in your new area. When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

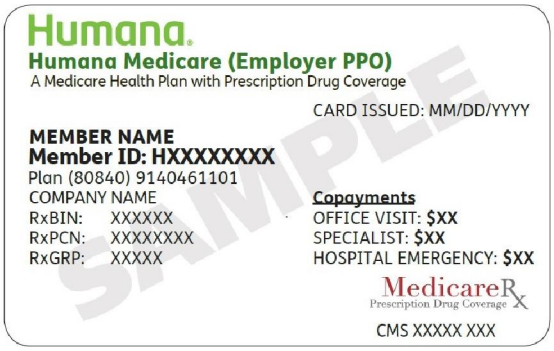
Section 2.3 U.S. citizen or lawful presence

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify Humana Group Medicare Advantage PPO Plan if you are not eligible to remain a member on this basis. Humana Group Medicare Advantage PPO Plan must disenroll you if you do not meet this requirement.

SECTION 3 Important membership materials you will receive

Section 3.1 Your plan membership card

While you are a member of our plan, you must use your membership card for our plan whenever you get services covered by this plan and for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card, if applicable. Here's a sample membership card to show you what yours will look like:



Do NOT use your red, white, and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare approved clinical research studies (also called clinical trials).

If your plan membership card is damaged, lost, or stolen, call Customer Care right away and we will send you a new card.

Section 3.2 *Provider Directory*

The Provider Directory lists our current network providers. **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost-sharing as payment in full.

Why do you need to know which providers are part of our network?

As a member of our plan, you can choose to receive care from out-of-network providers. Our plan will cover services from either in-network providers or out-of-network providers, as long as the services are covered benefits and medically necessary. However, if you use an out-of-network provider, your share of the costs for your covered services may be higher.

The Provider Directory lists our network pharmacies.

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

If you don't have the *Provider Directory,* you can get a copy from Customer Care. Requests for hard copy Provider Directories will be mailed to you within three business days. You can also find this information on our website at **www.humana.com**.

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

The plan has a *Prescription Drug Guide* (Formulary). We call it the *"Drug Guide"* for short. It tells which Part D prescription drugs are covered by Humana Group Medicare Advantage PPO Plan. The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the Humana Group Medicare Advantage PPO Plan *"Drug Guide"*.

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

You can view the most complete and current *"Drug Guide"* information by visiting our website at **www.humana.com**. (See Chapter 6, Section 1.1 of this booklet for how to access the *"Drug Guide"*.) You can also call Customer Care to find out if a particular drug is in the plan's *"Drug Guide"* or to ask for a copy of the latest version of the *"Drug Guide"*. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

SECTION 4 Your monthly costs for Humana Group Medicare Advantage PPO Plan

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Part D Late Enrollment Penalty (Section 4.3)
- Income Related Monthly Adjustment Amount (Section 4.4)

In some situations, your plan premium could be less

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. The "Extra Help" program helps people with limited resources pay for their drugs. Chapter 2, Section 7 tells more about these programs. If you qualify, enrolling in the program might lower your monthly plan premium.

If you are *already enrolled* and getting help from one of these programs, **the information about premiums in this Evidence of Coverage may not apply to you**. We have included a separate insert called the Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs (also known as the Low Income Subsidy Rider or the LIS Rider), which tells you about your drug coverage. If you don't have this insert, please call Customer Care.

Medicare Part B and Part D premiums differ for people with different incomes. If you have questions about these premiums, review your copy of *Medicare & You 2024* handbook, the section called "2024 Medicare Costs." If you need a copy you can download it from the Medicare website (**www.medicare.gov**). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.1 Plan premium

Your coverage is provided through a contract with your former employer or union. Please contact your former employer or union's benefits administrator for information about your plan premium.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

You must continue paying your Medicare premiums to remain a member of the plan. This includes your premium for Part B. It may also include a premium for Part A which affects members who aren't eligible for premium free Part A.

Section 4.3 Part D Late Enrollment Penalty

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

The Part D late enrollment penalty is added to the plan's monthly premium. When you first enroll in Humana Group Medicare Advantage PPO Plan, we let you know the amount of the penalty. If you do not pay your Part D late enrollment penalty, you could lose your prescription drug benefits.

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

- You receive "Extra Help" from Medicare to pay for your prescription drugs.
- You have gone less than 63 days in a row without creditable coverage.
- You have had creditable drug coverage through another source such as a former employer, union, TRICARE, or Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.

- **Note:** Any notice must state that you had creditable prescription drug coverage that is expected to pay as much as Medicare's standard prescription drug plan pays.
- **Note:** The following are not creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.

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

- If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, the plan will count the number of full months that you did not have coverage. The penalty is 1% for every month that you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.

- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2023, this average premium amount was **$32.74**. This amount may change for 2024.

- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here, it would be 14% times **$32.74**, which equals **$4.58**. This rounds to **$4.60**. This amount would be added to the monthly premium for someone with a **Part D late enrollment penalty**.

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

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

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

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

Section 4.4 Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA. The extra charge is figured out using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit **https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans.**

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

SECTION 5 More information about your monthly premium

Section 5.1 There are several ways you can pay your plan premium.

For questions regarding premium payment, please call Customer Care. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

If you think we have wrongfully ended your membership, you have a right to ask us to reconsider this decision by making a complaint. Chapter 9, Section 10 of this booklet tells how to make a complaint. If you had an emergency circumstance that was out of your control and it caused you to not be able to pay your premiums within our grace period, you can ask us to reconsider this decision by calling Customer Care. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.) You must make your request no later than 60 days after the date your membership ends.

Section 5.2 Can we change your monthly plan premium during the year?

No. We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year we will tell you in your *Annual Notice of Change.*

However, in some cases the part of the premium that you have to pay can change during the year. This happens if you become eligible for the "Extra Help" program or if you lose your eligibility for the "Extra Help" program during the year. If a member qualifies for "Extra Help" with their prescription drug costs, the "Extra Help" program will pay all or part of the member's monthly plan premium. A member who loses their eligibility during the year will need to start paying their full monthly premium. You can find out more about the "Extra Help" program in Chapter 2, Section 7.

SECTION 6 Keeping your plan membership record up to date

Your membership record has information about you, including your address and telephone number. It shows your specific plan coverage.

The doctors, hospitals, pharmacists, and other providers in the plan's network need to have correct information about you. **These network providers use your membership record to know what services and drugs are covered and the cost-sharing amounts for you**. Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

- Changes to your name, your address, or your phone number.
- Changes in any other health insurance coverage you have (such as from your employer, your spouse or domestic partner's employer, Workers' Compensation, or Medicaid).
- If you have any liability claims, such as claims from an automobile accident.
- If you have been admitted to a nursing home.
- If you receive care in an out-of-area or out-of-network hospital or emergency room.
- If your designated responsible party (such as a caregiver) changes.
- If you are participating in a clinical research study. (Note: You are not required to tell your plan about the clinical research studies you intend to participate in but we encourage you to do so).

If any of this information changes, please let us know by calling Customer Care. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

Read over the information we send you about any other insurance coverage you have

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see Section 10 in this chapter.)

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Customer Care.

SECTION 7 How other insurance works with our plan

Other insurance

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. This is called **Coordination of Benefits**.

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Customer Care. You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the primary payer and pays up to the limits of its coverage. The one that pays second, called the secondary payer, only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs. If you have other insurance, tell your doctor, hospital, and pharmacy.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
    - If you're under 65 and disabled and you or your family member is still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
    - If you're over 65 and you or your spouse or domestic partner is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' Compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

CHAPTER 2:

Important phone numbers and resources

SECTION 1 Humana Group Medicare Advantage PPO Plan contacts (how to contact us, including how to reach Customer Care)

How to contact our plan's Customer Care

For assistance with claims, billing or member card questions, please call or write to the Humana Group Medicare Advantage PPO Plan Customer Care. We will be happy to help you.

Method	Customer Care - Contact Information
CALL	Customer Care at (866) 396-8810. Calls to this number are free. We are available Monday through Friday from 8 a.m. to 9 p.m., Eastern time. Our phone system may answer your call after hours, and on Saturdays, Sundays, and some holidays. Customer Care also has free language interpreter services available for non-English speakers.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WRITE	Humana P.O. Box 14168 Lexington, KY 40512-4168
WEBSITE	**www.humana.com**

How to contact us when you are asking for a coverage decision or appeal about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or Part D prescription drugs. An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on asking for coverage decisions about your medical care or Part D prescription drugs, see Chapter 9 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).*

Method	Coverage Decisions For Medical Care - Contact Information
CALL	Customer Care at the telephone number located in Section 1 of this chapter. Calls to this number are free. We are available Monday through Friday from 8 a.m. to 9 p.m., Eastern time. Our phone system may answer your call after hours, and on Saturdays, Sundays, and some holidays. Customer Care also has free language interpreter services available for non-English speakers.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
FAX	1-800-949-2961 for expedited coverage decisions only
WRITE	Humana P.O. Box 14168 Lexington, KY 40512-4168

Method	Coverage Decisions For Part D Prescription Drugs - Contact Information
CALL	Customer Care at the telephone number located in Section 1 of this chapter. Calls to this number are free. We are available Monday through Friday from 8 a.m. to 9 p.m., Eastern time. Our phone system may answer your call after hours, and on Saturdays, Sundays, and some holidays. Customer Care also has free language interpreter services available for non-English speakers.
FAX	1-877-486-2621 for accepting expedited coverage determinations. Be sure to ask for a "fast", "expedited", or "24-hour" review.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WRITE	Humana Clinical Pharmacy Review Attn: Medicare Part D Coverage Determinations P.O. Box 33008 Louisville, KY 40232
WEBSITE	**www.Humana.com/member/member-rights/pharmacy-authorizations**

Method	Appeals For Medical Care or Part D prescription drugs - Contact Information
CALL	Customer Care at the telephone number located in Section 1 of this chapter. Calls to this number are free. We are available Monday through Friday from 8 a.m. to 9 p.m., Eastern time. Our phone system may answer your call after hours, and on Saturdays, Sundays, and some holidays. For expedited appeals please call 1-800-867-6601. Customer Care also has free language interpreter services available for non-English speakers.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
FAX	1-800-949-2961 for expedited appeals only.
WRITE	Humana Grievance and Appeal Dept. P.O. Box 14165 Lexington, KY 40512-4165

How to contact us when you are making a complaint about your medical care

You can make a complaint about us or one of our network providers or pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your medical care, see Chapter 9 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).*

Method	Complaints About Medical Care - Contact Information
CALL	Customer Care at the telephone number located in Section 1 of this chapter. Calls to this number are free. We are available Monday through Friday from 8 a.m. to 9 p.m., Eastern time. Our phone system may answer your call after hours, and on Saturdays, Sundays, and some holidays. For expedited appeals please call 1-800-867-6601. Customer Care also has free language interpreter services available for non-English speakers.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
FAX	1-800-949-2961 for expedited grievances only
WRITE	Humana Grievance and Appeal Dept. P.O. Box 14165 Lexington, KY 40512-4165
MEDICARE WEBSITE	You can submit a complaint about your Humana Group Medicare Advantage PPO Plan directly to Medicare. To submit an online complaint to Medicare, go to **www.medicare.gov/MedicareComplaintForm/home.aspx**.

Where to send a request asking us to pay for our share of the cost for medical care or a drug you have received

If you have received a bill or paid for services (such as a provider bill) that you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. See Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*).

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

Method	Payment Requests - Contact Information
CALL	Customer Care at the telephone number located in Section 1 of this chapter. Calls to this number are free. We are available Monday through Friday from 8 a.m. to 9 p.m., Eastern time. Our phone system may answer your call after hours, and on Saturdays, Sundays, and some holidays. Customer Care also has free language interpreter services available for non-English speakers.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WRITE	Humana P.O. Box 14168 Lexington, KY 40512-4168

SECTION 2 Medicare
(how to get help and information directly from the Federal Medicare program)

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called CMS). This agency contracts with Medicare Advantage organizations including us.

Method	Medicare - Contact Information
CALL	1-800-MEDICARE or 1-800-633-4227 Calls to this number are free, 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.

Method	Medicare (continued) - Contact Information
WEBSITE	**www.medicare.gov** This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about Humana Group Medicare Advantage PPO Plan: • **Tell Medicare about your complaint:** You can submit a complaint about Humana Group Medicare Advantage PPO Plan directly to Medicare. To submit a complaint to Medicare, go to **www.medicare.gov/MedicareComplaintForm/home.aspx**. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or you can call Medicare and tell them what information you are looking for. They will find the information on the website and review the information with you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.) • **Minimum essential coverage (MEC)**: Coverage under this Plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at **www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-individual-shared-responsibility-provision** for more information on the individual requirement for MEC.

SECTION 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. Contact information for your State Health Insurance Assistance Program (SHIP) can be found in "Exhibit A" in the back of this document.

The State Health Insurance Assistance Program (SHIP) is an independent (not connected with any insurance company or health plan) state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

The State Health Insurance Assistance Program (SHIP) counselors can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. State Health Insurance Assistance Program (SHIP) counselors can also help you with Medicare questions or problems and help you understand your Medicare plan choices and answer questions about switching plans.

METHOD TO ACCESS SHIP and OTHER RESOURCES:

- Visit **https://www.shiphelp.org** (Click on SHIP LOCATOR in the middle of page)
- Select your **STATE** from the list. This will take you to a page with phone numbers and resources specific to your state.

Contact information for your State Health Insurance Assistance Program (SHIP) can be found in "Exhibit A" in the back of this booklet.

SECTION 4 Quality Improvement Organization
(paid by Medicare to check on the quality of care for people with Medicare)

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state.

The Quality Improvement Organization (QIO) is a group of doctors and other health care professionals who are paid by Medicare to check on and help improve the quality of care for people with Medicare. The Quality Improvement Organization (QIO) is an independent organization. It is not connected with our plan.

You should contact your Quality Improvement Organization (QIO) in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

Contact information for your state Quality Improvement Organization (QIO) can be found in "Exhibit A" in the back of this booklet.

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

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

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

Method	**Social Security - Contact Information**
CALL	1-800-772-1213 Calls to this number are free. Available 8:00 a.m. to 7:00 p.m., Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8:00 a.m. to 7:00 p.m., Monday through Friday.
WEBSITE	**www.ssa.gov/**

SECTION 6 Medicaid

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

The programs offered through Medicaid help people with Medicare pay their Medicare costs, such as their Medicare premiums. These Medicare Savings Programs include:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact your state Medicaid office. **Contact information for your state Medicaid Office can be found in "Exhibit A" in the back of this booklet.**

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

The Medicare.gov website (https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap/5-ways-to-get-help-with-prescription-costs) provides information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, described below.

Medicare's "Extra Help" Program

Medicare provides "Extra help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you can get help paying for any Medicare drug plan's monthly premium, yearly deductible, and prescription copayments or coinsurance. This "Extra Help" also counts toward your out-of-pocket costs.

If you automatically qualify for "Extra help," Medicare will mail you a letter. You will not have to apply. If you do not automatically qualify you may be able to get "Extra Help" to pay for your prescription drug premiums and costs. To see if you qualify for getting "Extra Help", call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
- The Social Security Office at 1-800-772-1213, between 8:00 a.m. to 7:00 p.m., Monday through Friday. TTY users should call 1-800-325-0778 (applications); or
- Your State Medicaid Office (applications) (See "Exhibit A" located in the back of this booklet for contact information).

If you believe you have qualified for "Extra Help" and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has a process for you to either request assistance in obtaining evidence of your proper cost-sharing level, or if you already have the evidence, to provide this evidence to us.

If you already have a document that proves you have qualified for "Extra Help," you can also show it the next time you go to a pharmacy to have a prescription filled. You can use any one of the following documents to provide evidence to us, or to show as proof at the pharmacy:

Proof that you already have "Extra Help" status

- A copy of your Medicaid card showing your name and the date you became eligible for "Extra Help." The date has to be in the month of July or later of last year.

- A letter from the Social Security Administration showing your "Extra Help" status. This letter could be called Important Information, Award Letter, Notice of Change, or Notice of Action.

- A letter from the Social Security Administration showing that you receive Supplemental Security Income. If that's the case, you also qualify for "Extra Help."

Proof that you have active Medicaid status

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

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

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

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

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

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

- When we receive the evidence showing your copayment or coinsurance level, we will update our system so that you can pay the correct copayment or coinsurance when you get your next prescription at the pharmacy. If you overpay your copayment or coinsurance, we will reimburse you. Either we will forward a check to you in the amount of your over payment, or we will offset future copayments or coinsurance. If the pharmacy hasn't collected a copayment or coinsurance from you and is carrying your copayment or coinsurance as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make the payment directly to the state. Please contact Customer Care if you have questions. (Phone numbers for Customer Care are located in Section 1 of this chapter).

What if you have coverage from a State Pharmaceutical Assistance Program (SPAP)?

Many states and the U.S. Virgin Islands offer help paying for prescriptions, drug plan premiums and/or other drug costs. If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (other than "Extra Help"), you still get the **70%** discount on covered brand name drugs. Also, the plan pays **5%** of the costs of brand drugs in the coverage gap. The **70%** discount and the **5%** paid by the plan are both applied to the price of the drug before any SPAP or other coverage.

What if you have coverage from an AIDS Drug Assistance Program (ADAP)?
What is the AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps ADAP - eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also on the ADAP formulary qualify for prescription cost-sharing assistance.

Note: To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. If you change plans please notify your local ADAP enrollment worker so you can continue to receive assistance. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the ADAP operating in your State.

If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. Contact information for your AIDS Drug Assistance Program (ADAP) can be found in “Exhibit A” in the back of this document.

State Pharmaceutical Assistance Programs

Many states have State Pharmaceutical Assistance Programs that help some people pay for prescription drugs based on financial need, age, medical condition or disabilities. Each state has different rules to provide drug coverage to its members.

Contact information for your State Pharmaceutical Assistance Program (SPAP) can be found in "Exhibit A" in the back of this booklet.

SECTION 8 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

Method	Railroad Retirement Board - Contact Information
CALL	1-877-772-5772 Calls to this number are free. If you press "0", you may speak with an RRB representative from 9:00 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9:00 am to 12:00 pm on Wednesday. If you press "1", you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.
WEBSITE	**rrb.gov**

SECTION 9 Do you have group insurance or other health insurance from an employer?

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner's) employer or retiree group as a part of this plan, you may call the employer/union benefits administrator or Customer Care if you have any questions. You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Customer Care are located in Section 1 of this Chapter.) You may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan.

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

CHAPTER 3:

Using the plan for your medical services

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

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

For the details on what medical care is covered by our plan and how much you pay when you get this care, use the benefits chart in the next chapter, Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*).

Section 1.1 What are network providers and covered services?

- **Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.

- **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.

- **Covered services** include all the medical care, health care services, supplies, equipment, and prescription drugs that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

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

As a Medicare health plan, Humana Group Medicare Advantage PPO Plan must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

Humana Group Medicare Advantage PPO Plan will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits Chart**. (This chart is in Chapter 4 of this document).

- **The care you receive is considered medically necessary**. Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

- **You receive your care from a provider who is eligible to provide services under Original Medicare**. As a member of our plan, you can receive your care from either a network provider or an out-of-network provider. (For more about this, see Section 2 in this chapter.)
    - The providers in our network are listed in the *Provider Directory.*
    - **Please note:** While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you go to a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.

SECTION 2 Using network and out-of-network providers to get your medical care

Section 2.1 How to get care from specialists and other network providers

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

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

We list the providers that participate with our plan in our *Provider Directory.*

You don't need to get a referral for covered services. Some services require prior authorization from providers. However, before getting services from out-of-network providers, you may want to confirm with us that the services you are getting are covered by us and are medically necessary. See Chapter 4, Section 2.1 for more information about which services require prior authorization. If an out-of-network provider sends you a bill that you think we should pay, refer to Chapter 7 (*Asking the plan to pay its share of a bill you have received for covered services or drugs*) for information on how to ask us to pay that bill for you. We will pay your doctor for our share of the bill and will let you know what, if anything, you must pay.

You won't have to pay an out-of-network provider any more than what he or she would have gotten if you had been covered with the Original Medicare Plan. It is best to ask an out-of-network provider to bill us first, but if you have already paid for the covered services, we will reimburse you for our share of the cost. (Please note that we cannot pay a provider who has opted out of the Medicare program. Check with your provider before receiving services to confirm that they have not opted out of Medicare.) 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.

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

We may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. If your doctor or specialist leaves your plan, you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.

- We will notify you that your provider is leaving our plan so that you have time to select a new provider.

    - If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.

    - If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.

- We will assist you in selecting a new qualified in-network provider that you may access for continued care.

- If you are currently undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment or therapies you are receiving continues.

- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.

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

- If you find out that your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.

- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file a quality of care complaint to the QIO, a quality of care grievance to the plan, or both. Please see Chapter 9.

Contact Customer Care at the telephone number listed in Chapter 2, Section 1 for assistance with selecting a new qualified provider to continue managing your health care needs.

Section 2.2 How to get care from out-of-network providers

As a member of our plan, you can choose to receive care from out-of-network providers. However, please note providers that do not contract with us are under no obligation to treat you, except in emergency situations. Our plan will cover services from either network or out-of-network providers, as long as the services are covered benefits and are medically necessary. However, **if you use an out-of-network provider, your share of the costs for your covered services may be higher**. Here are other important things to know about using out-of-network providers:

- You can get your care from an out-of-network provider; however, in most cases that provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you receive care from a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.

- You may not need to get a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers you may want to ask for a pre-visit coverage decision to confirm that the services you are getting are covered and are medically necessary. (See Chapter 9, Section 4 for information about asking for coverage decisions.) This is important because:

- Without a pre-visit coverage decision, 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. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. See Chapter 9 *(What to do if you have a problem or complaint)* to learn how to make an appeal.

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

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

Section 3.1 Getting care if you have a medical emergency

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

A **medical emergency** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent your loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP. You do not need to use a network doctor. You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they are not part of our network.

- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Call the phone number located in Chapter 2, Section 1 of this booklet.

What is covered if you have a medical emergency?

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency.

The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over, you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by our plan.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all. If it turns out that it was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor has said that it was *not* an emergency, the amount of cost-sharing that you pay will depend on whether you get the care from network providers or out-of-network providers.

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

What are urgently needed services?

An urgently needed service is a non-emergency situation requiring immediate medical care but given your circumstances, it is not possible or not reasonable to obtain these services from a network provider. The plan must cover urgently needed services provided out of network. Some examples of urgently needed services are i) a severe sore throat that occurs over the weekend or ii) an unforeseen flare-up of a known condition when you are temporarily outside the service area.

Our plan covers urgently needed services if you receive the care outside of the United States. See Chapter 4 *(Medical Benefits Chart, what is covered and what you pay)* for more information. If you have already paid for the covered services, we will reimburse you for our share of the cost for covered services. You can send the bill to us for payment. See Chapter 7 *(Asking us to pay our share of a bill you have received for covered medical services or drugs)* for information about what to do if you receive a bill or if you need to ask for reimbursement.

Section 3.3 Getting care during a disaster

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

Please visit the following website: **www.humana.com/alert** for information on how to obtain needed care during a disaster.

If you cannot use a network provider during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost-sharing. If you cannot use a network pharmacy during a disaster, you may be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5, Section 2.5 for more information.

SECTION 4 What if you are billed directly for the full cost of your services?

Section 4.1 You can ask us to pay our share of the cost of covered services

If you have paid more than your plan cost-sharing for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 7 *(Asking us to pay our share of a bill you have received for covered medical services or drugs)* for information about what to do.

Section 4.2 If services are not covered by our plan, you must pay the full cost

Humana Group Medicare Advantage PPO Plan covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4 of this document. If you receive services not covered by our plan, you are responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you have used up your benefit for that type of covered service. Paying for costs once a benefit limit has been reached will not count toward your out-of-pocket maximum.

You can call Customer Care when you want to know how much of your benefit limit you have already used.

SECTION 5 How are your medical services covered when you are in a clinical research study?

Section 5.1 What is a clinical research study?

A clinical research study (also called a clinical trial) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically request volunteers to participate in the study.

Once Medicare approves the study and you express interest, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study *and* you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in any Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. If you tell us that you are in a qualified clinical trial, then you are only responsible for the in-network cost sharing for the services in that trial. If you paid more, for example, if you already paid the Original Medicare cost-sharing amount, we will reimburse the difference between what you paid and the in-network cost sharing. However, you will need to provide documentation to show us how much you paid.

If you want to participate in any Medicare-approved clinical research study, you do *not* need to tell us or to get approval from us. The providers that deliver your care as part of the clinical research study do not need to be part of our plan's network of providers. Please note that this does not include benefits for which our plan is responsible that include, as a component, a clinical trial or registry to assess the benefit. These include certain benefits specified under national coverage determinations (NCDs) and investigational device trials (IDE) and may be subject to prior authorization and other plan rules.

Although you do not need to get our plan's permission to be in a clinical research study, covered for Medicare Advantage enrollees by Original Medicare, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

If you participate in a study that Medicare has *not* approved, *you will be responsible for paying all costs for your participation in the study.*

Section 5.2 When you participate in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you receive as part of the study, including:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure if it is part of the research study.
- Treatment of side effects and complications of the new care.

After Medicare has paid its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan. However, you are required to submit documentation showing how much cost sharing you paid. Please see Chapter 7 for more information for submitting requests for payments.

Here's an example of how the cost-sharing works: Let's say that you have a lab test that costs **$100** as part of the research study. Let's also say that your share of the costs for this test is **$20** under Original Medicare, but the test would be **$10** under our plan's benefits. In this case, Original Medicare would pay **$80** for the test and you would pay the **$20** copay required under Original Medicare. You would then notify your plan that you received a qualified clinical trial service and submit documentation such as a provider bill to the plan. The plan would then directly pay you **$10.** Therefore, your net payment is **$10,** the same amount you would pay under our plan's benefits. Please note that in order to receive payment from your plan, you must submit documentation to your plan such as a provider bill.

When you are part of a clinical research study, **neither Medicare nor our plan will pay for any of the following**:

- Generally, Medicare will *not* pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were *not* in a study.
- Items and services the study gives you or any participant for free.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.

Do you want to know more?

You can get more information about joining a clinical research study by visiting the Medicare website to read or download the publication Medicare and Clinical Research Studies. (The publication is available at: **www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf**.) You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 6 Rules for getting care covered in a religious non-medical health care institution

Section 6.1 What is a religious non-medical health care institution?

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

Section 6.2 Receiving care from a religious non-medical health care institution

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

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

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

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in a facility, the following condition applies:
    - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.

You are covered for an unlimited number of medically necessary inpatient hospital days. See Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*).

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 Will you own the durable medical equipment after making a certain number of payments under our plan?

Durable medical equipment (DME) includes items such as wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of Humana Group Medicare Advantage PPO Plan, however, you usually will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan, even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under certain limited circumstances we will transfer ownership of the DME item to you. Call Customer Care for more information.

What happens to payments you made for durable medical equipment if you switch to Original Medicare?

If you did not acquire ownership of the DME item while in our plan, you will have to make 13 new consecutive payments after you switch to Original Medicare in order to own the item. The payments made while enrolled in your plan do not count.

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare do not count. You will have to make 13 payments to our plan before owning the item.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You were in our plan but did not obtain ownership while in our plan. You then go back to Original Medicare. You will have to make 13 consecutive new payments to own the item once you join Original Medicare again. All previous payments (whether to our plan or to Original Medicare) do not count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage, then for as long as you are enrolled, Humana Group Medicare Advantage PPO Plan will cover:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related oxygen accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

If you leave Humana Group Medicare Advantage PPO Plan or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

What happens if you leave your plan and return to Original Medicare?

Original Medicare requires an oxygen supplier to provide you services for five years. During the first 36 months you rent the equipment. The remaining 24 months the supplier provides the equipment and maintenance (you are still responsible for the copayment for oxygen). After five years you may choose to stay with the same company or go to another company. At this point, the five-year cycle begins again, even if you remain with the same company, requiring you to pay copayments for the first 36 months. If you join or leave our plan, the five-year cycle starts over.

CHAPTER 4:

Medical Benefits Chart (what is covered and what you pay)

SECTION 1 Understanding your out-of-pocket costs for covered services

This chapter provides a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of Humana Group Medicare Advantage PPO Plan. Later in this chapter, you can find information about medical services that are not covered.

Section 1.1 Types of out-of-pocket costs you may pay for your covered services

To understand the payment information, we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

- The **Deductible** is the amount you must pay for medical services before our plan begins to pay its share.
- A **Copayment** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)
- **Coinsurance** is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable.

Section 1.2 What is your plan deductible?

Your combined deductible is $300.00.

Until you have paid the combined deductible amount, you must pay the full cost for most of your covered services. (The deductible does not apply to the services that are listed below.) Once you have paid your combined deductible, we will begin to pay our share of the costs for covered medical services and you will pay your share (your copayment or coinsurance amount) for the rest of the calendar year.

The combined deductible does not apply to some services, including certain in-network preventative services. This means that we will pay our share of the costs for these services even if you haven't paid your yearly deductible yet. The combined deductible does not apply to the following services:

- Part D Pharmacy
- Health and Wellness Education Programs
- Worldwide Coverage
- Insulin furnished through an item of durable medical equipment.

Please refer to the Medical Benefits Chart in Section 2 of this chapter for additional deductible exclusions.

Section 1.3 What is the most you will pay for Medicare Part A and Part B covered medical services?

Under our plan, there are two different limits on what you have to pay out-of-pocket for covered medical services:

- Your **in-network maximum out-of-pocket amount** is $3,000.00. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from network providers. The amounts you pay for deductibles, copayments, and coinsurance for covered services from network providers count toward this in-network maximum out-of-pocket amount. (The amounts you pay for plan premiums and Part D prescription drugs and services from out-of-network providers do not count toward your in-network maximum out-of-pocket amount.) In addition, amounts you pay for some services do not count toward your in-network maximum out-of-pocket amount. (See the Medical Benefits Chart in Section 2, below) If you have paid $3,000.00 for covered Part A and Part B services from network providers, you will not have any out-of-pocket costs for the rest of the year when you see our network providers. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

- Your **combined maximum out-of-pocket amount** is $3,000.00. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from both in-network and out-of-network providers. The amounts you pay for deductibles, copayments, and coinsurance for covered services count toward this combined maximum out-of-pocket amount. (The amounts you pay for your plan premiums and for your Part D prescription drugs do not count toward your combined maximum out-of-pocket amount.) In addition, amounts you pay for some services do not count toward your combined maximum out-of-pocket amount. (See the Medical Benefits Chart in Section 2, below.) If you have paid $3,000.00 for covered services, you will have 100% coverage and will not have any out-of-pocket costs for the rest of the plan year for covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.4 Our plan does not allow providers to balance bill you

As a member of Humana Group Medicare Advantage PPO Plan, an important protection for you is that, after you meet any deductibles, you only have to pay your cost-sharing amount when you get services covered by our plan. Providers may not add additional separate charges, called balance billing. This protection applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.

Here is how this protection works:

- If your cost-sharing is a copayment (a set amount of dollars, for example, $15.00), then you pay only that amount for any covered services from a network provider. You will generally have higher copays when you obtain care from out-of-network providers.

- If your cost-sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:

    - If you obtain covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).

    - If you obtain covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.

    - If you obtain covered services from an out-of-network provider who does not participate with Medicare, then you pay the coinsurance amount multiplied by the Medicare payment rate for non-participating providers.

- If you believe a provider has balanced billed you, call Customer Care.

SECTION 2 Use the Medical Benefits Chart to find out what is covered and how much you will pay

Section 2.1 Your medical benefits and costs as a member of the plan

The Medical Benefits Chart on the following pages lists the services Humana Group Medicare Advantage PPO Plan covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.

- Your services (including medical care, services, supplies, equipment, and Part B prescription drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

- Some of the services listed in the Medical Benefits Chart are covered as in-network services *only* if your doctor or other network provider gets approval in advance (sometimes called prior authorization) from Humana Group Medicare Advantage PPO Plan.

Covered services that need approval in advance to be covered as in-network services are marked in the bulleted section of the Medical Benefits Chart. In addition, the following services not listed in the Benefits Chart require approval in advance:

- The preauthorization list can be found here: **www.humana.com/PAL**

You never need approval in advance for out-of-network services from out-of-network providers.

- While you may not need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.

Other important things to know about our coverage:

- For benefits where your cost-sharing is a coinsurance percentage, the amount you pay depends on what type of provider you receive the services from:

- If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).

- If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.

- If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less.* (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2024* handbook. View it online at **www.medicare.gov** or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048).

- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.

- If Medicare adds coverage for any services during 2024, either Medicare or our plan will cover those services.

You will see this apple next to the preventive services in the benefits chart.

Medical Benefits Chart

Services that are covered for you	What you must pay when you get these services
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	In Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit $0 copayment for each freestanding radiological facility visit $0 copayment for each outpatient hospital visit Benefit does not apply to your combined deductible Out of Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit $0 copayment for each freestanding radiological facility visit $0 copayment for each outpatient hospital visit Benefit does not apply to your combined deductible

Services that are covered for you	What you must pay when you get these services
Acupuncture (Medicare-covered) for chronic low back pain Covered services include: Up to 20 combined In & Out of Network visits per year are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • Nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, disease etc); • Not associated with surgery; and • Not associated with pregnancy. Your plan allows services to be received by a provider licensed to perform acupuncture or by providers meeting the Original Medicare provider requirements. Prior authorization requirements may apply.	In Network $0 copayment for each specialist's office visit Out of Network $0 copayment for each specialist's office visit

Services that are covered for you	What you must pay when you get these services
Acupuncture (Routine) Covered services include: • Insertion of one or more needles with electrical stimulation • Insertion of one or more needles without electrical stimulation • 20 combined In & Out of Network visit limit per plan year	In Network $10 copayment for each specialist's office visit Benefit does not apply to your combined maximum out-of-pocket or combined deductible Out of Network $10 copayment for each specialist's office visit Benefit does not apply to your combined maximum out-of-pocket or combined deductible

Services that are covered for you	What you must pay when you get these services
Advanced imaging Covered services include, but are not limited to: • CT scans • MRI • MRA • Prior authorization may be required. Contact the plan for details.	In Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit $0 copayment for each freestanding radiological facility visit $0 copayment for each outpatient hospital visit Out of Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit $0 copayment for each freestanding radiological facility visit $0 copayment for each outpatient hospital visit

Services that are covered for you	What you must pay when you get these services
Allergy shots and serum Administration and serum related to medically necessary allergy shots.	In Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit Out of Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit

Services that are covered for you	What you must pay when you get these services
Ambulance services • Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. • If the covered ambulance services are not for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.	Emergency In Network $0 copayment per date of service regardless of the number of trips. Limited to Medicare-covered transportation Emergency Out of Network $0 copayment per date of service regardless of the number of trips. Limited to Medicare-covered transportation Non-Emergency In Network $0 copayment per date of service regardless of the number of trips. Limited to Medicare-covered transportation Non-Emergency Out of Network $0 copayment per date of service regardless of the number of trips. Limited to Medicare-covered transportation

Services that are covered for you	What you must pay when you get these services
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. Any lab or diagnostic procedures that are ordered are not covered under this benefit and you pay your plan cost-sharing amount for those services separately. **Note**: Your first annual wellness visit can't take place within 12 months of your Welcome to Medicare preventive visit. However, you don't need to have had a Welcome to Medicare visit to be covered for annual wellness visits after you've had Part B for 12 months.	In Network $0 copayment for each primary care physician's office visit Benefit does not apply to your combined deductible Out of Network $0 copayment for each primary care physician's office visit Benefit does not apply to your combined deductible

Services that are covered for you	What you must pay when you get these services
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	In Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit $0 copayment for each freestanding radiological facility visit $0 copayment for each outpatient hospital visit Benefit does not apply to your combined deductible Out of Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit $0 copayment for each freestanding radiological facility visit $0 copayment for each outpatient hospital visit Benefit does not apply to your combined deductible

Services that are covered for you	What you must pay when you get these services
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women aged 40 and older • Clinical breast exams once every 24 months	In Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit $0 copayment for each freestanding radiological facility visit $0 copayment for each outpatient hospital visit Benefit does not apply to your combined deductible Out of Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit $0 copayment for each freestanding radiological facility visit $0 copayment for each outpatient hospital visit Benefit does not apply to your combined deductible

Services that are covered for you	What you must pay when you get these services
Cardiac rehabilitation services • Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	In Network $0 copayment for each specialist's office visit $0 copayment for each outpatient hospital visit Out of Network $0 copayment for each specialist's office visit $0 copayment for each outpatient hospital visit
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	In Network $0 copayment for each primary care physician's office visit Benefit does not apply to your combined deductible Out of Network $0 copayment for each primary care physician's office visit Benefit does not apply to your combined deductible

Services that are covered for you	What you must pay when you get these services
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease), covered once every 5 years (60 months).	In Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit Benefit does not apply to your combined deductible Out of Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit Benefit does not apply to your combined deductible

Services that are covered for you	What you must pay when you get these services
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months	In Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit Benefit does not apply to your combined deductible Out of Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit Benefit does not apply to your combined deductible

Services that are covered for you	What you must pay when you get these services
Chemotherapy drugs Medically-necessary chemotherapy services and treatments. • Prior authorization may be required. Contact the plan for details.	In Network $0 copayment for each specialist's office visit $0 copayment for each outpatient hospital visit Benefit does not apply to your combined deductible Out of Network $0 copayment for each specialist's office visit $0 copayment for each outpatient hospital visit Benefit does not apply to your combined deductible

Services that are covered for you	What you must pay when you get these services
Chiropractic services (Medicare-covered) Covered services include: • We cover only manual manipulation of the spine to correct subluxation	In Network $10 copayment for each specialist's office visit Benefit does not apply to your combined deductible Out of Network $10 copayment for each specialist's office visit Benefit does not apply to your combined deductible
Chiropractic services (Routine) • 30 combined In & Out of Network visit limit per plan year Additional coverage for chiropractic services that are not covered under Original Medicare. Covered services include, but are not limited to: • Pain relief • Neuromusculoskeletal disorders • Nausea	In Network $10 copayment for each specialist's office visit Benefit does not apply to your combined maximum out-of-pocket or combined deductible Out of Network $10 copayment for each specialist's office visit Benefit does not apply to your combined maximum out-of-pocket or combined deductible

Services that are covered for you	What you must pay when you get these services
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patient not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.	In Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit $0 copayment for each ambulatory surgical center visit $0 copayment for each outpatient hospital visit Benefit does not apply to your combined deductible Out of Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit $0 copayment for each ambulatory surgical center visit $0 copayment for each outpatient hospital visit Benefit does not apply to your combined deductible

Services that are covered for you	What you must pay when you get these services
Dental services (Medicare-covered) In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. However, Medicare currently pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation. In addition, we cover: • 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 or neoplastic disease • Services that would be covered when provided by a doctor	In Network $10 copayment for each specialist's office visit Out of Network $10 copayment for each specialist's office visit
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	In Network $0 copayment for each primary care physician's office visit Benefit does not apply to your combined deductible Out of Network $0 copayment for each primary care physician's office visit Benefit does not apply to your combined deductible

Services that are covered for you	What you must pay when you get these services
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	In Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit Benefit does not apply to your combined deductible Out of Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit Benefit does not apply to your combined deductible

Services that are covered for you	What you must pay when you get these services
Diabetes self-monitoring supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • These are the only covered brands of blood glucose monitors and test strips: ACCU-CHEK® manufactured by Roche, or Trividia products sometimes packaged under your pharmacy's name. • Humana covers any blood glucose monitors and test strips specified within the preferred brand list above. In general, alternate non-preferred brand products are not covered unless your doctor provides adequate information that the use of an alternate brand is medically necessary in your specific situation. If you are new to Humana and are using a brand of blood glucose monitor and test strips that are not on the preferred brand list, you may contact us within the first 90 days of enrollment into the plan to request a temporary supply of the alternate non-preferred brand. During this time, you should talk with your doctor to decide whether any of the preferred product brands listed above are medically appropriate for you. Non-preferred brand products will not be covered following the initial 90 days of coverage without an approved prior authorization for a coverage exception.	In Network Diabetic self-monitoring supplies $0 copayment from a preferred durable medical equipment provider $0 copayment from a durable medical equipment provider $0 copayment from a pharmacy Benefit does not apply to your combined deductible Continuous Glucose Monitors 0% coinsurance from a durable medical equipment provider 0% coinsurance from a pharmacy Medicare-covered diabetic monitoring supplies received from a pharmacy do not apply to your combined deductible.

Services that are covered for you	What you must pay when you get these services
Diabetes self-monitoring supplies (continued)	
• Preferred Continuous Glucose Monitors (CGMs) are available at pharmacies. Preferred CGMs are Dexcom & Freestyle Libre. Non-preferred CGMs are not available through a pharmacy unless your doctor provides adequate information that the use of an alternate brand is medically necessary. All CGMs will continue to be available through durable medical equipment providers (DME). • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.	Out of Network Diabetic self-monitoring supplies $0 copayment from a durable medical equipment provider $0 copayment from a pharmacy Benefit does not apply to your combined deductible Continuous Glucose Monitors 0% coinsurance from a durable medical equipment provider 0% coinsurance from a pharmacy Medicare-covered diabetic monitoring supplies received from a pharmacy do not apply to your combined deductible.

Services that are covered for you	What you must pay when you get these services
Diabetes self-management training For all people who have diabetes (insulin and non-insulin users) covered services include: • Diabetes self-management training is covered under certain conditions	In Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit $0 copayment for each outpatient hospital visit Benefit does not apply to your combined deductible Out of Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit $0 copayment for each outpatient hospital visit Benefit does not apply to your combined deductible

Services that are covered for you	What you must pay when you get these services
Diabetic Eye Exam For people with diabetes, screening for diabetic retinopathy is covered once per year. Contact the plan for details.	In Network $0 copayment for each specialist's office visit Benefit does not apply to your combined deductible Out of Network $0 copayment for each specialist's office visit Benefit does not apply to your combined deductible

Services that are covered for you	What you must pay when you get these services
Diagnostic Colonoscopy Colonoscopy services performed due to past or present history (such as gastrointestinal symptoms or disease, polyps, or cancer) or physical symptoms such as rectal bleeding or pain. • Prior authorization may be required. Contact the plan for details.	In Network $0 copayment for each specialist's office visit $0 copayment for each ambulatory surgical center visit $0 copayment for each outpatient hospital visit Benefit does not apply to your combined deductible Out of Network $0 copayment for each specialist's office visit $0 copayment for each ambulatory surgical center visit $0 copayment for each outpatient hospital visit Benefit does not apply to your combined deductible

Services that are covered for you	What you must pay when you get these services
Durable medical equipment (DME) and related supplies (For a definition of durable medical equipment, see Chapter 12 as well as Chapter 3, Section 7 of this document.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, walkers, and Continuous Glucose Monitors*. Also covers Part B insulin used through an insulin pump. You are covered for custom made and custom fitted compression stockings (unlimited pair(s) per year). One pair of therapeutic shoes with inserts, OR one pair of custom-made or custom-fit arch supports, and the fitting each calendar year, as durable medical equipment (DME). Therapeutic shoes with inserts are defined as: No more than 1 pair of custom-molded shoes (including inserts provided with the shoes) and 2 additional pairs of inserts; OR No more than 1 pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes). We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at **www.humana.com** Prior authorization may be required. *For Continuous Glucose Monitors, see Diabetes self-monitoring supplies	In Network 0% coinsurance at a durable medical equipment provider 0% coinsurance at a pharmacy Durable medical equipment received from a pharmacy do not apply to your combined deductible 0% coinsurance for custom made and custom fitted compression stockings (unlimited pair(s) per year). Benefit does not apply to your combined maximum out-of-pocket or combined deductible Cost sharing for covered Part B Insulin furnished through a covered item of durable medical equipment will be no more than $35 for a one-month (up to 30-day) supply and if your plan has a deductible, it does not apply to Part B Insulin. Plan requires prior authorization for durable medical equipment and related supplies. Call 1-800-523-0023, (TTY # 711)

Services that are covered for you	What you must pay when you get these services
Durable medical equipment (DME) and related supplies (continued)	Out of Network 0% coinsurance at a durable medical equipment provider 0% coinsurance at a pharmacy Durable medical equipment received from a pharmacy do not apply to your combined deductible 0% coinsurance for custom made and custom fitted compression stockings (unlimited pair(s) per year). Benefit does not apply to your combined maximum out-of-pocket or combined deductible Cost sharing for covered Part B Insulin furnished through a covered item of durable medical equipment will be no more than $35 for a one-month (up to 30-day) supply and if your plan has a deductible, it does not apply to Part B Insulin. Plan requires prior authorization for durable medical equipment and related supplies. Call 1-800-523-0023, (TTY # 711)

Services that are covered for you	What you must pay when you get these services
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost-sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. You are covered for emergency care worldwide. If you have an emergency outside of the U.S. and its territories, you will be responsible to pay for the services rendered upfront. You must submit to Humana for reimbursement; for more information please see Chapter 7. We may not reimburse you for all out-of-pocket expenses. This is because our contracted rates may be lower than provider rates outside of the U.S. and its territories. You are responsible for any costs exceeding our contracted rates as well as any applicable member cost-share.	You do not pay the emergency room visit cost share if you are admitted to the same hospital within 24 hours for the same condition, even if you are at a hospital outside of the United States. <u>In Network</u> $65 copayment for emergency services in an emergency room Benefit does not apply to your combined deductible <u>Out of Network</u> $65 copayment for emergency services in an emergency room Benefit does not apply to your combined deductible Worldwide Coverage: $65 copayment for emergency services outside of the U.S. and its territories. Benefit does not apply to your combined deductible or your combined out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Emergency care (continued)	If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital in order to pay the in-network cost-sharing amount for the part of your stay after you are stabilized. If you stay at the out-of-network hospital, your stay will be covered but you will pay the out-of-network cost-sharing amount for the part of your stay after you are stabilized.
Glaucoma screening For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older and Hispanic Americans who are 65 or older.	In Network $0 copayment for each specialist's office visit Benefit does not apply to your combined deductible Out of Network $0 copayment for each specialist's office visit Benefit does not apply to your combined deductible

Services that are covered for you	What you must pay when you get these services
Health and wellness education programs **Additional Telehealth Services** Use a phone, computer, tablet or other video technology for diagnosis and treatment of certain non-emergency medical care when your regular healthcare provider is not available. While this benefit is not intended to replace your regular healthcare provider, a virtual visit can sometimes be another option when your regular healthcare provider's office is not available or open. You are not required to use this benefit, and you can contact your regular healthcare provider's office to request an appointment. When you have an emergency, such as a life-threatening injury, illness or major trauma, call 911 or go to your nearest emergency room. Humana is not responsible for the availability or ongoing participation of any provider. Provider availability may change. Always make sure your provider is in the network before you receive care. If you want the name of the provider or need a provider directory you may access **www.humana.com/finder/provider-directories/** or call Customer Care. Covered services include but are not limited to: • Primary care physician services • Specialist services • Behavioral health and substance abuse services • Urgently needed care You have the option of getting these services either through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service via telehealth.	$0 copayment for each primary care physician - virtual visit $10 copayment for each specialist - virtual visit $0 copayment for each behavioral health and substance abuse - virtual visit $0 copayment for each urgent care - virtual visit Benefit does not apply to your combined deductible

Services that are covered for you	What you must pay when you get these services
Humana Health Coaching Work toward wellness with Humana Health Coaching • Develop a personalized action plan with a coach to set goals for a healthier lifestyle • Experience unlimited and ongoing (year-round) one-on-one interactions with a coach to reinforce healthy changes • Get support and guidance from a professional to help you achieve your health and wellness goals Contact Humana Health Coaching at 1-877-567-6450 (TTY: 711) Monday - Friday, 8 a.m. - 6 p.m., Eastern time for further details or to take advantage of this benefit.	$0 copayment Benefit does not apply to your combined maximum out-of-pocket or combined deductible Humana Health Coaching is available in all states.
Post-Discharge Personal Home Care With the Personal Home Care (PHC) benefit you will be eligible to receive services for a minimum of 4 hours per day up to a maximum of 8 hours per discharge from an inpatient hospitalization or skilled nursing facility stay. PHC includes certain in-home support services to assist individuals with disabilities and/or medical conditions in performing activities of daily living (ADLs) and Instrumental Activities of Daily living (IADLs) within the home by a qualified aide (e.g., assistance with bathing, dressing, toileting, walking, eating, shopping on behalf of the member for groceries or personal items, performing light housework, laundry, dishes, and/or using a telephone and preparing meals). A member must be receiving assistance with a minimum of one ADL to receive assistance with any IADL. Personal home care services must be initiated within 30 days of discharge event and utilized within 60 days of discharge. Prior authorization rules may apply. Call Customer Care for further details or to take advantage of this benefit after your discharge.	$0 copayment Benefit does not apply to your combined maximum out-of-pocket or combined deductible Personal Home Care is not available in Puerto Rico or U.S. territories.

Services that are covered for you	What you must pay when you get these services
Post-Discharge Transportation You are covered for 12 one-way trip(s) to plan-approved locations per inpatient facility discharge by car, van, or wheelchair access vehicle. There is a maximum allowed travel distance of 50 miles per trip. Benefit must be utilized within 60 days of inpatient discharge event. Benefit is subject to transportation provider availability within the plan service area. Please contact Customer Care for information on how to arrange transportation. Customer Care will confirm your benefits and guide you to the transportation provider to plan your trip. If you choose to receive services from an out-of-network provider, you will be responsible to pay for the entire cost of the services upfront. We may not reimburse you for all out-of-pocket expenses. You are responsible for any costs exceeding our contracted rates as well as any applicable member cost share. When using an out-of-network provider, you are responsible for submitting an out-of-network claim form with itemized receipt(s). For additional information, see Chapter 7.	<u>In Network</u> $0 copayment Benefit does not apply to your combined maximum out-of-pocket or combined deductible Post-Discharge Transportation is available in all states. <u>Out of Network</u> $0 copayment Benefit does not apply to your combined maximum out-of-pocket or combined deductible
SilverSneakers® Fitness SilverSneakers® is a fitness program for seniors that is included at no additional charge with qualifying Medicare health plans. Members have access to thousands of fitness locations across the country that may include weights and machines plus group exercise classes led by trained instructors at select locations. Access online education on SilverSneakers.com, watch workout videos on SilverSneakers On-Demand™ or download the SilverSneakers GO™ fitness app, for additional workout ideas. Any fitness center services that usually have an extra fee are not included in your membership.	$0 copayment Benefit does not apply to your combined maximum out-of-pocket or combined deductible SilverSneakers® Fitness is available in all states.

Services that are covered for you	What you must pay when you get these services
Smoking Cessation Program Stop smoking with help from a health coach. The Humana Health Horizons Wellness Coaching comprehensive tobacco and vaping cessation program includes: unlimited one-on-one coaching and access to resources. For eligible members, services also include a 3 month's supply of nicotine replacement therapy products. Contact Humana Health Horizons Wellness Coaching at 1-877-567-6450 (TTY: 711) Monday - Friday, 8 a.m. - 6 p.m., Eastern time for further details or to take advantage of this benefit.	$0 copayment Benefit does not apply to your combined maximum out-of-pocket or combined deductible Available in all states.
Post-Discharge Well Dine™ Meal Program After your inpatient stay in either the hospital or a nursing facility, you are eligible to receive 2 meals per day for 14 days, at no cost to you. 28 nutritious meals will be delivered to your home. These meals can be ordered by your care manager or may be ordered directly from the meal order vendor. The request must be completed within 30 days of your inpatient stay. Call Customer Care for further details or to take advantage of this benefit after your discharge. If you choose to receive services from an out-of-network provider, you will be responsible to pay for the entire cost of the services upfront. We may not reimburse you for all out-of-pocket expenses. You are responsible for any costs exceeding our contracted rates as well as any applicable member cost share. When using an out-of-network provider, you are responsible for submitting an out-of-network claim form with itemized receipt(s). For additional information, see Chapter 7.	<u>In Network</u> $0 copayment Benefit does not apply to your combined maximum out-of-pocket or combined deductible Well Dine™ Meal Program is available in all states. <u>Out of Network</u> $0 copayment Benefit does not apply to your combined maximum out-of-pocket or combined deductible

Services that are covered for you	What you must pay when you get these services
Hearing services (Medicare-covered)	
Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.	In Network $10 copayment for each specialist's office visit Out of Network $10 copayment for each specialist's office visit

Services that are covered for you	What you must pay when you get these services
Hearing services (Routine) You are covered for supplemental hearing benefits. Services that are covered for you: **Hearing Exam:** 1 routine hearing exam per year. **Hearing Aids:** An allowance applicable towards the cost of up to two [2] non-implantable hearing aid[s] in the applicable TruHearing formulary. After plan-paid benefit, you are responsible for the remaining costs, if any.* You must see a TruHearing provider to use this benefit. Call 1-888-939-3635 to schedule an appointment (for TTY, dial 711). Humana is not responsible for the availability or ongoing participation of any provider. In network hearing aid purchase includes: • First year of follow-up provider visits • 60-day trial period • 3-year extended warranty • 80 batteries per aid for non-rechargeable models In network benefit does not include or cover any of the following: • OTC hearing aids • Ear molds • Hearing aid accessories • Additional provider visits • Additional batteries • Hearing aids that are not in the applicable catalog • Costs associated with loss & damage warranty claims	<u>In Network</u> $0 copayment for routine hearing exams up to 1 per year. $500 maximum benefit coverage amount for each hearing aid(s) (all types) up to 1 per ear every 3 years. Note: Includes 80 batteries per aid and 3 year warranty. Benefit does not apply to your combined maximum out-of-pocket or combined deductible Any amount in excess of your allowance.* *Costs you pay for hearing services, including hearing exam copayments and hearing aid costs, will not count toward your out-of-pocket maximum. Routine Hearing benefit is not available in Puerto Rico

Services that are covered for you	What you must pay when you get these services
Hearing services (Routine) (continued)	
Costs associated with excluded items are the responsibility of the member and not covered by the plan. Provider availability may change. Always make sure your provider is in the TruHearing network before you receive care by scheduling appointments through TruHearing.	Out of Network $0 copayment for routine hearing exams up to 1 per year. $500 maximum benefit coverage amount for each hearing aid(s) (all types) up to 1 per ear every 3 years. Note: Includes 80 batteries per aid and 3 year warranty. Benefit does not apply to your combined maximum out-of-pocket or combined deductible *Routine hearing exam and hearing aid cost shares are not subject to the out-of-pocket maximum. If you choose to receive services from an out-of-network provider, you will be responsible to pay for the entire cost of the services upfront. We may not reimburse you for all out-of-pocket expenses. You are responsible for any costs exceeding our contracted rates as well as any applicable member cost share. When using an out-of-network provider, you are responsible for submitting an out-of-network claim form with itemized receipt(s). For additional information, see Chapter 7. .

Services that are covered for you	What you must pay when you get these services
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	In Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit Benefit does not apply to your combined deductible Out of Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit Benefit does not apply to your combined deductible

Services that are covered for you	What you must pay when you get these services
Home health agency care Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week.) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies • Prior authorization may be required for home health services. Contact the plan for details.	In Network $0 copayment for each home health visit Plan requires prior authorization for home health services. Call 1-800-523-0023, (TTY# 711) Out of Network $0 copayment for each home health visit Plan requires prior authorization for home health services. Call 1-800-523-0023, (TTY# 711)

Services that are covered for you	What you must pay when you get these services
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier	<u>In Network – Medical Supplies</u> 0% coinsurance at a medical supply provider 0% coinsurance at a pharmacy Medical supplies received from a pharmacy do not apply to your combined deductible <u>In Network - Medicare Part B Covered Drugs</u> 0% coinsurance for Medicare Part B drugs at a pharmacy $0 copayment for administration of drugs at a primary care physician's office $0 copayment for administration of drugs at a specialist's office Medicare Part B prescription drugs received from a pharmacy do not apply to your combined deductible <u>In Network - Physician/Practitioner services, including doctor's office visits</u> $5 copayment for each primary care physician's office visit

Services that are covered for you	What you must pay when you get these services
Home infusion therapy (continued)	Out of Network – Medical Supplies 0% coinsurance at a medical supply provider 0% coinsurance at a pharmacy Medical supplies received from a pharmacy do not apply to your combined deductible Out of Network – Medicare Part B Covered Drugs 0% coinsurance for Medicare Part B drugs at a pharmacy $0 copayment for administration of drugs at a primary care physician's office $0 copayment for administration of drugs at a specialist's office Medicare Part B prescription drugs received from a pharmacy do not apply to your combined deductible Out of Network – Physician/Practitioner services, including doctor's office visits $5 copayment for each primary care physician's office visit

Services that are covered for you	What you must pay when you get these services
Hospice care You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you are admitted to a hospice you have the right to remain in your plan; if you chose to remain in your plan you must continue to pay plan premiums. <u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis:</u> Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the consultation services that Original Medicare pays for. You will be billed Original Medicare cost sharing. <u>For services that are covered by Medicare Part A or B and are not related to your terminal prognosis:</u> If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (such as if there is a requirement to obtain prior authorization).	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Humana Group Medicare Advantage PPO Plan.

Services that are covered for you	What you must pay when you get these services
Hospice care (continued) • If you obtain the covered services from a network provider and follow plan rules for obtaining services, you only pay the plan cost-sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay the plan cost-sharing for out-of-network services For services that are covered by Humana Group Medicare Advantage PPO Plan but are not covered by Medicare Part A or B: Humana Group Medicare Advantage PPO Plan will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. For drugs that may be covered by the plan's Part D benefit: If these drugs are unrelated to your terminal hospice condition you pay cost sharing. If they are related to your terminal hospice condition then you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 *(What if you're in Medicare-certified hospice).* **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.	

Services that are covered for you	What you must pay when you get these services
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • COVID-19 Vaccine • Other vaccines if you are at risk and meet Medicare Part B coverage rules We also cover some vaccines under our Part D prescription drug benefit.	In Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit Benefit does not apply to your combined deductible Out of Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit Benefit does not apply to your combined deductible

Services that are covered for you	What you must pay when you get these services
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. You are covered for unlimited number of days for medically necessary services. Covered services include, but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals, including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational and speech language therapy • Inpatient substance abuse services	Your inpatient benefits will begin on day one each time you are admitted or transferred to a specific facility type, including Inpatient Rehabilitation facilities, Long Term Acute Care (LTAC) facilities, Inpatient Acute Care facilities, and Inpatient Psychiatric facilities. <u>In Network</u> $0 copayment per admission $0 copayment for physician services while inpatient at a hospital Plan requires prior authorization for inpatient services. Call 1-800-523-0023, (TTY# 711) <u>Out of Network</u> $0 copayment per admission $0 copayment for physician services while inpatient at a hospital Plan requires prior authorization for inpatient services. Call 1-800-523-0023, (TTY# 711)

Services that are covered for you	What you must pay when you get these services
Inpatient hospital care (continued) • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If Humana Group Medicare Advantage PPO Plan provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. If you are sent outside of your community for a transplant, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need- you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated to you by you or someone else. All other components of blood are covered beginning with the first pint used. • Physician services • Prior authorization is required for inpatient hospital care	

Services that are covered for you	What you must pay when you get these services
Inpatient hospital care (continued) • All transplant services must receive prior authorization. Call 1-866-421-5663 (TTY# 711) Monday-Friday 8:30 am-5 pm EST. **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called Are You a Hospital Inpatient or Outpatient? If You Have Medicare-Ask! This fact sheet is available on the Web at **https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf** or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	

Services that are covered for you	What you must pay when you get these services
Inpatient services in a psychiatric hospital	
• Covered services include mental health care services that require a hospital stay. • 190-day lifetime limit for inpatient services in a psychiatric hospital. • The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital. • The benefit days used under the Original Medicare program will count toward the 190-day lifetime reserve days when enrolling in a Medicare Advantage plan. • Prior authorization is required for inpatient mental health care.	Your inpatient benefits will begin on day one each time you are admitted or transferred to a specific facility type, including Inpatient Rehabilitation facilities, Long Term Acute Care (LTAC) facilities, Inpatient Acute Care facilities, and Inpatient Psychiatric facilities. <u>In Network</u> $0 copayment per admission in an inpatient hospital $0 copayment per admission in an inpatient psychiatric hospital $0 copayment for physician services at an inpatient psychiatric hospital Plan requires prior authorization for inpatient mental health care services. Call 1-800-523-0023, (TTY# 711) <u>Out of Network</u> $0 copayment per admission in an inpatient hospital $0 copayment per admission in an inpatient psychiatric hospital $0 copayment for physician services at an inpatient psychiatric hospital Plan requires prior authorization for inpatient mental health care services. Call 1-800-523-0023, (TTY# 711)

Services that are covered for you	What you must pay when you get these services
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy	<u>In Network</u> You are covered for these services according to Medicare guidelines when the psychiatric hospital or SNF days are not or are no longer covered. $0 copayment for physician services at an inpatient psychiatric hospital $0 copayment for physician services at a skilled nursing facility <u>Out of Network</u> You are covered for these services according to Medicare guidelines when the psychiatric hospital or SNF days are not or are no longer covered. $0 copayment for physician services at an inpatient psychiatric hospital $0 copayment for physician services at a skilled nursing facility

Services that are covered for you	What you must pay when you get these services
Laboratory services Covered services include, but are not limited to: • Blood tests • Tissue specimen tests • Screening tests • Urinalysis • Prior authorization may be required. Contact the plan for details.	In Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit $0 copayment for each urgent care center visit $0 copayment for each freestanding laboratory visit $0 copayment for each outpatient hospital visit Laboratory services received from a urgent care do not apply to your combined deductible

Services that are covered for you	What you must pay when you get these services
Laboratory services (continued)	Out of Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit $0 copayment for each urgent care center visit $0 copayment for each freestanding laboratory visit $0 copayment for each outpatient hospital visit Laboratory services received from a urgent care do not apply to your combined deductible

Services that are covered for you	What you must pay when you get these services
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when referred by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage Plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's referral. A physician must prescribe these services and renew their referral yearly if your treatment is needed into the next calendar year.	In Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit $0 copayment for each outpatient hospital visit Benefit does not apply to your combined deductible Out of Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit $0 copayment for each outpatient hospital visit Benefit does not apply to your combined deductible

Services that are covered for you	What you must pay when you get these services
Medical supplies Coverage for certain non-durable health care materials ordered by a provider. Covered items include, but are not limited to: • Catheters • Cotton swabs • IV set-ups and supplies • Surgical supplies including bandages and dressings • General supplies	In Network 0% coinsurance at a medical supply provider 0% coinsurance at a pharmacy Medical supplies received from a pharmacy do not apply to your combined deductible Out of Network 0% coinsurance at a medical supply provider 0% coinsurance at a pharmacy Medical supplies received from a pharmacy do not apply to your combined deductible
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	In Network $0 copayment Benefit does not apply to your combined deductible Out of Network $0 copayment Benefit does not apply to your combined deductible

Services that are covered for you	What you must pay when you get these services
Medicare Part B prescription drugs These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • 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, and erythropoiesis-stimulating agents (such as Epogen(R), Procrit(R), Epoetin Alfa, Aranesp(R), or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases	In Network $0 copayment for administration of drugs at a primary care physician's office $0 copayment for administration of drugs at a specialist's office 0% coinsurance for Medicare Part B drugs at a pharmacy Medicare Part B prescription drugs received from pharmacy do not apply to your combined deductible You will pay no more than $35 for a one-month (up to 30-day) supply for all Part B insulin covered by our plan, and if your plan has a deductible it does not apply to the Part B insulin.

Services that are covered for you	What you must pay when you get these services
Medicare Part B prescription drugs (continued) • Prior authorization may be required for Part B drugs. You may also have to try a different drug first before we will agree to cover the drug you are requesting. This is called "step therapy." Contact the plan for details. The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: **www.humana.com/PAL** We also cover some vaccines under our Part B and Part D prescription drug benefit. Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.	Out of Network $0 copayment for administration of drugs at a primary care physician's office $0 copayment for administration of drugs at a specialist's office 0% coinsurance for Medicare Part B drugs at a pharmacy Medicare Part B prescription drugs received from pharmacy do not apply to your combined deductible You will pay no more than $35 for a one-month (up to 30-day) supply for all Part B insulin covered by our plan, and if your plan has a deductible it does not apply to the Part B insulin.
Nuclear medicine Covered services include, but are not limited to: • PET scans • NOPR • SPECT • Prior authorization may be required. Contact the plan for details.	In Network $0 copayment for nuclear medicine at a freestanding radiological facility $0 copayment for nuclear medicine at an outpatient hospital Out of Network $0 copayment for nuclear medicine at a freestanding radiological facility $0 copayment for nuclear medicine at an outpatient hospital

Services that are covered for you	What you must pay when you get these services
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	In Network $0 copayment for each primary care physician's office visit Benefit does not apply to your combined deductible Out of Network $0 copayment for each primary care physician's office visit Benefit does not apply to your combined deductible

Services that are covered for you	What you must pay when you get these services
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications. • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	In Network $0 copayment for each specialist's office visit $0 copayment for each outpatient hospital visit Benefit does not apply to your combined deductible Out of Network $0 copayment for each specialist's office visit $0 copayment for each outpatient hospital visit Benefit does not apply to your combined deductible

Services that are covered for you	What you must pay when you get these services
Outpatient Basic Radiological Services Covered services include, but are not limited to: • Radiologic examination • X-rays • Prior authorization may be required. Contact the plan for details.	In Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit $0 copayment for each urgent care center visit $0 copayment for each freestanding radiological facility visit $0 copayment for each outpatient hospital visit Out of Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit $0 copayment for each urgent care center visit $0 copayment for each freestanding radiological facility visit $0 copayment for each outpatient hospital visit

Services that are covered for you	What you must pay when you get these services
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used • Other outpatient diagnostic tests • Prior authorization may be required. Contact the plan for details.	<u>In Network</u> $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit $0 copayment for each urgent care center visit $0 copayment for each freestanding radiological facility visit $0 copayment for each outpatient hospital visit <u>Out of Network</u> $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit $0 copayment for each urgent care center visit $0 copayment for each freestanding radiological facility visit $0 copayment for each outpatient hospital visit

Services that are covered for you	What you must pay when you get these services
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask! This fact sheet is available on the Web at **https:/www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf** or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	In Network $0 copayment for each outpatient hospital visit Out of Network $0 copayment for each outpatient hospital visit

Services that are covered for you	What you must pay when you get these services
Outpatient mental health care (Group Session) Covered services include: Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.	In Network $5 copayment for each primary care physician's office visit $5 copayment for each specialist's office visit $10 copayment for each urgent care center visit $5 copayment for each outpatient hospital visit Out of Network $5 copayment for each primary care physician's office visit $5 copayment for each specialist's office visit $10 copayment for each urgent care center visit $5 copayment for each outpatient hospital visit

Services that are covered for you	What you must pay when you get these services
Outpatient mental health care (Individual Session)	
Covered services include: Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.	In Network $10 copayment for each primary care physician's office visit $10 copayment for each specialist's office visit $10 copayment for each urgent care center visit $10 copayment for each outpatient hospital visit Out of Network $10 copayment for each primary care physician's office visit $10 copayment for each specialist's office visit $10 copayment for each urgent care center visit $10 copayment for each outpatient hospital visit

Services that are covered for you	What you must pay when you get these services
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs). Prior authorization is required for physical, occupational, and speech therapies.	In Network $0 copayment for each specialist's office visit $0 copayment for each comprehensive outpatient rehabilitation facility (CORF) visit $0 copayment for each outpatient hospital visit Out of Network $0 copayment for each specialist's office visit $0 copayment for each comprehensive outpatient rehabilitation facility (CORF) visit $0 copayment for each outpatient hospital visit

Services that are covered for you	What you must pay when you get these services
Outpatient substance abuse services (Group Session) You are covered for group outpatient mental health services for treatment to prevent alcohol and drug abuse. • Prior authorization may be required. Contact the plan for details.	In Network $5 copayment for each primary care physician's office visit $5 copayment for each specialist's office visit $10 copayment for each urgent care center visit $5 copayment for each outpatient hospital visit Out of Network $5 copayment for each primary care physician's office visit $5 copayment for each specialist's office visit $10 copayment for each urgent care center visit $5 copayment for each outpatient hospital visit

Services that are covered for you	What you must pay when you get these services
Outpatient substance abuse services (Individual Session) You are covered for individual outpatient mental health services for treatment to prevent alcohol and drug abuse. • Prior authorization may be required. Contact the plan for details.	<u>In Network</u> $10 copayment for each primary care physician's office visit $10 copayment for each specialist's office visit $10 copayment for each urgent care center visit $10 copayment for each outpatient hospital visit <u>Out of Network</u> $10 copayment for each primary care physician's office visit $10 copayment for each specialist's office visit $10 copayment for each urgent care center visit $10 copayment for each outpatient hospital visit

Services that are covered for you	What you must pay when you get these services
Outpatient surgery, including services provided at hospital facilities and ambulatory surgical centers **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient. • Prior authorization is required for abdominoplasty, balloon sinuplasty, blepharoplasty, breast procedures, otoplasty, elective outpatient cardiac catheterizations, penile implant, rhinoplasty, obesity, oral surgeries, and surgery for obstructive sleep apnea	In Network $5 copayment for each primary care physician's office visit $10 copayment for each specialist's office visit $10 copayment for each urgent care center visit $0 copayment for each ambulatory surgical center visit $0 copayment for each outpatient hospital visit Out of Network $5 copayment for each primary care physician's office visit $10 copayment for each specialist's office visit $10 copayment for each urgent care center visit $0 copayment for each ambulatory surgical center visit $0 copayment for each outpatient hospital visit

Services that are covered for you	What you must pay when you get these services
Partial hospitalization services and Intensive outpatient services (Group Session) Partial hospitalization is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's or therapist's office but less intense than partial hospitalization. Prior authorization is required for partial hospitalization services	In Network $0 copayment for each partial hospitalization visit Out of Network $0 copayment for each partial hospitalization visit

Services that are covered for you	What you must pay when you get these services
Partial hospitalization services and Intensive outpatient services (Individual Session) Partial hospitalization is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's or therapist's office but less intense than partial hospitalization. Prior authorization is required for partial hospitalization services	In Network $0 copayment for each partial hospitalization visit Out of Network $0 copayment for each partial hospitalization visit
Physical exams (Routine) In addition to the Annual Wellness Visit or the Welcome to Medicare physical exam, you are covered for the following exam once per year: • Comprehensive preventive medicine evaluation and management, including an age and gender appropriate history, examination, and counseling/anticipatory guidance/risk factor reduction interventions • **Note**: Any lab or diagnostic procedures that are ordered are not covered under this benefit and you pay your plan cost-sharing amount for those services separately.	In Network $0 copayment for each primary care physician's office visit Benefit does not apply to your combined deductible Out of Network $0 copayment for each primary care physician's office visit Benefit does not apply to your combined deductible

Services that are covered for you	What you must pay when you get these services
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment • Certain telehealth services including consultation, diagnosis, and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare • You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if:	<u>In Network</u> $5 copayment for each primary care physician's office visit $10 copayment for each specialist's office visit <u>Out of Network</u> $5 copayment for each primary care physician's office visit $10 copayment for each specialist's office visit

Services that are covered for you	What you must pay when you get these services
Physician/Practitioner services, including doctor's office visits (continued) • You have an in-person visit within 6 months prior to your first telehealth visit • You have an in-person visit every 12 months while receiving these telehealth services • Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if:** • You're not a new patient **and** • The check-in isn't related to an office visit in the past 7 days **and** • The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if:** • You're not a new patient **and** • The evaluation isn't related to an office visit in the past 7 days **and** • The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record • Second opinion by another network provider prior to surgery	

Services that are covered for you	What you must pay when you get these services
Physician/Practitioner services, including doctor's office visits (continued) • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)	

Services that are covered for you	What you must pay when you get these services
Podiatry services (Medicare-covered) Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs)	In Network $10 copayment for each specialist's office visit Out of Network $10 copayment for each specialist's office visit
Podiatry services (Routine) Covered services include the following: • Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs • 6 combined In & Out of Network visit limit per plan year	In Network $10 copayment for each specialist's office visit Benefit does not apply to your combined maximum out-of-pocket or combined deductible Out of Network $10 copayment for each specialist's office visit Benefit does not apply to your combined maximum out-of-pocket or combined deductible

Services that are covered for you	What you must pay when you get these services
Private duty nursing We cover skilled nursing services provided by a private duty nurse who holds a valid, recognized nursing certificate and is licensed according to the state law in the state where services are received. Valid, recognized nursing certificates and licenses include those of a registered nurse (RN), licensed practical nurse (LPN), or licensed vocational nurse (LVN). $5000 combined In & Out of Network maximum benefit coverage amount per year Note: Custodial and domestic services are not covered.	In Network 0% coinsurance for each member home visit Benefit does not apply to your combined maximum out-of-pocket or combined deductible Out of Network 0% coinsurance for each member home visit Benefit does not apply to your combined maximum out-of-pocket or combined deductible

Services that are covered for you	What you must pay when you get these services
Prostate cancer screening exams For men, age 50 and older, covered services include the following once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	In Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit Benefit does not apply to your combined deductible Out of Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit Benefit does not apply to your combined deductible

Services that are covered for you	What you must pay when you get these services
Prosthetic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see Vision Care later in this section for more detail. • Prior authorization is required for prosthetic devices	In Network 0% coinsurance from a prosthetics provider Plan requires prior authorization for prosthetic devices and related supplies. Call 1-800-523-0023, (TTY# 711) Out of Network 0% coinsurance from a prosthetics provider Plan requires prior authorization for prosthetic devices and related supplies. Call 1-800-523-0023, (TTY# 711)

Services that are covered for you	What you must pay when you get these services
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	In Network $10 copayment for each specialist's office visit $0 copayment for each comprehensive outpatient rehabilitation facility (CORF) visit $0 copayment for each outpatient hospital visit Out of Network $10 copayment for each specialist's office visit $0 copayment for each comprehensive outpatient rehabilitation facility (CORF) visit $0 copayment for each outpatient hospital visit

Services that are covered for you	What you must pay when you get these services
Radiation therapy Covered services include: • Radiation (radium and isotope) therapy including technician materials and supplies • Prior authorization is required for radiation therapy	In Network $0 copayment for each specialist's office visit $0 copayment for each freestanding radiological facility visit $0 copayment for each outpatient hospital visit Out of Network $0 copayment for each specialist's office visit $0 copayment for each freestanding radiological facility visit $0 copayment for each outpatient hospital visit

Services that are covered for you	What you must pay when you get these services
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	In Network $0 copayment for each primary care physician's office visit Benefit does not apply to your combined deductible Out of Network $0 copayment for each primary care physician's office visit Benefit does not apply to your combined deductible

Services that are covered for you	What you must pay when you get these services
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are:** people aged 50-77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack/years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making 'visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or a qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	In Network $0 copayment for each specialist's office visit $0 copayment for each freestanding radiological facility visit $0 copayment for each outpatient hospital visit Benefit does not apply to your combined deductible Out of Network $0 copayment for each specialist's office visit $0 copayment for each freestanding radiological facility visit $0 copayment for each outpatient hospital visit Benefit does not apply to your combined deductible

Services that are covered for you	What you must pay when you get these services
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to two individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	In Network $0 copayment for each primary care physician's office visit Benefit does not apply to your combined deductible Out of Network $0 copayment for each primary care physician's office visit Benefit does not apply to your combined deductible

Services that are covered for you	What you must pay when you get these services
Services to treat kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3), or when your provider for this service is temporarily unavailable or inaccessible • Inpatient dialysis treatments (if you are admitted to a hospital for special care). • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments). • Home dialysis equipment and supplies. • Certain home support services (such as when medically necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply). Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section Medicare Part B prescription drugs.	**Kidney Disease Education Services** <u>In Network</u> $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit $0 copayment for each outpatient hospital visit Benefit does not apply to your combined deductible <u>Out of Network</u> $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit $0 copayment for each outpatient hospital visit Benefit does not apply to your combined deductible

Services that are covered for you	What you must pay when you get these services
Services to treat kidney disease(continued)	**Renal Dialysis Services** In Network $0 copayment for each dialysis center visit $0 copayment for each outpatient hospital visit Out of Network $0 copayment for each dialysis center visit $0 copayment for each outpatient hospital visit

Services that are covered for you	What you must pay when you get these services
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility, see the chapter titled "Definitions of Important Words" of this document. Skilled nursing facilities are sometimes called SNFs.) You are covered for medically necessary days 1-100 for each benefit period. Prior hospital stay is not required. Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need- you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated to you by you or someone else. All other components of blood are covered beginning with the first pint used • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment.	Per benefit period, you pay: <u>In Network</u> $0 copayment at a skilled nursing facility per day, days 1-100 $0 copayment for physician services at a skilled nursing facility Plan requires prior authorization for skilled nursing facility care services. Call 1-800-523-0023, (TTY# 711) <u>Out of Network</u> $0 copayment at a skilled nursing facility per day, days 1-100 $0 copayment for physician services at a skilled nursing facility Plan requires prior authorization for skilled nursing facility care services. Call 1-800-523-0023, (TTY# 711)

Services that are covered for you	What you must pay when you get these services
Skilled nursing facility (SNF) care (continued) • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital • Prior authorization is required for inpatient skilled nursing care A new skilled nursing benefit period will begin on day one when you first enroll in a Humana Medicare Advantage plan, or you have been discharged from a skilled nursing facility (or not received inpatient skilled level of care) for **60** consecutive days.	

Services that are covered for you	What you must pay when you get these services
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)	
If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you from a network provider. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period; however, you will pay the applicable inpatient or outpatient cost-sharing. Each counseling attempt includes up to four face-to-face visits.	If you use tobacco, but do not have signs or symptoms of tobacco-related disease: In Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit Benefit does not apply to your combined deductible Out of Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit Benefit does not apply to your combined deductible

Services that are covered for you	What you must pay when you get these services
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, compromising a therapeutic exercise-training program for PAD patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	In Network $0 copayment for each specialist's office visit $0 copayment for each outpatient hospital visit Out of Network $0 copayment for each specialist's office visit $0 copayment for each outpatient hospital visit

Services that are covered for you	What you must pay when you get these services
Transportation (Routine)	
Coverage for non-emergent transportation of a patient to plan-approved facilities. Transportation benefit through ModivCare Contact ModivCare at 1-866-588-5121 for information on how to arrange transportation. ModivCare will confirm your benefits and guide you to the transportation provider to plan your trip. If you choose to receive services from an out-of-network provider, you will be responsible to pay for the entire cost of the services upfront. We may not reimburse you for all out-of-pocket expenses. You are responsible for any costs exceeding our contracted rates as well as any applicable member cost share. When using an out-of-network provider, you are responsible for submitting an out-of-network claim form with itemized receipt(s). For additional information, see Chapter 7.	In Network $0 copayment for plan approved location up to 24 one-way trip(s) per year by car, van, wheelchair access vehicle. This benefit is not to exceed 50 miles per trip. Benefit does not apply to your combined maximum out-of-pocket or combined deductible Out of Network $0 copayment for plan approved location up to 24 one-way trip(s) per year by car, van, wheelchair access vehicle. This benefit is not to exceed 50 miles per trip. Benefit does not apply to your combined maximum out-of-pocket or combined deductible

Services that are covered for you	What you must pay when you get these services
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. If it is unreasonable given your circumstances to immediately obtain the medical care from a network provider, then your plan will cover the urgently needed services from a provider out-of-network. Services must be immediately needed and medically necessary. Examples of urgently needed services that the plan must cover out of network occur if: You are temporarily outside the service area of the plan and require medically needed immediate services for an unforeseen condition but it is not a medical emergency; or it is unreasonable given your circumstances to immediately obtain the medical care from a network provider. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. You are covered for urgently needed services world-wide. If you have an urgent need for care while outside of the U.S. and its territories, you will be responsible to pay for the services rendered upfront. You must submit proof of payment to Humana for reimbursement. For more information please see the chapter titled *"Asking us to pay our share of a bill you have received for covered medical services or drugs"*. We may not reimburse you for all out of pocket expenses. This is because our contracted rates may be lower than provider rates outside of the U.S. and its territories. You are responsible for any costs exceeding our contracted rates as well as any applicable member cost-share.	In Network $5 copayment for each primary care physician's office visit $10 copayment for each specialist's office visit $10 copayment for each urgent care center visit Benefit does not apply to your combined deductible Out of Network $5 copayment for each primary care physician's office visit $10 copayment for each specialist's office visit $10 copayment for each urgent care center visit Benefit does not apply to your combined deductible

Services that are covered for you	What you must pay when you get these services
Vision services (Medicare-covered)	
Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. • For people with diabetes, screening for diabetic retinopathy is covered once per year. • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.	<u>In Network</u> $10 copayment for each specialist's office visit $0 copayment for eyeglasses and contact lenses following cataract surgery Eyewear (Post Cataract Surgery) received at a specialist's office do not apply to your combined deductible <u>Out of Network</u> $10 copayment for each specialist's office visit $0 copayment for eyeglasses and contact lenses following cataract surgery Eyewear (Post Cataract Surgery) received at a specialist's office do not apply to your combined deductible

Services that are covered for you	What you must pay when you get these services
Vision services (Routine): Exam only Benefit Vision benefit through **Humana Medicare Insight Network** includes: Routine exam (includes refraction*) • The benefit can only be used one time. Any remaining benefit dollars do not "roll over" to a future plan years. *Refraction is only covered in conjunction with a comprehensive routine eye exam OR A refraction exam may be covered (1 per calendar year) when completed during a comprehensive eye exam and performed by a Humana network medical provider Please inform the network provider that you are part of the **Humana Medicare Insight Network**. When using an out-of-network provider, you will be responsible for costs above the plan approved amount. The provider locator for the Humana Medicare Insight Network for routine vision can be found at **Humana.com > Find a Doctor > Select the Vision Care icon > Select Medicare > Select Medicare Advantage.**	In Network $0 copayment for routine exam (includes refraction) up to 1 per year. Benefit does not apply to your combined maximum out-of-pocket or combined deductible Out of Network $175 combined maximum benefit coverage amount per year for routine exam (includes refraction). $0 copayment for routine exam (includes refraction) up to 1 per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. Benefit does not apply to your combined maximum out-of-pocket or combined deductible *Benefit is limited to one time use per year.

Services that are covered for you	What you must pay when you get these services
Welcome to Medicare preventive visit The plan covers the one-time Welcome to Medicare preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the Welcome to Medicare preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your Welcome to Medicare preventive visit. Note: Any lab or diagnostic procedures that are ordered are not covered under this benefit and you pay your plan cost-sharing amount for those services separately.	In Network $0 copayment for each primary care physician's office visit Benefit does not apply to your combined deductible Out of Network $0 copayment for each primary care physician's office visit Benefit does not apply to your combined deductible

Services that are covered for you	What you must pay when you get these services
Wigs (medically necessary) Coverage for medically necessary wigs related to ongoing treatment. • Prior authorization may be required. Contact the plan for details. • $750 combined In & Out of Network maximum benefit coverage amount per year	In Network 0% coinsurance from prosthetics provider 0% coinsurance from durable medical equipment provider Benefit does not apply to your combined maximum out-of-pocket or combined deductible Out of Network 0% coinsurance from prosthetics provider 0% coinsurance from durable medical equipment provider Benefit does not apply to your combined maximum out-of-pocket or combined deductible

SECTION 3 What services are not covered by the plan?

Section 3.1 Services we do not cover (exclusions)

This section tells you what services are excluded from Medicare coverage and therefore, are not covered by this plan.

The chart below lists services and items that either are not covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you receive the excluded services at an emergency facility, the excluded services are still not covered and our plan will not pay for them.

The only exception: is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 5.3 in this document.)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Cosmetic surgery or procedures		• Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. • Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Custodial care Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.	Not covered under any condition	
Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance)		• Covered only when medically necessary
Experimental medical and surgical procedures, equipment, and medications Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community		• May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)
Fees charged for care by your immediate relatives or members of your household	Not covered under any condition	
Full-time nursing care in your home	Not covered under any condition	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Home-delivered meals		• If included in the Well Dine™ benefit
Homemaker services include basic household assistance, including light housekeeping or light meal preparation	Not covered under any condition	
Naturopath services (uses natural or alternative treatments)	Not covered under any condition	
Non-routine dental care		• Dental care required to treat illness or injury may be covered as inpatient or outpatient care
Orthopedic shoes or supportive devices for the feet		• Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease
Personal items in your room at a hospital or skilled nursing facility, such as a telephone or a television	Not covered under any condition	
Private room in a hospital		• Covered only when medically necessary
Reversal of sterilization procedures and/or non-prescription contraceptive supplies	Not covered under any condition	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Routine dental care, such as cleanings, fillings or dentures	Not covered under any condition	
Services considered not reasonable and necessary, according to Original Medicare standards	Not covered under any condition	
Services provided to veterans in Veterans Affairs (VA) facilities		• When emergency services are received at VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts
Purchase, instead of rental, of durable medical equipment that Original Medicare does not allow to be purchased outright.	Not covered under any condition	

CHAPTER 5:

Using the plan's coverage for Part D prescription drugs

SECTION 1 Introduction

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

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

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

- You must have a provider (a doctor, dentist or other prescriber) write you a prescription which must be valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription. (See Section 2, *Fill your prescriptions at a network pharmacy or through the plan's mail-order service.*)
- Your drug must be in the plan's *Prescription Drug Guide* (Formulary) (we call it the "*Drug Guide*" for short). (See Section 3, *Your drugs need to be on the plan's "Drug Guide"*).
- Your drug must be used for a medically accepted indication. A medically accepted indication is a use of the drug that is either approved by the Food and Drug Administration or supported by certain references. (See Section 3 for more information about a medically accepted indication.)

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

Section 2.1 Use a network pharmacy

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

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

Section 2.2 Network pharmacies

How do you find a network pharmacy in your area?

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

You may go to any of our network pharmacies. Some of our network pharmacies provide preferred cost sharing, which may be lower than the cost sharing at a pharmacy that offers standard cost sharing. *The Pharmacy Directory* will tell you which of the network pharmacies offer preferred cost sharing. Contact us to find out more about how your out-of-pocket costs could vary for different drugs.

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

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

What if you need a specialized pharmacy?

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

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

To locate a specialized pharmacy, look in your *Provider Directory* or call Customer Care.

Section 2.3 Using the plan's mail-order service

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

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

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

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

New prescriptions the pharmacy receives directly from your doctor's office.

The pharmacy will automatically fill and deliver new prescriptions it receives from health care providers, without checking with you first, if either:

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

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

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

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

To opt out of automatic deliveries of new prescriptions received directly from your health care provider's office, please contact us by calling Customer Care.

Refills on mail order prescriptions. For refills, please contact your pharmacy 14 business days before your current prescription will run out to make sure your next order is shipped to you in time.

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

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

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

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs. Your *Provider Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Customer Care for more information.

2. You may also receive maintenance drugs through our mail-order program. Please see Section 2.3 for more information.

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

Your prescription may be covered in certain situations

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

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

- **If you need a prescription because of a medical emergency**

  - We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care. In this situation, you will have to pay the full cost (rather than paying just your copayment or coinsurance) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a paper claim form. If the prescription is covered, it will be covered at an out-of-network rate. If you go to an out-of-network pharmacy, you may be responsible for paying the difference between what we would pay for a prescription filled at a network pharmacy and what the out-of-network pharmacy charged for your prescription. (Chapter 7, Section 2.1 explains how to ask the plan to pay you back.)

- **If you need coverage while you are traveling away from the plan's service area**

  - If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. You may be able to order your prescription drugs ahead of time through our prescription mail-order or through a retail network pharmacy that offers an extended supply. If you are traveling outside of your plan's service area but within the United States and territories and become ill, or run out of your prescription drugs, call Customer Care to find a network pharmacy in your area where you can fill your prescription. If a network pharmacy is not available, we will cover prescriptions that are filled at an out-of-network pharmacy if you follow all other coverage rules identified within this document. In this situation, you will have to pay the full cost (rather than paying just your copayment or coinsurance) when you fill your prescription.

  - **If the prescription is covered, it will be covered at an out-of-network rate**. You may be responsible for paying the difference between what we would pay for a prescription filled at an in-network pharmacy and what the out-of-network pharmacy charged for your prescription. You can ask us to reimburse you for our share of the cost by submitting a paper claim form. (Chapter 7, Section 2 explains how to ask the plan to pay you back.)

- **Please recognize, however, that multiple non-emergency occurrences of out-of-network pharmacy claims will result in claim denials. In addition, we cannot pay for any stolen medications or prescriptions that are filled by pharmacies outside the United States and territories, even for a medical emergency, for example on a cruise ship.**

Other times you can get your prescription covered if you go to an out-of-network pharmacy. These situations will be covered at an out-of-network rate. In these situations, you will have to pay the full cost (rather than paying just your copayment or coinsurance) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a paper claim form. If you go to an out-of-network pharmacy or provider, you may be responsible for paying the difference between what we would pay for a prescription filled at an in-network pharmacy and what the out-of-network pharmacy charged for your prescription. (Chapter 7, Section 2.1 explains how to ask the plan to pay you back.) We will cover your prescription at an out-of-network pharmacy if at least one of the following applies:

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

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 7, Section 2.1 explains how to ask the plan to pay you back.)

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

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

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

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

The drugs in the "Drug Guide" are only those covered under Medicare Part D.

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

- Approved by the Food and Drug Administration for the diagnosis or condition for which it is being prescribed.

- -- *or* -- Supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

The "Drug Guide" includes brand name and generic drugs

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Brand name drugs that are more complex than typical drugs (for example, drugs that are based on a protein) are called biological products. On the "Drug Guide", when we refer to drugs, this could mean a drug or a biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Generally, generics work just as well as the brand name drug and usually cost less. There are generic drug substitutes available for many brand name drugs and some biological products.

Over-the-Counter Drugs

Our plan may also cover certain over-the-counter drugs. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. For more information, call Customer Care.

What is *not* in the "Drug Guide"?

The plan does not cover all prescription drugs.

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

Section 3.2 There are four cost-sharing tiers for drugs in the "Drug Guide"

Every drug in the plan's "Drug Guide" is in one of four cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug:

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

To find out which cost-sharing tier your drug is in, look it up in the plan's "Drug Guide". The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6 (*What you pay for your Part D prescription drugs*).

Section 3.3 How can you find out if a specific drug is in the "Drug Guide"?

You have four ways to find out:

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

2. Visit the plan's website **www.humana.com**. The "Drug Guide" on the website is always the most current

3. Call Customer Care to find out if a particular drug is in the plan's "Drug Guide" or to ask for a copy of the "Drug Guide".

4. Use the plan's "Real-Time Benefit Tool" by visiting **www.humana.com** and logging into MyHumana or by calling Customer Care. With this tool you can search for drugs on the "Drug Guide" to see an estimate of what you will pay and if there are alternative drugs on the "Drug Guide" that could treat the same condition.

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective ways.

To find out if any of these restrictions apply to a drug you take or want to take, check the "Drug Guide". If a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option.

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

Section 4.2 What kinds of restrictions?

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

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

Restricting brand name drugs or original biological products when a generic or interchangeable biosimilar version is available

Generally, a **generic** drug or interchangeable biosimilar works the same as a brand name drug or original biological product and usually costs less. **When a generic or interchangeable biosimilar version of a brand name drug or original biological product is available, our network pharmacies will provide you the generic or interchangeable biosimilar version instead of the brand name drug or original biological product.** However, if your provider has told us the medical reason that neither the generic drug, interchangeable biosimilar, nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug or original biological product. (Your share of the cost may be greater for the brand name drug or original biological product than for the generic drug or interchangeable biosimilar.)

Getting plan approval in advance

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

Trying a different drug first

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

Quantity limits

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

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

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

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

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug as explained in Section 4.
- The drug is covered, but it is in a cost-sharing tier that makes your cost-sharing more expensive than you think it should be.

There are things you can do if your drug is not covered in the way that you would like it to be covered.

- If your drug is not in the "Drug Guide" or if your drug is restricted, go to Section 5.2 to learn what you can do.
- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.

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

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

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

You may be able to get a temporary supply

Under certain circumstances, the plan must provide a temporary supply of a drug that you are already taking. This temporary supply gives you time to talk with your provider about the change in coverage and decide what to do.

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

- **If you are a new member,** we will cover a temporary supply of your drug during the first 90 days of your membership in the plan.

- **If you were in the plan last year,** we will cover a temporary supply of your drug during the first 90 days of the calendar year.

- This temporary supply will be for a maximum of 30 days. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of 30 days of medication. The prescription must be filled at a network pharmacy. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

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

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

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

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

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

- You transfer from one skilled nursing facility to another.

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

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

Policies for Temporary Drug Supplies During the Transition Period

We consider the first 90 days of the 2024 plan year a transition period if you're a new member, you changed plans, or there were changes in your drug coverage. As described above, there are several ways we make sure you can get a temporary supply of your drugs, if needed, during the transition period. During the first 90 days, you can get a temporary supply if you have a current prescription for a drug that's not in our "Drug Guide" or requires prior authorization because of restrictions. The conditions for getting a temporary supply are described below.

One-Time Transition Supply at a Retail or Mail-Order Pharmacy

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

Transition Supply if you're in a Long-Term Care Facility

We'll cover up to a 31-day supply of a drug covered by Medicare Part D. This coverage is available anytime during the 90-day transition period, as long as your current prescription is filled at a pharmacy in a long-term care facility. If you have a problem getting a prescribed drug later in the plan year (after the 90-day transition period), we'll cover up to a 31-day emergency supply of a drug covered by Medicare Part D. The emergency supply will let you continue your drug treatment while you and your doctor request an exception or prior authorization to continue.

Transition Period Extension

If you have requested an exception or made an appeal for drug coverage, it may be possible to extend the temporary transition period while we're processing your request. Call Customer Care if you believe we need to extend the transition period to make sure you continue to receive your drugs as needed.

Costs for Temporary Supplies

Your copayment or coinsurance for a temporary drug supply will be based on your plan's approved drug cost-sharing tiers. [If you're eligible for the low-income subsidy (LIS) in 2024, your copayment or coinsurance won't exceed your LIS limit.]

For questions about a temporary supply, call Customer Care.

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

1) You can change to another drug

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

2) You can ask for an exception

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

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

If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells you what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Section 5.3 What can you do if your drug is in a cost-sharing tier you think is too high?

If your drug is in a cost-sharing tier you think is too high, here are things you can do:

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, talk to your provider. There may be different drug in a lower cost-sharing tier that might work just as well for you. Call Customer Care to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

You can ask for an exception

For drugs in Cost Sharing Tier 2 - Generic, Cost Sharing Tier 3 - Preferred Brand, or Cost Sharing Tier 4 - Non-Preferred Drugs, you and your provider can ask the plan to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule.

If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells you what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Drugs in our Specialty Tier are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in this tier.

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

Section 6.1 The "Drug Guide" can change during the year

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

- **Add or remove drugs from the "Drug Guide".**
- **Move a drug to a higher or lower cost-sharing tier**
- **Add or remove a restriction on coverage for a drug**
- **Replace a brand name drug with a generic version of the drug**
- **Replace an original biological product with an interchangeable biosimilar version of the biological product.**

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

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

Information on changes to drug coverage

When changes to the "Drug Guide" occur we post information on our website about those changes. We also update our online "Drug Guide" on a regularly scheduled basis. Below we point out the times that you would get direct notice if changes are made to a drug that you are taking.

Changes to your drug coverage that affect you during the current plan year

- **A new generic drug replaces a brand name drug in the "Drug Guide" (or we change the cost-sharing tier or add new restrictions to the brand name drug or both).**

- We may immediately remove a brand name drug in our "Drug Guide" if we are replacing it with a newly approved generic version of the same drug. The generic drug will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. We may decide to keep the brand name drug in our "Drug Guide", but immediately move it to a higher cost-sharing tier or add new restrictions or both when the new generic is added.

- We may not tell you in advance before we make that change -- even if you are currently taking the brand name drug. If you are taking the brand name drug at the time we make the change, we will provide you with information about the specific change(s). This will also include information on the steps you may take to request an exception to cover the brand name drug. You may not get this notice before we make the change.

- You or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 9.

- **Unsafe drugs and other drugs in the "Drug Guide" that are withdrawn from the market**

  - Sometimes, a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the "Drug Guide". If you are taking that drug, we will tell you right away.

  - Your prescriber will also know about this change and can work with you to find another drug for your condition.

- **Other changes to drugs in the "Drug Guide"**

  - We may make other changes once the year has started that affect drugs you are taking. For example, we might add a generic drug that is not new to the market to replace a brand name drug on the Drug Guide or change the cost-sharing tier or add new restrictions to the brand name drug or both. We also might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare.

  - For these change, we must give you at least 30 days advance notice of the change or give you notice of the change and a 30-day refill of the drug you are taking at a network pharmacy.

  - After you receive notice of the change, you should work with your provider to switch to a different drug that we cover or to satisfy any new restrictions on the drug you are taking.

  - You or your prescriber can ask us to make an exception and continue to cover the drug for you. For information on how to ask for an exception, see Chapter 9

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

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

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

- we move your drug into a higher cost-sharing tier.
- we put a new restriction on the use of your drug.
- we remove your drug from the "Drug Guide".

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

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

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

Section 7.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are excluded. This means Medicare does not pay for these drugs.

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

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

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States or its territories.
- Our plan usually cannot cover off-label use. Off-label use is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.

- Coverage for off-label use is allowed only when the use is supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

In addition, by law, the following categories of drugs are not covered by Medicare drug plans (Our plan covers certain drugs listed below through our enhanced drug coverage, for which you may be charged an additional premium. More information is provided below.)

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra, and Caverject
- Drugs used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

We offer additional coverage of some prescription drugs (enhanced drug coverage) not normally covered in a Medicare prescription drug plan. The amount you pay for these drugs does not count toward qualifying you for the Catastrophic Coverage Stage. (The Catastrophic Coverage Stage is described in Chapter 6, Section 7 of this document.)

In addition, if you are **receiving "Extra Help"** to pay for your prescriptions, the "Extra Help" program will not pay for the drugs not normally covered. (Please refer to the plan's "Drug Guide" or call Customer Care for more information. Phone numbers for Customer Care are printed on the back cover of this booklet.) However, if you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

SECTION 8 Filling a prescription

Section 8.1 Provide your membership information

To fill your prescription, provide your plan membership information, which can be found on your membership card, at the network pharmacy you choose. The network pharmacy will automatically bill the plan for *our* share of your drug cost. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription.

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

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

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

SECTION 9 Part D drug coverage in special situations

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

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

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

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

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

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

Please refer to Section 5.2 about a temporary or emergency supply

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

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

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

Special note about creditable coverage:

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

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

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

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

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

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

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

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

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

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

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

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

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

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

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

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

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

We have programs that can help our members with complex health needs.

One program is called a Medication Therapy Management (MTM) program. This program is voluntary and free. A team of pharmacists and doctors developed the program for us to help make sure that our members get the most benefit from the drugs they take.

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

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

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

CHAPTER 6:

What you pay for your Part D prescription drugs

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you**. We have included a separate insert, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the Low Income Subsidy Rider or the LIS Rider), which tells you about your drug coverage. If you don't have this insert, please call Customer Care and ask for the LIS Rider.

SECTION 1 Introduction

Section 1.1 Use this chapter together with other materials that explain your drug coverage

This chapter focuses on what you pay for Part D prescription drugs. To keep things simple, we use drug in this chapter to mean a Part D prescription drug. As explained in Chapter 5, not all drugs are Part D drugs - some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 5, Sections 1 through 4 explain these rules. When you use the plan's "Real-Time Benefit Tool" to look up drug coverage (see Chapter 5, Section 3.3), the cost shown is provided in "real time" meaning the cost you see in the tool reflects a moment in time to provide an estimate of the out-of-pocket costs you are expected to pay. You can also obtain information provided by the "Real-Time Benefit Tool" by calling Customer Care.

Section 1.2 Types of out-of-pocket costs you may pay for covered drugs

There are different types of out-of-pocket costs for Part D drugs. The amount that you pay for a drug is called *cost-sharing*, and there are three ways you may be asked to pay.

- **Deductible** is the amount you pay for drugs before our plan begins to pay its share.
- **Copayment** is a fixed amount you pay each time you fill a prescription.
- **Coinsurance** is a percentage of the total cost you pay each time you fill a prescription.

Section 1.3 How Medicare calculates your out-of-pocket costs

Medicare has rules about what counts and what does not count toward your out-of-pocket costs. Here are the rules we must follow to keep track of your out-of-pocket costs.

These payments <u>are included</u> in your out-of-pocket costs

<u>Your out-of-pocket costs include</u> the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 5):

- The amount you pay for drugs when you are in any of the following drug payment stages:
  - The Initial Coverage Stage
  - Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

It matters who pays:

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are *also included* in your out-of-pocket costs if they are made on your behalf by **certain other individuals or organizations**. This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, by a State Pharmaceutical Assistance Program that is qualified by Medicare, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.
- Some payments made by the Medicare Coverage Gap Discount Program are included in your out-of-pocket costs. The amount the manufacturer pays for your brand name drugs is included. But the amount the plan pays for your generic drugs is not included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $8,000 in out-of-pocket costs within the calendar year, you will move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

These payments <u>are not included</u> in your out-of-pocket costs

Your out-of-pocket costs **do not include** any of these types of payments:

- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.
- Prescription drugs covered by Part A or Part B.

- Payments you make toward drugs covered under our additional coverage but not normally covered in a Medicare Prescription Drug Plan.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments made by the plan for your brand or generic drugs while in the Coverage Gap.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Affairs.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan by calling Customer Care.

How can you keep track of your out-of-pocket total?

- **We will help you**. The Part D Explanation of Benefits (EOB) report you receive includes the current amount of your out-of-pocket costs. When this amount reaches $8,000, this report will tell you that you have left the Initial Coverage Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need**. Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

SECTION 2 What you pay for a drug depends on which drug payment stage you are in when you get the drug

Section 2.1 What are the drug payment stages for this plan's members?

There are four drug payment stages for your prescription drug coverage under your plan. How much you pay depends on what stage you are in when you get a prescription filled or refilled. Details of each stage are in Sections 4 through 7 of this chapter. The stages are:

Stage 1: Yearly Deductible Stage

Stage 2: Initial Coverage Stage

Stage 3: Coverage Gap Stage

Stage 4: Catastrophic Coverage Stage

SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in

Section 3.1 We send you a monthly summary called the *SmartSummary*

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

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

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

- **Information for that month**. This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.

- **Totals for the plan year.** This is called year-to-date information. It shows the total drug costs and total payments for your drugs since the plan year began.

- **Drug price information.** This information will display the total drug price, and information about increases in price from first fill for each prescription claim of the same quantity.

- **Available lower cost alternative prescriptions.** This will include information about other available drugs with lower cost-sharing for each prescription claim.

Section 3.2 Help us keep our information about your drug payments up to date

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

- **Show your membership card every time you get a prescription filled.** This helps us make sure we know about the prescriptions you are filling and what you are paying.

- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. Here are examples of when you should give us copies of your drug receipts:

- When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.
- When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
- Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
- If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.

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

SECTION 4 There is no deductible for this plan

There is no deductible for this plan. You begin in the Initial Coverage Stage when you fill your first prescription of the year. See Section 5 for information about your coverage in the Initial Coverage Stage.

SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs, and you pay your share

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription

During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share (your copayment or coinsurance amount). Your share of the cost will vary depending on the drug and where you fill your prescription.

The plan has four cost-sharing tiers

Every drug on the plan's *"Drug Guide"* is in one of four cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

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

To find out which cost-sharing tier your drug is in, look it up in the plan's *"Drug Guide"*. To see what you pay for drugs in the Initial Coverage Stage, including insulins, see Section 5.2 below.

Your pharmacy choices

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

- A network retail pharmacy
- A pharmacy that is not in the plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5 to find out when we will cover a prescription filled at an out-of-network pharmacy
- The plan's mail-order pharmacy

For more information about these pharmacy choices and filling your prescriptions, see Chapter 5 the plan's *Provider Directory.*

Section 5.2 A table that shows your costs for a *one-month* supply of a drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

As shown in the table below, the amount of the copayment or coinsurance depends on the cost-sharing tier.

Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

Your share of the cost when you get a *one-month* supply of a covered Part D prescription drug:

	Standard retail cost-sharing (in-network) (up to a 30 day supply)	**Mail-order cost-sharing (up to a 30 day supply)**	**Long-term care (LTC) cost-sharing (up to a 31 day supply)**	**Out-of-network cost-sharing (up to a 30 day supply)** (coverage is limited to certain situations; see Chapter 5 for details.)*
Cost-Sharing Tier 1 (Generic or Preferred Generic)	$8	$8	$8	$8
Cost-Sharing Tier 2 (Preferred Brand	$35	$35	$35	$35
Cost-Sharing Tier 3 (Non-Preferred Drug)	50% coinsurance ($100 minimum and $200 maximum out-of-pocket per prescription)	50% coinsurance ($100 minimum and $200 maximum out-of-pocket per prescription)	50% coinsurance ($100 minimum and $200 maximum out-of-pocket per prescription)	50% coinsurance ($100 minimum and $200 maximum out-of-pocket per prescription)
Cost-Sharing Tier 4 (Specialty)	50% coinsurance ($100 maximum out-of-pocket per prescription)	50% coinsurance ($100 maximum out-of-pocket per prescription)	50% coinsurance ($100 maximum out-of-pocket per prescription)	50% coinsurance ($100 maximum out-of-pocket per prescription)

You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.

Please see Section 8 of this chapter for more information on Part D vaccines cost sharing for Part D vaccines.

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

Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply

Typically, the amount you pay for a prescription drug covers a full month's supply. There may be times when you or your doctor would like you to have less than a month's supply of a drug (for example, when you are trying a medication for the first time.) You can also ask your doctor to prescribe, and your pharmacists to dispense, less than a full month's supply of your drugs, if this will help you better plan refill dates for different prescriptions.

If you receive less than a full month's supply of certain drugs, you will not have to pay the full month's supply.

- If you are responsible for coinsurance, you pay a percentage of the total cost of the drug. Since the coinsurance is based on the total cost of the drug, your cost will be lower since the total cost for the drug will be lower

- If you are responsible for a copayment for the drug, you will only pay for the number of days of the drug that you receive instead of a whole month. We will calculate the amount you pay per day for your drug (the daily cost-sharing rate) and multiply it by the number of days of the drug you receive.

Section 5.4 A table that shows your costs for a *long-term* (up to a 90-day) supply of a drug

- For some drugs, you can get a long-term supply (also called an extended supply). A long-term supply is up to a 90-day supply.
- The table below shows what you pay when you get a long-term supply of a drug.
- Sometimes the cost of the drug is lower than your copayment. In these cases you pay the lower price for the drug instead of the copayment.

Your share of the cost when you get a *long-term* supply of a covered Part D prescription drug:

	Standard retail cost-sharing (in-network) (up to a 90 day supply)	**Mail-order cost-sharing (in-network) (up to a 90 day supply)**
Cost-Sharing Tier 1 (Generic or Preferred Generic)	$24	$16
Cost-Sharing Tier 2 (Preferred Brand)	$105	$70
Cost-Sharing Tier 3 (Non-Preferred Drug)	50% coinsurance ($300 minimum and $600 maximum out-of-pocket per prescription)	50% coinsurance ($200 minimum and $400 maximum out-of-pocket per prescription)
Cost-Sharing Tier 4 (Specialty)	A long-term supply is not available for drugs in Tier 4	A long-term supply is not available for drugs in Tier 4

You won't pay more than $105 for a three-month supply of each covered insulin product regardless of the cost-sharing tier.

Regardless of tier placement, Specialty drugs are limited to a one-month supply.

Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach $8,000

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach $8,000. You then move on to the Catastrophic Coverage Stage.

The *SmartSummary* that you receive will help you keep track of how much you, the plan, and any third parties, have spent on your behalf during the year. Many people do not reach the $8,000 limit in a year.

We will let you know if you reach this $8,000 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage. See Section 1.3 on how Medicare calculates your out-of-pocket costs.

SECTION 6 There is no coverage gap for this plan

There is no coverage gap for *this plan.* Once you leave the Initial Coverage Stage, you move on to the Catastrophic Coverage Stage (see Section 7).

SECTION 7 During the Catastrophic Coverage Stage, the plan pays the full cost for your drugs

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $8,000 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

- During this stage, the plan pays most of the full cost for your covered Part D drugs. You pay nothing.

Once a member reaches the Maximum Out-of-Pocket of $5,000.00, the plan will be responsible for 100% of the drug cost.

SECTION 8 Part D Vaccines. What you pay for vaccinations covered by Part D depends on how and where you get them

Important Message About What You Pay for Vaccines - Some vaccines are considered medical benefits. Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's "Drug Guide". Our plan covers most adult Part D vaccines at no cost to you. Refer to your plan's "Drug Guide" or contact Customer Care for coverage and cost-sharing details about specific vaccines.

There are two parts to our coverage of Part D vaccinations:

- The first part of coverage is the cost of the vaccine itself.
- The second part of coverage is for the cost of **giving you the vaccine**. (This is sometimes called the administration of the vaccine.)

Your costs for a Part D vaccination depend on three things:

1. **Whether the vaccine is recommended for adults by an organization called the Advisory Committee or Immunization Practices (ACIP).**
    - Most adult Part D vaccinations are recommended by ACIP and cost you nothing.
2. **Where you get the vaccine.**
    - The vaccine itself may be dispensed by a pharmacy or provided by the doctor’s office.
3. **Who gives you the vaccine.**
    - A pharmacist or another provider may give the vaccine in the pharmacy. Alternatively, a provider may give it in the doctor’s office.

What you pay at the time you get the Part D vaccination can vary depending on the circumstances and what **drug payment stage** you are in.

- Sometimes when you get a vaccination, you have to pay for the entire cost for both the vaccine itself and the cost for the provider to give you the vaccine. You can ask our plan to pay you back for our share of the cost under your Part D benefit. For most adult Part D vaccines, this means you will be reimbursed the entire cost you paid.

- Other times, when you get the vaccination, you will pay only your share of the cost under your Part D benefit. For most adult Part D vaccines, you will pay nothing.

Below are three examples of ways you might get a Part D vaccine.

Situation 1: You get the Part D vaccination at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to give certain vaccines.)

- For most adult Part D vaccines, you will pay nothing.
- For other Part D vaccines, you will pay the pharmacy your coinsurance or copayment for the vaccine itself, which includes the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

Situation 2: You get the Part D vaccination at your doctor's office.

- When you get the vaccines, you may have to pay for the entire cost of the vaccine itself and the cost for the provider to give it to you.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 7.
- For most adult Part D vaccines, you will be reimbursed the full amount you paid. For other Part D vaccines, you will be reimbursed the amount you paid less any coinsurance or copayment for the vaccine (including administration), and less any difference between the amount the doctor charges and what we normally pay. (If you get "Extra Help", we will reimburse you for this difference.)

Situation 3: You buy the Part D vaccine itself at the network pharmacy, and then the network take it to your doctor's office where they give you the vaccine.

- For most adult Part D vaccines, you will pay nothing for the vaccine itself.
- For other Part D vaccines, you will pay the pharmacy your coinsurance or copayment for the vaccine itself.
- When your doctor gives you the vaccine, you may have to pay the entire cost for this service.
- You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7.
- For most adult Part D vaccines, you will be reimbursed the full amount you paid. For other Part D vaccines, you will be reimbursed the amount you paid less any coinsurance for the vaccine administration.
- , and less any difference between the amount the doctor charges and what we normally pay. (If you get "Extra Help", we will reimburse you for this difference.)

CHAPTER 7:

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

SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered services or drugs

Sometimes when you get medical care or a prescription drug, you may need to pay the full cost. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In these cases, you can ask our plan to pay you back (paying you back is often called reimbursing you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs that are covered by our plan. There may be deadlines that you must meet to get paid back. Please see Section 2 of this chapter.

There may also be times when you get a bill from a provider for the full cost of medical care you have received, or possibly for more than your share of cost sharing as discussed in the document. First try to resolve the bill with the provider. If that does not work, send the bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly. If we decide not to pay it, we will notify the provider. You should never pay more than plan-allowed cost sharing. If this provider is contracted you still have the right to treatment.

Here are examples of situations in which you may need to ask our plan to pay you back or to pay a bill you have received:

1. **When you've received emergency or urgently needed medical care from a provider who is not in our plan's network**

   Outside the service area, you can receive emergency services from any provider, whether or not the provider is a part of our network. When you received care from a provider who is not part of our network, you are only responsible for paying your share of the cost. (Your share of the cost may be higher for an out-of-network provider than for a network provider.) Ask the provider to bill the plan for our share of the cost.

   - You are only responsible for paying your share of the cost for emergency or urgently needed services. Emergency providers are legally required to provide emergency care. If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.

   - You may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.

     - If the provider is owed anything, we will pay the provider directly.
     - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.

- **Please note:** While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If the provider is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive.

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

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

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

   - Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.

   - If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

3. **If you are retroactively enrolled in our plan.**

   Sometimes a person's enrollment in the plan is retroactive. (This means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

   If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered services or drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork such as receipts and bills for us to handle the reimbursement.

   Please call Customer Care for additional information about how to ask us to pay you back and deadlines for making your request. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

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

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

   - Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out-of-network pharmacies in limited circumstances. See Chapter 5, Section 2.5 for a discussion of these circumstances.

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

   If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

   - Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

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

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

   - For example, the drug may not be on the plan's *"Drug Guide"*; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it. (See Chapter 6, Section 1.1 of this booklet for how to access the *Drug Guide*.)

   - Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 9 of this document has information about how to make an appeal.

SECTION 2 How to ask us to pay you back or to pay a bill you have received

You may request us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it will help us process the information faster. Send us your request for payment along with the following information:
  - Proof of payment
  - Itemized bill listing the item or service received
  - Physician order (if applicable)
  - Medical records
  - Any other supporting documentation
- Either download a copy of the form from our website at **(https://www.humana.com/member/documents-and-forms)** or call Customer Care and ask for the form. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

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

Requests for payment for Medical Services:

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

Requests for payment for Part D Drugs:

Humana
P.O. Box 14140
Lexington, KY 40512-4140

SECTION 3 We will consider your request for payment and say yes or no

Section 3.1 We check to see whether we should cover the service or drug and how much we owe

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the medical care or drug is covered and you followed all the rules, we will pay for our share of the cost. If you have already paid for the service or drug, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider.

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

Section 3.2 If we tell you that we will not pay for all or part of the medical care or drug, you can make an appeal

If you think we have made a mistake in turning down your request for payment or the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 9 of this document.

CHAPTER 8:

Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities as a member of the plan

Section 1.1 We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, in Braille, in large print, or other alternate formats, etc.)

Your plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how a plan may meet these accessibility requirements include, but are not limited to provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in Braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Customer Care.

Our plan is required to give female enrollees the option of direct access to a women’s health specialist within the network for women’s routine and preventive health care services.

If providers in the plan’s network for a specialty are not available, it is the plan’s responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you will only pay in-network cost sharing. If you find yourself in a situation where there are no specialists in the plan’s network that cover a service you need, call the plan for information on where to go to obtain this service at in-network cost sharing.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Humana Grievances and Appeals Dept. at 1-800-457-4708. You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

Para obtener información de parte de nosotros de una forma que se ajuste a sus necesidades, llame a Atención al Cliente. (Los números de teléfono del Atención al Cliente están en el Capítulo 2, Sección 1 de este folleto.)

Nuestro plan cuenta con personal y servicios gratuitos de intérpretes disponibles para responder preguntas de afiliados discapacitados y de los que no hablan inglés. También podemos darle información en Braille, en letra grande o en otros formatos alternativos sin costo en caso de ser necesario. Se nos exige darle información sobre los beneficios del plan en un formato que sea accesible y apropiado para usted. Para obtener información de parte de nosotros de una forma que se ajuste a sus necesidades, llame a Atención al cliente (los números de teléfono del Atención al Cliente están en el Capítulo 2, Sección 1 de este folleto).

Si tiene alguna dificultad para obtener información de nuestro plan en un formato que sea accesible y apropiado, llame para presentar una queja formal ante el Departamento de quejas formales y apelaciones de Humana al 1-800-457-4708. También puede presentar una queja ante Medicare si llama al 1-800-MEDICARE (1-800-633-4227) o directamente ante la Oficina de Derechos Civiles. La información de contacto está incluida en esta *Evidencia de Cobertura* o en esta correspondencia, o puede contactar al 1-800-457-4708 para obtener información adicional.

Section 1.2 We must ensure that you get timely access to your covered services and drugs

You have the right to choose a primary care physician (PCP) in the plan's network. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral and still pay the in-network cost-sharing amount.

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

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9, Section 10 tells what you can do.

Section 1.3 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your personal health information includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- You have rights related to your information and controlling how your health information is used. We give you a written notice, called a Notice of Privacy Practice, that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you or someone you have given legal power to make decisions for you first.*
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
    - We are required to release health information to government agencies that are checking on quality of care.
    - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.

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

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

Insurance ACE
Notice of Privacy Practices

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

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

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

We reserve the right to change our privacy practices and the terms of this notice at any time, as allowed by law. This includes the right to make changes in our privacy practices and the revised terms of our notice effective for all personal and health information we maintain. This includes information we created or received before we made the changes. When we make a significant change in our privacy practices, we will change this notice and send the notice to our health plan subscribers.

What is Nonpublic personal or health information?
Health information - from now on referred to as "information" - includes both medical information and individually identifiable information, like your name, address, telephone number, or Social Security number, account numbers, payment information, or demographic information. The term "information" in this notice includes any nonpublic personal and health information created or received by a health care provider or health plan that relates to your physical or mental health or condition, providing health care to you, or the payment for such health care. We protect this information in all formats including electronic, written, and oral information.

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

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

How do we protect your information?
In keeping with federal and state laws and our own policy, we have a responsibility to protect the privacy of your information. We have administrative, technical and physical safeguards in place to protect your information in various ways including:
- Limiting who may see your information
- Limiting how we use or disclose your information
- Informing you of our legal duties about your information
- Training our associates about company privacy programs and procedures

How do we use and disclose your information?
We must use and disclose your information:
- To you or someone who has the legal right to act on your behalf
- To the Secretary of the Department of Health and Human Services
- Where required by law

We have the right to use and disclose your information:

- To a doctor, a hospital, or other health care provider so you can receive medical care.

- For payment activities, include claims payment for covered services provided to you by healthcare providers and for health plan premium payments.

- For health care operation activities including processing your enrollment, responding to your inquiries and requests for services, coordinating your care, resolving disputes, conducting medical management, improving quality, reviewing the competence of health care professionals, and determining premiums.

- For performing underwriting activities. However, we will not use any results of genetic testing or ask questions regarding family history.

- To your plan sponsor to permit them to perform, plan administration functions such as eligibility, enrollment and disenrollment activities. We may share summary level health information about you with your plan sponsor in certain situations such as to allow your plan sponsor to obtain bids from other health plans. We will not share detailed health information to your plan sponsor unless you provide us your permission, or your plan sponsor must certify they agree to maintain the privacy of your information.

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

Will we use your information for purposes not described in this notice?
In all situations other than described in this notice, we will request your written permission before using or disclosing your information. You may revoke your permission at any time by notifying us in writing. We will not use or disclose your information for any reason not described in this notice without your permission. The following uses and disclosures will require an authorization:

- Most uses and disclosures of psychotherapy notes
- Marketing purposes
- Sale of personal and protected health information

What do we do with your information when you are no longer a member or you do not obtain coverage through us?
Your information may continue to be used for purposes described in this notice when your membership is terminated or you do not obtain coverage through us. After the required legal retention period, we destroy the information following strict procedures to maintain the confidentiality.

What are my rights concerning my information?
The following are your rights with respect to your information. We are committed to responding to your rights request in a timely manner:

- Access - You have the right to review and obtain a copy of your information that may be used to make decisions about you, such as claims and case or medical management records. You also may receive a summary of this health information. As required under applicable law, we will make this personal information available to you or to your designated representative.

- Adverse Underwriting Decision - You have the right to be provided a reason for denial or adverse underwriting decision if we decline your application for insurance.*

- Alternate Communications - You have the right to receive confidential communications of information in a different manner or at a different place to avoid a life-threatening situation. We will accommodate your request if it is reasonable.

- Amendment - You have the right to request correction of any of this personal information through amendment or deletion. Within 60 business days of receipt of your written request, we will notify you of our amendment or deletion of the information in dispute, or of our refusal to make such correction after further investigation. If we refuse to amend or delete the information in dispute, you have the right to submit to us a written statement of the reasons for your disagreement with our assessment of the information in dispute and what you consider to be the correct information. We shall make such a statement accessible to any and all parties reviewing the information in dispute.

- Disclosure - You have the right to receive a listing of instances in which we or our business associates have disclosed your information for purposes other than treatment, payment, health plan operations, and certain other activities. We maintain this information and make it available to you for a period of six years at your request. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

- Notice - You have the right to receive a written copy of this notice any time you request.

- Restriction - You have the right to ask to restrict uses or disclosures of your information. We are not required to agree to these restrictions, but if we do, we will abide by our agreement. You also have the right to agree to or terminate a previously submitted restriction.

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

What should I do if I believe my privacy has been violated?
If you believe your privacy has been violated in any way, you may file a complaint with us by calling us at 1-866-861-2762 any time.

You may also submit a written complaint to the U.S. Department of Health and Human Services, Office of Civil Rights (OCR). We will give you the appropriate OCR regional address on request. You also have the option to e-mail your complaint to **OCRComplaint@hhs.gov**. We support your right to protect the privacy of your personal and health information. We will not retaliate in any way if you elect to file a complaint with us or with the U.S. Department of Health and Human Services.

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

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

We can change the terms of this notice, and the changes will apply to all information we have about you.

The new notice will be available upon request, in our office, and on our web site.

How do I exercise my rights or obtain a copy of this notice?
All of your privacy rights can be exercised by obtaining the applicable forms. You may obtain any of the forms by:
- Contacting us at 1-866-861-2762
- Accessing our Website at **Humana.com** and going to the Privacy Practices link
- Send completed request form to:

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

Section 1.4 We must give you information about the plan, its network of providers, and your covered services

As a member of Humana Group Medicare Advantage PPO Plan, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call Customer Care.

- **Information about our plan**. This includes, for example, information about the plan's financial condition.

- **Information about our network providers and pharmacies.** You have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.

- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services. Chapter 5 and 6 provide information about Part D prescription drug coverage.

- **Information about why something is not covered and what you can do about it.** Chapter 9 provides information on asking for a written explanation on why a medical service or Part D drug is not covered or if your coverage is restricted. Chapter 9 also provides information on asking us to change a decision, also called an appeal.

Section 1.5 We must support your right to make decisions about your care

You have the right to know your treatment options and participate in decisions about your health care

You have the right to get full information from your doctors and other health care providers. Your providers must explain your medical condition and your treatment choices *in a way that you can understand.*

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** You have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.

- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.

- **The right to say "no".** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself.

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, *if you want to,* you can:

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

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

The legal documents that you can use to give your directions in advance in these situations are called **advance directives**. There are different types of advance directives and different names for them. Documents called **living will** and **power of attorney for health care** are examples of advance directives.

If you want to use an advance directive to give your instructions, here is what to do:

- **Get the form.** You can get an advance directive form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.

- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.

- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital**.

- The hospital will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with your state's Quality Improvement Organization (QIO). Contact information can be found in "Exhibit A" in the back of this book.

Section 1.6 You have the right to make complaints and to ask us to reconsider decisions we have made

At Humana, a process called Utilization Management (UM) is used to determine whether a service or treatment is covered and appropriate for payment under your benefit plan. Humana does not reward or provide financial incentives to doctors, other individuals or Humana employees for denying coverage or encouraging under use of services. In fact, Humana works with your doctors and other providers to help you get the most appropriate care for your medical condition. If you have questions or concerns related to Utilization Management, staff are available at least eight hours a day during normal business hours. Humana has free language interpreter services available to answer questions related to Utilization Management from non-English speaking members. TTY/TDD users should call 1-800-457-4708 (TTY: 711).

Humana decides about coverage of new medical procedures and devices on an ongoing basis. This is done by checking peer-reviewed medical literature and consulting with medical experts to see if the new technology is effective and safe. Humana also relies on guidance from the Centers for Medicare & Medicaid Services (CMS), which often makes national coverage decisions for new medical procedures or devices.

If you have any problems, concerns, or complaints and need to request coverage, or make an appeal, Chapter 9 of this document tells what you can do. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

Section 1.7 What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, sexual orientation, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you are having:

- You can **call Customer Care.**
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY users should call 1-877-486-2048).

Section 1.8 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can **call Customer Care.**
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- You can contact **Medicare**.
    - You can visit the Medicare website to read or download the publication Medicare Rights & Protections. (The publication is available at: **www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf**.)
    - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 2 You have some responsibilities as a member of the plan

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Care.

- **Get familiar with your covered services or drugs and the rules you must follow to get these covered services or drugs.** Use this Evidence of Coverage to learn what is covered for you and the rules you need to follow to get your covered services.
    - Chapters 3 and 4 give the details about your medical services.
    - Chapters 5 and 6 give the details about your Part D prescription drug coverage.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us**. Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
    - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
    - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
    - If you have any questions, be sure to ask and get an answer you can understand.

- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.

- **Pay what you owe.** As a plan member, you are responsible for these payments:

  - If you have a monthly plan premium, you must pay your plan premiums to continue being a member of our plan.

  - You must continue to pay your Medicare Part B premiums to remain a member of the plan.

  - For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug.

  - If you are required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.

  - If you are required to pay the extra amount for Part D because of your yearly income, you must continue to pay the extra amount directly to the government to remain a member of the plan.

- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.

- **If you move *outside* of our plan service area, you cannot remain a member of our plan.**

- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

CHAPTER 9:

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

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

This chapter explains two types of processes for handling problems and concerns:

- For some problems, you need to use the **process for coverage decisions and appeals**.
- For other problems, you need to use the **process for making complaints**; also called grievances.

Both of these processes have been approved by Medicare. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

The guide in Section 3 will help you identify the right process to use and what you should do.

Section 1.2 What about the legal terms?

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand. To make things easier, this chapter:

- Uses simpler words in place of certain legal terms. For example, this chapter generally says, making a complaint rather than filing a grievance, coverage decision rather than organization determination and Independent Review Organization instead of Independent Review Entity.
- It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms. Knowing which terms to use will help you communicate more accurately to get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 Where to get more information and personalized assistance

We are always available to help you. Even if you have a complaint about our treatment of you, we are obligated to honor your right to complain. Therefore, you should always reach out to customer service for help. But in some situations, you may also want help or guidance from someone who is not connected with us. Below are two entities that can assist you.

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers and website URLs in "Exhibit A" of this document.

Medicare

You can also contact Medicare. To contact Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can also visit the Medicare website **www.medicare.gov/**

SECTION 3 To deal with your problem, which process should you use?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

Is your problem or concern about your benefits or coverage?

This includes problems about whether medical care (medical items, services and/or Part B prescription drugs) are covered or not, the way they are covered, and problems related to payment for medical care.

Yes.	No.
Go on to the next section of this chapter, **Section 4, A guide to the basics of coverage decisions and appeals.**	Skip ahead to **Section 10** at the end of this chapter: **How to make a complaint about quality of care, waiting times, customer service or other concerns.**

COVERAGE DECISIONS AND APPEALS

SECTION 4 A guide to the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals: the big picture

Coverage decisions and appeals deal with problems related to your benefits and coverage for medical care (services, items and Part B prescription drugs, including payment). To keep things simple, we generally refer to medical items, services and Medicare Part B prescription drugs as **medical care**. You use the coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions prior to receiving benefits

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical care. For example, if your plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either your network doctor can show that you received a standard denial notice for this medical specialist, or the Evidence of Coverage makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical care before you receive it, you can ask us to make a coverage decision for you. In limited circumstances a request for your coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide medical care or drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after a benefit is received, and you are not satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, which we discuss later, you can request an expedited or **fast appeal** of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we were properly following the rules. When we have completed the review, we give you our decision.

In limited circumstances a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we say no to all or part of your Level 1 appeal for medical care, your appeal will automatically go on to a Level 2 appeal conducted by an independent review organization that is not connected to us.

- You do not need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we do not fully agree with your Level 1 appeal.
- See **Section 6.6** of this chapter for more information about Level 2 appeals.
- For Part D drug appeals, if we say no to all or part of your appeal, you will need to ask for a Level 2 appeal. Part D appeals are discussed further in Section 6 of this chapter.

If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (Section 9 in this chapter explains the Level 3, 4, and 5 appeal processes).

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- **You can call Customer Care.**
- You **can get free help** from your State Health Insurance Assistance Program.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Please call Customer Care and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at **www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.)**
    - For medical care or Part B prescription drugs, your doctor can request a coverage decision or a Level 1 Appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
    - For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied, your doctor or prescriber can request a Level 2 appeal.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your representative to ask for a coverage decision or make an appeal.

- If you want a friend, relative or other person to be your representative, call Customer Care and ask for the *Appointment of Representative* form (The form is also available on Medicare's website at **www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf** or on our website at **https://docushare-web.apps.cf.humana.com/Marketing/docushare-app?file=639132**). The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.

- While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.

- **You also have the right to hire a lawyer.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.3 Which section of this chapter gives the details for your situation?

There are four different types of situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 5** of this chapter: "Your medical care: How to ask for a coverage decision or make an appeal"

- **Section 6** of this chapter: "Your Part D prescription drugs: How to ask for a coverage decision or make an appeal"

- **Section 7** of this chapter: "How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon"

- **Section 8** of this chapter: "How to ask us to keep covering certain medical services if you think your coverage is ending too soon" (*Applies only to these services*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which section you should be using, please call Customer Care. You can also get help or information from government organizations such as your State Health Insurance Assistance Program.

SECTION 5 Your medical care: How to ask for a coverage decision or make an appeal of a coverage decision

Section 5.1 This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care

This section is about your benefits for medical care. These benefits are described in Chapter 4 of this document *Medical Benefits Chart (what is covered and what you pay*). In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

This section tells what you can do if you are in any of the five following situations:

1. You are not getting certain medical care you want, and you believe that this is covered by our plan. **Ask for a coverage decision. Section 5.2.**

2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan. **Ask for a coverage decision. Section 5.2.**

3. You have received medical care that you believe should be covered by the plan, but we have said we will not pay for this care. **Ask for a coverage decision. Section 5.3.**

4. You have received and paid for medical care that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5**

5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 5.3.**

NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, hospice care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read sections 7 and 8 of this Chapter. Special rules apply to these types of care.

Section 5.2 Step-by-step: How to ask for a coverage decision

Legal Terms
"When a coverage decision involves your medical care, it is called an **organization determination.** A fast coverage decision is called an **expedited determination.**"

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

A standard coverage decision is usually made within 14 days or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. In order to get a fast coverage decision, you must meet two requirements:

- You may *only ask* for coverage for medical items and/or services (not requests for payment for items and/or services already received).
- You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor tells us that your health requires a fast coverage decision, we will automatically agree to give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
  - Explains that we will use the standard deadlines.
  - Explains if your doctor asks for the fast coverage decision, we will automatically give you a fast coverage decision.
  - Explains that you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested.

Step 2: Ask our plan to make a coverage decision or fast coverage decision.

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this. Chapter 2 has contact information.

Step 3: We consider your request for medical care coverage and give you our answer.

For standard coverage decisions we use the standard deadlines.

This means we will give you an answer within 14 calendar days after we receive your request **for a medical item or service.** If your request is for a **Medicare Part B prescription drug,** we will give you an answer **within 72 hours** after we receive your request.

- **However,** if you ask for more time, or if we need more information that may benefit you **we can take up to 14 more days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a fast complaint. We will give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. See Section 10 of this chapter for information on complaints.)

For Fast Coverage decisions we use an expedited timeframe

A fast coverage decision means we will answer within 72 hours if your request is for a medical item or service. If your request is for a Medicare Part B prescription drug, we will answer within 24 hours.

- **However,** if you ask for more time, or if we need more information that may benefit you **we can take up to 14 more days**. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

- If you believe we should not take extra days, you can file a fast complaint. (See Section 10 of this chapter for information on complaints.) We will call you as soon as we make the decision.

- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Step 4: If we say no to your request for coverage for medical care, you can appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the medical care coverage you want. If you make an appeal, it means you are going on to Level 1 of the appeals process.

Section 5.3 Step-by-step: How to make a Level 1 appeal

Legal Terms
An appeal to the plan about a medical care coverage decision is called a plan **reconsideration.** A fast appeal is also called an **expedited reconsideration.**

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

A standard appeal is usually made within 30 days or 7 days for Part B drugs. A fast appeal is generally made within 72 hours.

- If you are appealing a decision we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we will give you a fast appeal.

- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 5.2 of this chapter.

Step 2: Ask our plan for an appeal or a Fast appeal

- **If you are asking for a standard appeal, submit your standard appeal in writing.** You may also ask for an appeal by calling us. Chapter 2 has contact information.

- **If you are asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.

- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal. We are allowed to charge a fee for copying and sending this information to you.**

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

- When our plan is reviewing your appeal, we take a careful look at all of the information. We check to see if we were following all the rules when we said no to your request.

- We will gather more information if needed possibly contacting you or your doctor.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal.** We will give you our answer sooner if your health requires us to.
    - However, if you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time if your request is for a Medicare Part B prescription drug.
    - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it receives your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
    - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
    - If you believe we should not take extra days, you can file a fast complaint. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (See Section 10 of this chapter for information on complaints.)
    - If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug.

- **If our plan says no to part or all of your appeal,** we will automatically send your appeal to the independent review organization for a Level 2 appeal.

Section 5.4 Step-by-step: How a Level 2 Appeal is done

Legal Terms
The formal name for the independent review organization is the **Independent Review Entity.** It is sometimes called the **IRE.**

The independent review organization is an independent organization hired by Medicare. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: The independent review organization reviews your appeal.

- We will send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file**. We are allowed to charge you a fee for copying and sending this information to you.

- You have a right to give the independent review organization additional information to support your appeal.

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

If you had a fast appeal at Level 1, you will also have a fast appeal at Level 2

- For the fast appeal the review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it receives your appeal.

- However, if your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

If you had a standard appeal at Level 1, you will also have a standard appeal at Level 2

- For the standard appeal if your request is for a medical item or service the review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it receives your appeal. If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it receives your appeal.

- However, if your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

Step 2: The independent review organization gives you their answer.

The independent review organization will tell you its decision in writing and explain the reasons for it.

- **If the review organization says yes to part or all of a request for a medical item or service,** we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization for standard requests. For expedited requests, we have 72 hours from the date the plan receives the decision from the review organization.

- **If the review organization says yes to part or all of a request for a Medicare Part B prescription drug**, we must authorize or provide the Part B prescription drug under dispute within **72 hours** after we receive the decision from the review organization for **standard requests.** For **expedited requests** we have **24 hours** from the date we receive the decision from the review organization.

- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called **upholding the decision**. It is also called **turning down your appeal**.) In this case, the independent review organization will send you a letter:

    - Explaining its decision
    - Notifying you of the right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
    - Telling you how to file a Level 3 appeal

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal.

- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter explains the Levels 3, 4, and 5 of the appeals processes.

Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?

Chapter 7 describes when you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork asking for reimbursement, you are asking for a coverage decision. To make this decision, we will check to see if the medical care you paid for is covered. We will also check to see if you followed all the rules for using your coverage for medical care.

- **If we say yes to your request:** If the medical care is covered and you followed all the rules, we will send you the payment for our share of the cost within 60 calendar days after we receive your request. If you haven't paid for the medical care, we will send the payment directly to the provider.

- **If we say no to your request:** If the medical care is not covered, or you did not follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the medical care and the reasons why.

If you do not agree with our decision to turn you down, you can make an appeal. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in Section 5.3. For appeals concerning reimbursement, please note:

- We must give you our answer within 60 calendar days after we receive your appeal. If you are asking us to pay you back for medical care you have already received and paid for, you are not allowed to ask for a fast appeal.

- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

SECTION 6 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

Section 6.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

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

- If you do not know if a drug is covered or if you meet the rules, you can ask us. Some drugs require that you get approval from us before we will cover it.

- If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

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

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

- Asking to cover a Part D drug that is not on the plan's *List of Covered Drugs*. **Ask for an exception. Section 6.2**

- Asking to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get). **Ask for an exception. Section 6.2**
- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier. **Ask for an exception. Section 6.2**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 6.4**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 6.4**

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

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

Section 6.2 What is an exception?

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

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

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

1. **Covering a Part D drug for you that is not on our "Drug Guide".** If we agree to cover a drug not on the "Drug Guide," you will need to pay the cost-sharing amount that applies to drugs in Cost-Sharing Tier 4 - Non-Preferred Drug. You cannot ask for an exception to the cost-sharing amount we require you to pay for the drug.

2. **Removing a restriction for a covered drug**. Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our "Drug Guide." If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our "Drug Guide" is in one of four cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

    - If our "Drug Guide" contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s).

    - If the drug you're taking is a biological product you can ask us to cover your drug at a lower cost-sharing amount. This would be the lowest tier that contains brand name alternatives for treating your condition.

    - If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.

    - If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.

    - If your drug is in the Non-Preferred Drug tier you can ask us to cover it at the cost sharing amount that applies to drugs in the Preferred Brand tier. Also, if your generic drug is in the Preferred Brand tier you can ask us to cover it at the cost-sharing amount that applies to the Preferred Generic and Generic tier. This would lower your share of the cost for the drug.

    - You cannot ask us to change the cost-sharing tier for any drug in the Specialty tier.

    - If we approve your tiering exception request and there is more than one lower cost-sharing tier with alternative drugs you can't take, you will usually pay the lowest amount.

Section 6.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

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

Typically, our "Drug Guide" includes more than one drug for treating a particular condition. These different possibilities are called **alternative** drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.

- If we say no to your request you can ask for a review by making an appeal.

Section 6.4 Step-by-step: How to ask for a coverage decision, including an exception

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

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

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

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

- You must be asking for a drug you have not yet received. (You cannot ask for fast coverage decision to be paid back for a drug you have already bought.)

- Using the standard deadlines could cause serious harm to your health or hurt your ability to function.

- **If your doctor or other prescriber tells us that your health requires a fast coverage decision, we will automatically give you a fast coverage decision.**

- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:

- Explains that we will use the standard deadlines.
- Explains if your doctor or other prescriber asks for the fast coverage decision, we will automatically give you a fast coverage decision.
- Tells you how you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. We will answer your complaint within 24 hours of receipt.

Step 2: Request a standard coverage decision or a fast coverage decision.

Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request form or on our plan's form, which is OR are available on our website. Chapter 2 has contact information. To assist us in processing your request, please be sure to include your name, contact information, and information identifying which denied claim is being appealed.

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

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

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

Deadlines for a fast coverage decision

- We must generally give you our answer **within 24 hours** after we receive your request.
    - For exceptions, we will give you our answer within 24 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
    - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

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

- We must generally give you our answer **within 72 hours** after we receive your request.
    - For exceptions, we will give you our answer within 72 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
    - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

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

- We must give you our answer **within 14 calendar days** after we receive your request.
    - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

<u>Step 4:</u> If we say no to your coverage request, you can make an appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the drug coverage you want. If you make an appeal, it means you are going on to Level 1 of the appeals process.

Section 6.5 Step-by-step: How to make a Level 1 appeal

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

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

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

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a fast appeal.

- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 6.4 of this chapter.

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

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

- **For fast appeals either submit your appeal in writing or call us at 1-800-867-6601.** Chapter 2 has contact information.

- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request form, which is available on our website. Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request.

- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal. We are allowed to charge a fee for copying and sending this information to you.

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

When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a fast appeal

- *For fast appeals*, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to.
    - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how you can appeal our decision.

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

- For standard appeals, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.
    - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we receive your appeal.

- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how you can appeal our decision.

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

- We must give you our answer **within 14 calendar days** after we receive your request.
    - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 30 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

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

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

Section 6.6 Step-by-step: How to make a Level 2 appeal

Legal Terms
The formal name for the independent review organization is the **Independent Review Entity.** It is sometimes called the **IRE.**

The independent review organization is an independent organization hired by Medicare. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

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

- We will send the information about your appeal to this organization. This information is called your **case file. You have the right to ask us for a copy of your case file**. We are allowed to charge you a fee for copying and sending this information to you.

- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal.

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

Deadlines for fast appeal

- If your health requires it, ask the independent review organization for a fast appeal.

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

Deadlines for standard appeal

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

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

For fast appeals

- **If the independent review organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

For standard appeals

- **If the independent review organization says yes to part or all of your request for coverage,** we must provide the drug coverage that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.

- **If the independent review organization says yes to part or all of your request to pay you back** for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to **part or all of** your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called **upholding the decision.** It is also called **turning down your appeal.**). In this case, the independent review organization will send you a letter:

- Explaining its decision.

- Notifying you of the right to a Level 3 appeal if the dollar value of the drug coverage you are requesting meets a certain minimum. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final.

- Telling you the dollar value that must be in dispute to continue with the appeals process.

Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).

- If you want to go on to Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal decision.

- The Level 3 Appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to cover a longer inpatient hospital stay if you think you are being discharged too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will help arrange for care you may need after you leave.

- The day you leave the hospital is called your **discharge date**.
- When your discharge date has been decided, your doctor or the hospital staff will tell you.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered.

Section 7.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

Within two days of being admitted to the hospital, you will be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice. If you do not get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, please call Customer Care or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you:

   - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.

   - Your right to be involved in any decisions about your hospital stay.

   - Where to report any concerns you have about quality of your hospital care.

   - Your right to **request an immediate review** of the decision to discharge you if you think you are being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time.

2. **You will be asked to sign the written notice to show that you received it and understand your rights.**

   - You or someone who is acting on your behalf will be asked to sign the notice.

   - Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date. Signing the notice **does *not* mean** you are agreeing on a discharge date.

3. **Keep your copy** of the notice handy so you will have the information about making an appeal (or reporting a concern about quality of care) if you need it.

   - If you sign the notice more than two days before discharge date, you will get another copy before you are scheduled to be discharged.

   - To look at a copy of this notice in advance, you can call Customer Care or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see the notice online at **www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices**

Section 7.2 Step-by-step: How to make a Level 1 appeal to change your hospital discharge date

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**

- **Meet the deadlines.**

- **Ask for help if you need it**. If you have questions or need help at any time, please call Customer Care or, call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

The **Quality Improvement Organization** is a group of doctors and other health care professionals paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts are not part of our plan.

<u>Step 1:</u> Contact the Quality Improvement Organization for your state and ask for a an immediate review of your hospital discharge. You must act quickly.

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge.**
    - **If you meet this deadline,** you are allowed to stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision on your appeal from the Quality Improvement Organization.
    - **If you do *not* meet this deadline,** and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see Section 7.4.

Once you request an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted, we will give you a **Detailed Notice of Discharge.** This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

You must use the network providers to get your medical care and services, by calling Customer Care or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at **<u>www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices</u>.**

<u>Step 2:</u> The Quality Improvement Organization conducts an independent review of your case.

- Health professionals at the Quality Improvement Organization (the *reviewers*) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.

- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.

- By noon of the day after the reviewers told us of your appeal, you will get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the review organization says *yes*, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**

- You will have to keep paying your share of the costs (such as deductibles or copayments if these apply). In addition, there may be limitations on your covered hospital services.

What happens if the answer is no?

- If the review organization says *no*, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.

- If the review organization says *no* to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization has said *no* to your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to **Level 2** of the appeals process.

Section 7.3 Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at their decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

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

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

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

Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.**

- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

- It means they agree with the decision they made on your Level 1 appeal. This is called upholding the decision.

- The notice you get will tell you in writing what you can do if you wish to continue with the review process.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.

- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7.4 What if you miss the deadline for making your Level 1 Appeal to change your hospital discharge date?

Legal Terms
A fast review (or fast appeal) is also called an **expedited appeal.**

You can appeal to us instead

As explained above, you must act quickly to start your Level 1 appeal of your hospital discharge. If you miss the deadline for contacting the Quality Improvement Organization, there is another way to make your appeal.

If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

Step 1: Contact us and ask for a fast review.

- Ask for a fast review. This means you are asking us to give you an answer using the fast deadlines rather than the standard deadlines. Chapter 2 has contact information.

Step 2: We do a fast review of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We see if the decision about when you should leave the hospital was fair and followed all the rules.

Step 3: We give you our decision within 72 hours after you ask for a fast review.

- **If we say yes to your fast appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date. Will keep providing your covered inpatient hospital services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)

- **If we say no to your fast appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.

    - If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

Step 4: If we say no to your appeal, your case will *automatically* be sent on to the next level of the appeals process.

Step-by-Step: Level 2 *Alternate* Appeal Process

Legal Terms
The formal name for the independent review organization is the **Independent Review Entity.** It is sometimes called the **IRE.**

The independent review organization is an independent organization hired by Medicare. It is not connected with our plan and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: We will automatically forward your case to the independent review organization.

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 of this chapter tells how to make a complaint.)

Step 2: The independent review organization does a fast review of your appeal. The reviewers give you an answer within 72 hours.

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

- **If this organization says *yes* to your appeal,** then we must (pay you back) for our share of the costs of hospital care you received since the date of your planned discharge. We must also continue the plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.

- **If this organization says *no* to your appeal,** it means they agree with us that your planned hospital discharge date was medically appropriate.

    - The written notice you get from the independent review organization will tell how to start a Level 3 appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 3: If the independent review organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 appeal, you decide whether to accept their decision or go on to Level 3 appeal.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 8.1 *This section is only about three services*: Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

When you are getting covered **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it is time to stop covering any of the four types of care for you, we are required to tell you in advance. When your coverage for that care ends, *we will stop paying our share of the cost for your care.*

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Section 8.2 We will tell you in advance when your coverage will be ending

Legal Terms
Notice of Medicare Non-Coverage. It tells you how you can request a **fast-track appeal.** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care.

1. **You receive a notice in writing** at least two days before our plan is going to stop covering your care. The notice tells you:
   - The date when we will stop covering the care for you.
   - How to request a fast track appeal to request us covering your care for a longer period of time.

2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you received it.** Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with the plan that it's time to stop getting the care.

Section 8.3 Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it**. If you have questions or need help at any time, please call Customer Care. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate.

The **Quality Improvement Organization** is a group of doctors and other health care experts paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts are not part of our plan.

Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization ask for a fast-track appeal. You must act quickly.

How can you contact this organization?

- The written notice you received *(Notice of Medicare Non-Coverage)* tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the Notice of Medicare Non-Coverage.

- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see Section 8.5.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

Legal Terms
Detailed Explanation of Non-Coverage. Notice that provides details on reasons for ending coverage.

What happens during this review?

- Health professionals at the Quality Improvement Organization (the reviewers) will ask you, or your representative, why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.

- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.

- By the end of the day the reviewers tell us of your appeal, and you will get the **Detailed Explanation of Non-Coverage** from us that explains in detail our reasons for ending our coverage for your services.

Step 3: Within one full day after they have all the information they need; the reviewers will tell you their decision.

What happens if the reviewers say yes?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it is medically necessary**.

- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say *no* to your appeal, then **your coverage will end on the date we have told you.**

- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If reviewers say *no* to your Level 1 appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make a Level 2 appeal.

Section 8.4 Step-by-step: How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or hospice care or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

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

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

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

Step 3: Within 14 days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes?

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.

- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision we made to your Level 1 appeal.

- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.

- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 8.5 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above you must act quickly to start your Level 1 appeal (within a day or two, at the most). If you miss the deadline for contacting the Quality Improvement Organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

Legal Terms
A fast review (or fast appeal) is also called an **expedited appeal.**

Step 1: Contact us and ask for a fast review.

- **Ask for a fast review.** This means you are asking us to give you an answer using the fast deadlines rather than the standard deadlines. Chapter 2 has contact information.

Step 2: We do a fast review of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan's coverage for services you were receiving.

Step 3: We give you our decision within 72 hours after you ask for a fast review.

- If we say yes to your appeal, it means we have agreed with you that you need services longer and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)

- If we say no to your appeal, then your coverage will end on the date we told you and we will not pay any share of the costs after this date.

- If you continued to get home health care, or skilled nursing facility care, hospice care or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end, then you will have to pay the full cost of this care.

Step 4: If we say no to your fast appeal, your case will automatically go on to the next level of the appeals process.

Legal Terms
The formal name for the independent review organization is the **Independent Review Entity.** It is sometimes called the **IRE.**

Step-by-Step: Level 2 *Alternate* appeal Process

During the Level 2 appeal, the **independent review organization** reviews the decision we made to your fast appeal. This organization decides whether the decision should be changed. **The independent review organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the independent review organization. Medicare oversees its work.

Step 1: We will automatically forward your case to the independent review organization.

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 of this chapter tells how to make a complaint.)

Step 2: The independent review organization does a fast review of your appeal. The reviewers give you an answer within 72 hours.

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

- If this organization says yes to your appeal, then we must pay you back for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.

- If this organization says no to your appeal, it means they agree with the decision our plan made to your first appeal and will not change it.

- The notice you get from the independent review organization will tell you in writing what you can do if you wish to go on to a Level 3 Appeal.

Step 3: If the independent review organization says no to your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.

- A level 3 appeal is reviewed by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 Taking your appeal to Level 3 and beyond

Section 9.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

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

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal	**An Administrative Law Judge or attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may* or *may not* be over**. Unlike a decision at Level 2 appeal, we have the right to appeal a Level 3 decision that is favorable to you. If we decide to appeal it will go to a Level 4 appeal.
    - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator's decision.
    - If we decide to appeal, we will send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over**.
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do a level 4 appeal.

Level 4 Appeal	The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may* or *may not* be ove**r. Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We will decide whether to appeal this decision to Level 5.
    - If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after receiving the Council's decision.
    - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over**.
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.

- If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 appeal and how to continue with a Level 5 appeal.

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

- A judge will review all of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Section 9.2 Appeal Levels 3, 4 and 5 for Part D Drug Requests

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

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal	**An Administrative Law Judge or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over**. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.

- **If the answer is no, the appeals process *may* or *may not* be over.**

  - If you decide to accept this decision that turns down your appeal, the appeals process is over.

  - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 Appeal	The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, the appeals process is over**. We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.

- **If the answer is no, the appeals process *may* or *may not* be over.**

  - If you decide to accept this decision that turns down your appeal, the appeals process is over.

  - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice will tell you whether the rules allow you to go on to a Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your appeal.

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

- A judge will review all of the information and decide yes or no to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

MAKING COMPLAINTS

SECTION 10 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 10.1 What kinds of problems are handled by the complaint process?

The complaint process is *only* used for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service. Here are examples of the kinds of problems handled by the complaint process.

Quality of your medical care

- Are you unhappy with the quality of the care you have received (including care in the hospital)?

Respecting your privacy

- Did someone not respect your right to privacy or share confidential information?

Disrespect, poor customer service, or other negative behaviors

- Has someone been rude or disrespectful to you?
- Are you unhappy with our Customer Care?
- Do you feel you are being encouraged to leave the plan?

Waiting times

- Are you having trouble getting an appointment, or waiting too long to get it?
- Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Customer Care or other staff at the plan?
    - Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.

Cleanliness

- Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?

Information you get from us

- Did we fail to give you a required notice?
- Is our written information hard to understand?

Timeliness

(These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)

If you have asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples:

- You asked us for a fast coverage decision or a fast appeal, and we have said no, you can make a complaint.
- You believe we are not meeting the deadlines for coverage decisions or appeals, you can make a complaint.
- You believe we are not meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint.
- You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 10.2 How to make a complaint

Legal Terms
• A **complaint** is also called a **grievance** . • **Making a complaint** is **filing a grievance** • **Using the process for complaints** is also called **using the process for filing a grievance.** • A **fast complaint** is also called an **expedited grievance.**

Section 10.3 Step-by-step: Making a complaint

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

- **Usually, calling Customer Care is the first step.** If there is anything else you need to do, Customer Care will let you know.

- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.

Grievance Filing Instructions

File a verbal grievance by calling Customer Care. (TTY users should call 711.) We are available Monday through Friday from 8 a.m. to 9 p.m. Eastern time.

Send a written grievance to:
Humana Grievances and Appeals Dept.
P.O. Box 14165
Lexington, KY 40512-4165

When filing a grievance, please provide:
- Name
- Address
- Telephone number
- Member identification number
- A summary of the complaint and any previous contact with us related to the complaint
- The action you are requesting from us
- A signature from you or your authorized representative and the date. If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Customer Care and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at **www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf**). The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.

- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.

- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.

- **If you are making a complaint because we denied your request for a fast coverage decision or a fast appeal, we will automatically give you a fast complaint.** If you have a fast complaint, it means we will give you **an answer within 24 hours.**

- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will include our reasons in our response to you.

Section 10.4 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization**. The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

- **You can make your complaint to both the Quality Improvement Organization and us at the same time.**

Section 10.5 You can also tell Medicare about your complaint

You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to **www.medicare.gov/MedicareComplaintForm/home.aspx**.

You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 10:

Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

Ending your membership in our Humana Group Medicare Advantage PPO 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. Sections 2 and 3 provide information on ending your membership voluntarily.

- There are also limited situations where we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, our plan must continue to provide your medical care and prescription drugs and you will continue to pay your cost share until your membership ends.

SECTION 2 When can you end your membership in our plan?

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 Care or your benefit administrator before you disenroll.

Section 2.1 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of Humana Group Medicare Advantage PPO Plan may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

- **You may be eligible to end your membership during a Special Enrollment Period** if any of the following situations apply to you. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website **www.medicare.gov**:

  - Usually, when you have moved.
  - If you have Medicaid.
  - If we violate our contract with you.
  - If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital.
  - Where applicable, if you enroll in the Program of All-inclusive Care for Elderly (PACE).

- **The enrollment periods may vary** depending on your situation.

- **To find out if you are eligible for a Special Enrollment Period,** please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:

- Another Medicare health plan with or without prescription drug coverage.
- Original Medicare *with* a separate Medicare prescription drug plan.
- - *or* - Original Medicare *without* a separate Medicare prescription drug plan.

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

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

If you receive "Extra Help" from Medicare to pay for your prescription drugs: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Section 2.2 Where can you get more information about when you can end your membership?

If you have any questions about ending your membership you can:

- **Call Customer Care**.
- Find the information in the ***Medicare & You 2024*** handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY 1-877-486-2048)

SECTION 3 How do you end your membership in our plan?

The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	**This is what you should do:**
• Another Medicare health plan.	• Enroll in the new Medicare health plan. • You will automatically be disenrolled from Humana Group Medicare Advantage PPO Plan when your new plan's coverage begins.
• Original Medicare *with* a separate Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan. • You will automatically be disenrolled from Humana Group Medicare Advantage PPO Plan when your new plan's coverage begins.
• Original Medicare *without* a separate Medicare prescription drug plan.	• **Send us a written request to disenroll.** Contact Customer Care if you need more information on how to do this. • You can also contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from Humana Group Medicare Advantage PPO Plan when your coverage in Original Medicare begins.

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

Until your membership ends, and your new Medicare coverage begins, you must continue to get your medical services, items and prescription drugs through our plan.

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

SECTION 5 Humana Group Medicare Advantage PPO Plan must end your membership in the plan in certain situations

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

Humana Group Medicare Advantage PPO Plan must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.
- If you move out of our service area.
- If you are away from our service area for more than six months.
    - If you move or take a long trip, call Customer Care to find out if the place you are moving or traveling to is in our plan's area.

- If you become incarcerated (go to prison).
- If you are not a United States citizen or lawfully present in the United States.
- If you lie or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

Where can you get more information?

If you have questions or would like more information on when we can end your membership call Customer Care.

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

Humana Group Medicare Advantage PPO Plan is not allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week (TTY 1-877-486-2048).

Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

CHAPTER 11:

Legal notices

SECTION 1 Notice about governing law

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

SECTION 2 Notice about non-discrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage Plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at **https://www.hhs.gov/ocr/index**.

If you have a disability and need help with access to care, please call us at Customer Care. If you have a complaint, such as a problem with wheelchair access, Customer Care can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, our plan, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

SECTION 4 Additional Notice about Subrogation (Recovery from a Third Party)

Our right to recover payment

If we pay a claim for you, we have subrogation rights. This is a very common insurance provision that means we have the right to recover the amount we paid for your claim from any third party that is responsible for the medical expenses or benefits related to your injury, illness, or condition. You assign to us your right to take legal action against any responsible third party, and you agree to:

1. Provide any relevant information that we request; and
2. Participate in any phase of legal action, such as discovery, depositions, and trial testimony, if needed.

If you don't cooperate with us or our representatives, or you do anything that interferes with our rights, we may take legal action against you. You also agree not to assign your right to take legal action to someone else without our written consent.

Our right of reimbursement

We also have the right to be reimbursed if a responsible third party pays you directly. If you receive any amount as a judgment, settlement, or other payment from any third party, you must immediately reimburse us, up to the amount we paid for your claim.

Our rights take priority

Our rights of recovery and reimbursement have priority over other claims, and will not be affected by any equitable doctrine. This means that we're entitled to recover the amount we paid, even if you haven't been compensated by the responsible third party for all costs related to your injury or illness. If you disagree with our efforts to recover payment, you have the right to appeal, as explained in Chapter 9.

We are not obligated to pursue reimbursement or take legal action against a third party, either for our own benefit or on your behalf. Our rights under Medicare law and this *Evidence of Coverage* will not be affected if we don't participate in any legal action you take related to your injury, illness, or condition.

SECTION 5 Notice of coordination of benefits

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

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

Who pays first when you have other coverage?

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

Employer and employee organization group health plans

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

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

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

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

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

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

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

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

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

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

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

Workers' Compensation and similar programs

If you have suffered a job-related illness or injury and workers' compensation benefits are available to you, workers' compensation must provide its benefits first for any health care 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 health care costs related to the accident or injury before we will provide any benefits for services related to your accident or injury.

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

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

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

Non-duplication of benefits

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

If we do provide benefits to you before any other type of health coverage you may have, we may seek recovery of those benefits in accordance with the Medicare Secondary Payer rules. Please also refer to the **Additional Notice about Subrogation (Recovery from a Third Party)** 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 called "Medicare & Other Health Benefits: Your Guide to Who Pays First." It is CMS Pub. No. 02179. Be sure to consult the most current version. Other details are explained in the Medicare Secondary Payer rules, such as the way the number of persons employed by an employer for purposes of the coordination of benefits rules is to be determined. The rules are published in the Code of Federal Regulations.

Appeal rights

If you disagree with any decision or action by our plan in connection with the coordination of benefits and payment rules outlined above, you must follow the procedures explained in Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints) in this *Evidence of Coverage.*

CHAPTER 12:

Definitions of important words

Chapter 12. Definitions of important words

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

Allowed Amount - Individual charge determined by a carrier for a covered medical service or supply.

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of our plan, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to balance bill or otherwise charge you more than the amount of cost-sharing your plan says you must pay.

Benefit Period – The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. For our plan, you will have a benefit period for your skilled nursing facility benefits. For some plans, this may also include the inpatient hospital benefit if the plan has a deductible associated with that benefit. A benefit period begins on the first day you go into an inpatient hospital or a skilled nursing facility. The benefit period will accumulate one day for each day you are inpatient at a hospital or SNF. The benefit period ends when you have not received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

Biological Product - A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. Biosimilars generally work just as well, and are as safe, as the original biological products.

Biosimilar - A prescription drug that is considered to be very similar, but not identical, to the original biological product. Biosimilars generally work just as well, and are as safe, as the original biological product; however, biosimilars generally require a new prescription to substitute for the original biological product. Interchangeable biosimilars have met additional requirements that allow them to be substituted for the original biological product at the pharmacy without a new prescription, subject to state laws.

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

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent $8,000 for Part D covered drugs during the covered year. During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

Centers for Medicare & Medicaid Services (CMS) - The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

Chronic-Care Special Needs Plan - C-SNPs are SNPs that restrict enrollment to MA eligible individuals who have one or more severe or disabling chronic conditions, as defined under 42 CFR 422.2, including restricting enrollment based on the multiple commonly co-morbid and clinically-linked condition groupings specified in 42 CFR 422.4(a)(1)(iv).

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services or prescription drugs.

Combined Maximum Out-of-Pocket Amount – If your plan has this feature, this is the most you will pay in a plan year for all Part A and Part B services from both network (preferred) providers and out-of-network (non-preferred) providers. See Chapter 4, Section 1.3 for information about your combined maximum out-of- pocket amount.

Complaint - The formal name for making a complaint is filing a grievance. The complaint process is used *only* for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

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

Contracted Rate - The rate the network provider or pharmacy has agreed to accept for covered services or prescription drugs.

Copayment (or copay) – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is usually a set amount (for example $10), rather than a percentage.

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

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of four cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

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

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

Covered Services – The term we use to mean all of the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care, provided by people who do not have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Customer Care – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

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

Deductible – The amount you must pay for health care or prescriptions before our plan pays.

Diagnostic Mammogram - A radiological procedure furnished to a man or woman with signs or symptoms of breast disease.

Disenroll or **Disenrollment** – The process of ending your membership in our plan.

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

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care – Covered services that are: (1) rendered by a provider qualified to furnish emergency services; and (2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

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

"Extra Help" – A Medicare or a State program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Freestanding Dialysis Center - 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 - 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 - 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.

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

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

Health Maintenance Organization (HMO) - A type of Medicare managed care plan where a group of doctors, hospitals, and other health care providers agree to give health care to Medicare beneficiaries for a set amount of money from Medicare every month. You usually must get your care from the network providers in the plan.

Home Health Aide – A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Home Health Care - 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 Chapter 4 under the heading "Home health care." If you need home health care services, our plan will cover these services for you provided the Medicare coverage requirements are met. Home health care can include services from a home health aide if the services are part of the home health plan of care for your illness or injury. They aren't covered unless you are also getting a covered skilled service. Home health services don't include the services of housekeepers, food service arrangements, or full-time nursing care at home.

Hospice - A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums, you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer. The hospice will provide special treatment for your state.

Hospice Care - 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 in the last months of life by giving comfort and relief from pain. The focus is on care, not cure. For more information on hospice care, visit **www.medicare.gov** and under "Search Tools" choose "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.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an outpatient.

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

Income Related Monthly Adjustment Amount (IRMAA) - If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Initial Coverage Limit – The maximum limit of coverage under the Initial Coverage Stage.

Initial Coverage Stage – This is the stage before your total drug costs including amounts you have paid and what your plan has paid on your behalf for the year have reached $5,030.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

In-Network Maximum Out-of-Pocket Amount – If applicable for your plan, this is the most you will pay for covered Part A and Part B services received from network (preferred) providers. After you have reached this limit, you will not have to pay anything when you get covered services from network providers for the rest of the contract year. However, until you reach your combined out-of-pocket amount, you must continue to pay your share of the costs when you seek care from an out-of-network (non-preferred) provider. See Chapter 4, Section 1.3 for information about your in-network maximum out-of-pocket.

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

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

Low Income Subsidy (LIS) – See "Extra Help."

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

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

Maximum Out-of-Pocket Amount - The most that you pay out-of-pocket during the calendar year for covered Part A and Part B services. Amounts you pay for your plan premiums, Medicare Part A and Part B premiums and prescription drugs do not count toward the maximum out-of-pocket amount. See Chapter 4 for information about your maximum out-of-pocket amount.

Medicaid (or Medical Assistance) – A joint Federal and State program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books.

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

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

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an i) HMO, ii) PPO, a iii) Private Fee-for-Service (PFFS) plan, or a iv) Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage.**

Medicare Allowable Charge - The amount allowed by Medicare for a particular benefit or service.

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand name drugs to Part D members who have reached the Coverage Gap Stage and who are not already receiving "Extra Help." Discounts are based on agreements between the Federal government and certain drug manufacturers. For this reason, most, but not all, brand name drugs are discounted.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and B. The term Medicare-Covered Services does not include the extra benefits, such as vision, dental or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Limiting Charge - In the Original Medicare plan, the highest amount of money you can be charged for a covered service by doctors and other health care suppliers who do not accept assignment. The limiting charge is 15 percent over Medicare's approved amount. The limiting charge only applies to certain services and does not apply to supplies or equipment.

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Medigap (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill gaps in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

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

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

Network Provider – Provider is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. **Network providers** have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called plan providers.

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 may not be covered by our plan or Original Medicare.

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

Observation Services - are hospital outpatient services given to help the doctor decide if a patient needs to be admitted as an inpatient or can be discharged. Observation services may be given in the emergency department or another area of the hospital. Even if you stay overnight in a regular hospital bed, you might be an outpatient.

Organization Determination - A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called coverage decisions in this document.

Original Medicare (Traditional Medicare or Fee-for-service Medicare) – Original Medicare is offered by the government, and not a private health plan such as Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Our plan – The plan you are enrolled in.

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

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that does not have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan.

Out-of-Pocket Costs – See the definition for cost-sharing above. A member's cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member's out-of-pocket cost requirement.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care services and supports (LTSS) for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

Part C – see "Medicare Advantage (MA) Plan."

Part D – The voluntary Medicare Prescription Drug Benefit Program.

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

Part D Late Enrollment Penalty - An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you are first eligible to join a Part D plan.

Plan Provider – see "Network Provider".

Point-of-Service (POS) Plan - A Medicare managed care plan option that lets you use doctors and hospitals outside the plan for an additional cost.

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

Preferred Cost-Sharing - Preferred cost-sharing means lower cost-sharing for certain covered Part D drugs at certain network pharmacies.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost-sharing may be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

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

Primary Care Physician (PCP) – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization – Approval in advance to get services or certain drugs. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary.

Prosthetics and Orthotics - Medical devices including, but are not limited to: arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

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

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

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Screening Mammogram - A radiological procedure for early detection of breast cancer, and; includes a physician's interpretation of the results.

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you permanently move out of the plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period - A set time when members can change their health or drug plan or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting "Extra Help" with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

Special Needs Plan - A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

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

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

Urgent Care Center - A 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.

Urgently Needed Services - Covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.

ALABAMA	
QIO	KEPRO 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609 1-888-317-0751 1-855-843-4776 (TTY) 1-833-868-4058 (fax)
SHIP	Alabama Department of Senior Services 201 Monroe St., Suite 350, Montgomery, AL 36104 1-800-243-5463 (1-800-AGELINE)(toll free) 1-334-242-5594 (fax) **http://www.alabamaageline.gov/**
SMO	Alabama Medicaid Agency 501 Dexter Avenue, P.O. Box 5624, Montgomery, AL 36103-5624 1-800-362-1504 (toll free) 1-334-242-5000 (local) **http://www.medicaid.alabama.gov/**
SPAP	Not Applicable
ADAP	Alabama AIDS Drug Assistance Programs, HIV/AIDS Division Alabama Department of Public Health The RSA Tower, 201 Monroe Street, Suite 1400, Montgomery, AL 36104 1-866-574-9964 1-334-206-6221 (fax) **http://www.alabamapublichealth.gov/hiv/adap.html**
ALASKA	
QIO	KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-305-6759 1-855-843-4776 (TTY) 1-833-868-4064 (fax)
SHIP	Alaska State Health Insurance Assistance Programs (SHIP) 550 W. 7th Ave., Suite 1230, Anchorage, AK 99501 1-800-478-6065 (toll free) 1-907-269-7800 (local) 1-800-770-8973 (TTY)(toll free) **www.medicare.alaska.gov**
SMO	Alaska Department of Health and Social Services 350 Main Street Room 304, P.O. Box 110640, Juneau, AK 99811 1-800-780-9972 (toll free) 1-907-465-3030 (local) 1-907-465-3068 (fax) **www.dhss.alaska.gov/dpa**
SPAP	Not Applicable
ADAP	Alaskan AIDS Assistance Association 1057 W. Fireweed Lane, Ste 102, Anchorage, AK 99503 1-800-478-2437 1-907-263-2051 (fax) **www.alaskanaids.org/index.php/client-services/adap**
ARIZONA	
QIO	Livanta BFCC-QIO Program 10820 Guilford Rd, Ste 202, Annapolis Junction, MD 20701 1-877-588-1123 1-855-887-6668 (TTY) 1-833-868-4063 (fax)

SHIP	Arizona State Health Insurance Assistance Program (SHIP) 1789 West Jefferson St., (Site Code 950A), Phoenix, AZ 85007 1-800-432-4040 (toll free) (Spanish available upon request) 1-602-542-4446 (local) 711 (TTY) **https://des.az.gov/services/older-adults/medicare-assistance**
SMO	Arizona Health Care Cost Containment System (AHCCCS) 801 E. Jefferson St., Phoenix, AZ 85034 1-800-523-0231 (toll free) 1-602-417-4000 (local) 1-602-252-6536 (fax) 1-602-417-4000 (Spanish) **http://www.azahcccs.gov/**
SPAP	Not Applicable
ADAP	Office of Disease Integration and Services, Arizona Department of Health Services 150 North 18th Avenue Suite 110, Phoenix, AZ 85007 1-800-334-1540 1-602-364-3610 1-602-364-3263 (fax) **https://www.azdhs.gov/preparedness/epidemiology-disease-control/disease-integration-services/index.php#aids-drug-assistance-program-home**
ARKANSAS	
QIO	KEPRO 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609 1-888-315-0636 1-855-843-4776 (TTY) 1-833-868-4060 (fax)
SHIP	Senior Health Insurance Information Program (SHIIP) 1 Commerce Way, Little Rock, AR 72202 1-800-282-9134 (toll free) 1-501-371-2782 (local) 1-501-371-2781 (fax) 1-501-683-4468 (TTY) **www.insurance.arkansas.gov/pages/consumer-services/senior-health/**
SMO	Arkansas Medicaid Donaghey Plaza South, P.O. Box 1437 Slot S401, Little Rock, AR 72203-1437 1-800-482-5431 (toll free) 1-501-682-8233 (local) 1-800-482-8988 (Spanish) 1-501-682-8820 (TTY) **www.medicaid.mmis.arkansas.gov/**
SPAP	Not Applicable
ADAP	Arkansas AIDS Drug Assistance Program, Arkansas Department of Health 4815 West Markham Street; Slot 33, Little Rock, AR 72205 1-501-661-2408 1-501-661-2082 (fax) **www.healthy.arkansas.gov/programs-services/topics/ryan-white-program**

CALIFORNIA	
QIO	Livanta BFCC-QIO Program 10820 Guilford Rd, Ste 202, Annapolis Junction, MD 20701 1-877-588-1123 1-855-887-6668 (TTY) 1-833-868-4063 (fax)
SHIP	California Health Insurance Counseling & Advocacy Program (HICAP) 1300 National Drive, Suite 200, Sacramento, CA 95834-1992 1-800-434-0222 (toll free) 1-916-928-2267 (fax) 1-800-735-2929 (TTY) **www.aging.ca.gov/HICAP/**
SMO	Medi-Cal (Medicaid) P.O. Box 997413 MS 4400, Sacramento, CA 95899-7413 1-800-541-5555 (toll free) 1-916-636-1980 (local) **www.medi-cal.ca.gov/**
SPAP	Not Applicable
ADAP	AIDS Drug Assistance Program California Department of Public Health, Office of AIDS MS 7700, P.O. Box 997426, Sacramento, CA 95899 1-844-421-7050 **https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OAadap.aspx**
COLORADO	
QIO	KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-317-0891 1-855-843-4776 (TTY) 1-833-868-4062 (fax)
SHIP	Senior Health Insurance Assistance Program (SHIP) 1560 Broadway, Suite 850, Denver, CO 80202 1-800-886-7675 (toll free) 1-866-665-9668 (Spanish) 1-303-894-7880 (TTY) **www.colorado.gov/dora/division-insurance**
SMO	Health First Colorado 1570 Grant Street, Denver, CO 80203-1818 1-800-221-3943 (toll free) 1-303-866-2993 (local) 1-303-866-4411 (fax) **www.colorado.gov/hcpf**
SPAP	Colorado Bridging the Gap, Colorado Department of Public Health and Environment 4300 Cherry Creek Drive South, Denver, CO 80246 1-303-692-2783 (local) 1-303-692-2716 (local) **https://www.colorado.gov/pacific/cdphe/prevention-care**
ADAP	Colorado AIDS Drug Assistance Program CDPHE Care and Treatment Program ADAP 4300 Cherry Creek Drive South, Denver, CO 80246-1530 1-303-692-2716 1-303-691-7736 (fax) **https://www.colorado.gov/pacific/cdphe/prevention-care**

CONNECTICUT	
QIO	KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-319-8452 1-855-843-4776 (TTY) 1-833-868-4055 (fax)
SHIP	CHOICES 55 Farmington Avenue, 12th Floor, Hartford, CT 06105-3730 1-800-994-9422 (toll free for in-state) 1-866-218-6631 (out of state callers) 1-860-424-4850 (fax) 1-860-247-0775 (toll free TTY) **www.ct.gov/agingservices**
SMO	HUSKY Health Connecticut 55 Farmington Avenue, Hartford, CT 06105-3730 1-855-626-6632 (toll free) 1-860-424-4908 (local) 1-800-842-4524 (TTY) **www.ct.gov/dss/site/default.asp**
SPAP	Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled Program (PACE) P.O. Box 5011, Hartford, CT 06102 1-800-423-5026 (toll free) 1-860-269-2029 (local) **www.payingforseniorcare.com/prescription-drugs/assistance-for-the-elderly.html**
ADAP	Connecticut AIDS Drug Assistance Program (CADAP) Department of Social Services Medical Operations Unit #4 25 Sigourney Street, Hartford, CT 06106-5033 1-800-233-2503 (toll free) **www.portal.ct.gov/DSS/Health-And-Home-Care/CADAP/Connecticut-AIDS-Drug-Assistance-Program-CADAP**
DELAWARE	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-396-4646 1-888-985-2660 (TTY) 1-833-868-4057 (fax)
SHIP	Delaware Medicare Assistance Bureau (DMAB) 1351 West North Street Suite 101, Dover, DE 19904 1-800-336-9500 (toll free) 1-302-674-7364 (local) **https://insurance.delaware.gov/divisions/dmab/**
SMO	Delaware Health and Social Services Division of Medicaid and Medical Assistance 1901 N. DuPont Highway, New Castle, DE 19720 1-800-372-2022 (toll free) 1-302-255-9500 (local) 1-302-255-4429 (fax) **http://www.dhss.delaware.gov/dhss/dmma/**

SPAP	Delaware Chronic Renal Disease Program 11-13 North Church Ave, Milford, DE 19963 0950 1-800-464-4357 (toll free) 1-302-424-7180 **https://www.dhss.delaware.gov/dhss/dmma/crdprog.html**
ADAP	Delaware HIV Consortium Thomas Collins Building, 540 S. DuPont Highway, Dover, DE 19901 1-302-744-1050 1-302-739-2548 (fax) **http://www.ramsellcorp.com/medical_professionals/de.aspx**
DISTRICT OF COLUMBIA	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-396-4646 1-888-985-2660 (TTY) 1-833-868-4057 (fax)
SHIP	Health Insurance Counseling Project (HICP) 500 K Street, NE, Washington, DC 20002 1-202-724-5626 (local) 711 (TTY) 1-202-724-2008 (fax) **https://dcoa.dc.gov/service/health-insurance-counseling**
SMO	Department of Health- District of Columbia 899 North Capitol Street NE, Washington, DC 20002 1-855-532-5465 (toll free) 1-202-442-5955 (local) 1-202-442-4795 (fax) 711 (TTY) **http://www.doh.dc.gov/**
SPAP	Not Applicable
ADAP	DC AIDS Drug Assistance Program District of Columbia Department of Health 899 North Capitol Street N.E. 4th floor, Washington, DC 20002 1-202-671-4900 1-202-673-4365 (fax) 1-202-671-4815 (DC ADAP Hotline) **https://www.dchealth.dc.gov/DC-ADAP**
FLORIDA	
QIO	KEPRO 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609 1-888-317-0751 1-855-843-4776 (TTY) 1-833-868-4058 (fax)
SHIP	Serving Health Insurance Needs of Elders (SHINE) 4040 Esplanade Way, Suite 270, Tallahassee, FL 32399-7000 1-800-963-5337 (toll free/llamada gratuito) 1-850-414-2150 (fax) 1-800-955-8770 (TTY) **www.floridaSHINE.org**

SMO	Florida Medicaid 1317 Winewood Blvd. Building 1, Room 202, Tallahassee, FL 32399-0700 1-866-762-2237 (toll free/llamada gratuito) 1-850-487-1111 (local) 1-850-922-2993 (fax) **www.ahca.myflorida.com/**
SPAP	Not Applicable/No corresponde
ADAP	Florida ADAP Program, HIV/AIDS Section 4052 Bald Cypress Way, Tallahassee, FL 32399 1-850-245-4422 1-800-545-7432 (1-800-545-SIDA) (español) 1-800-2437-101 (1-800-AIDS-101) (Creole/Kreyòl Ayisiyen) 1-888-503-7118 (TTY) **www.floridahealth.gov/diseases-and-conditions/aids/adap/index.html**
GEORGIA	
QIO	KEPRO 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609 1-888-317-0751 1-855-843-4776 (TTY) 1-833-868-4058 (fax)
SHIP	GeorgiaCares 2 Peachtree Street NW, 33rd Floor, Atlanta, GA 30303 1-866-552-4464 (Option 4) 1-404-657-1929 (TTY) **http://www.mygeorgiacares.org/**
SMO	Georgia Department of Community Health (DCH) (Medicaid) 2 Peachtree Street NW, Atlanta, GA 30303 1-800-436-7442 (toll free) 1-404-656-4507 (local) **http://www.dch.georgia.gov/**
SPAP	Not Applicable
ADAP	Georgia AIDS Drug Assistance Program Georgia Department of Public Health 2 Peachtree St. NW, Atlanta, GA 30303-3186 1-404-656-9805 **https://dph.georgia.gov/aids-drug-assistance-program-adap-0**
HAWAII	
QIO	Livanta BFCC-QIO Program 10820 Guilford Rd, Ste 202, Annapolis Junction, MD 20701 1-877-588-1123 1-855-887-6668 (TTY) 1-833-868-4063 (fax)
SHIP	Sage PLUS Program Executive Office on Aging No. 1 Capitol District 250 South Hotel St., Suite 406, Honolulu, HI 96813-2831 1-888-875-9229 (toll free) 1-808-586-7299 (local) 1-808-586-0185 (fax) 1-866-810-4379 (toll free TTY) **http://www.hawaiiship.org/**

SMO	Med QUEST 801 Dillingham Boulevard, 3rd Floor, Honolulu, HI 96817-4582 1-800-316-8005 (toll free) 1-808-524-3370 (local) 1-800-603-1201 (TTY) 1-800-316-8005 (Spanish) **http://www.med-quest.us/**
SPAP	Not Applicable
ADAP	HDAP, Harm Reduction Services Branch 728 Sunset Avenue, Honolulu, HI 96816 1-808-733-9360 **http://health.hawaii.gov/harmreduction/hiv-aids/hiv-programs/hiv-medical-management-services/**
IDAHO	
QIO	KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-305-6759 1-855-843-4776 (TTY) 1-833-868-4064 (fax)
SHIP	Senior Health Insurance Benefit Advisors (SHIBA) 700 West State Street 3rd Floor, P.O. Box 83720, Boise, ID 83720-0043 1-800-247-4422 (toll free) 1-208-334-4389 (fax) **www.doi.idaho.gov/SHIBA**
SMO	Idaho Health Plan Coverage P.O. Box 83720, Boise, ID 83720 1-877-456-1233 (toll free) 1-208-334-6700 (local) 1-866-434-8278 (fax) **www.healthandwelfare.idaho.gov/**
SPAP	Idaho AIDS Drug Assistance Program (IDAGAP), Department of Health and Welfare P. O. Box 83720, Boise, ID 83720 1-800-926-2588 (toll free) 1-208-334-5943 (local) **www.healthandwelfare.idaho.gov/Health/FamilyPlanningSTDHIV/HIVCareandTreatment/tabid/391/Default.aspx**
ADAP	Idaho ADAP, Idaho Ryan White Part B Program 450 West State Street, P.O. Box 83720, Boise, ID 83720-0036 1-208-334-5612 1-208-332-7346 (fax) **https://healthandwelfare.idaho.gov/Health/HIV,STD,HepatitisPrograms/HIVCare/tabid/391/Default.aspx**
ILLINOIS	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-524-9900 1-888-985-8775 (TTY) 1-833-868-4059 (fax)

SHIP	Senior Health Insurance Program (SHIP) One Natural Resources Way, Suite 100, Springfield, IL 62702-1271 1-800-252-8966 (toll free) 1-888-206-1327 (TTY) **www.illinois.gov/aging/SHIP**
SMO	Medical Assistance Program 100 South Grand Avenue East, Springfield, IL 62762 1-800-226-0768 (toll free) 1-217-782-4977(local) 1-800- 526-5812 (toll free TTY) 1-800-547-0466 (TTY) **www.illinois.gov/hfs/Pages/default.aspx**
SPAP	Not Applicable
ADAP	Illinois AIDS Drug Assistance Program, Illinois ADAP Office 525 West Jefferson Street First Floor, Springfield, IL 62761 1-217-524-5983 1-800-825-3518 (fax) 217-785-8013 (fax) **www.dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids/ryan-white-care-and-hopwa-services**
INDIANA	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-524-9900 1-888-985-8775 (TTY) 1-833-868-4059 (fax)
SHIP	State Health Insurance Assistance Program (SHIP) 311 West Washington Street, Suite 300, Indianapolis, IN 46204-2787 1-800-452-4800 (toll free) 1-765-608-2318 (local) 1-866-846-0139 (toll free TTY) **http://www.in.gov/ship**
SMO	Indiana Medicaid 402 West Washington Street, P.O. Box 7083, Indianapolis, IN 46204-7083 1-800-403-0864 (toll free) 1-317-233-4454 (local) 1-317-232-7867 (fax) **http://www.in.gov/fssa/**
SPAP	Hoosier RX 402 W. Washington St., Room W374 MS07, Indianapolis, IN 46204 1-866-267-4679 (toll free) 1-317-234-1381 (local) **https://www.in.gov/fssa/ompp/3526.htm**
ADAP	Indiana AIDS Drug Assistance Program Indiana State Department of Health 2 N Meridian St., Suite 6C, Indianapolis, IN 46204 1-866-588-4948 **http://www.in.gov/isdh/17740.htm**
IOWA	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-755-5580 1-888-985-9295 (TTY) 1-833-868-4061 (fax)

SHIP	Senior Health Insurance Information Program (SHIIP) 1963 Bell Avenue Suite 100, Des Moines, IA 50315 1-800-351-4664 (toll free) 1-800-735-2942 (toll free TTY) **https://shiip.iowa.gov/**
SMO	IA Health Link 1305 E Walnut St, Des Moines, IA 50319 1-800-338-8366 (toll free) 1-515-256-4606 (local) 1-515-725-1351 (fax) 1-800-735-2942 (TTY) **http://www.dhs.iowa.gov/iahealthlink**
SPAP	Not Applicable
ADAP	Iowa AIDS Drug Assistance Program, Iowa Department of Public Health 321 E. 12th Street, Des Moines, IA 50319-0075 1-515-725-2011 **http://www.idph.iowa.gov/hivstdhep/hiv/support**
KANSAS	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-755-5580 1-888-985-9295 (TTY) 1-833-868-4061 (fax)
SHIP	Senior Health Insurance Counseling for Kansas (SHICK) New England Building 503 S. Kansas Avenue, Topeka, KS 66603 1-800-860-5260 (toll free) 1-785-296-0256 (fax) **http://www.kdads.ks.gov/commissions/commission-on-aging/medicare-programs**
SMO	DCR (Formerly Department of Social and Rehabilitation Services of Kansas) Curtis State Office Building, 1000 SW Jackson, Topeka, KS 66612 1-800-766-9012 (toll free) 1-785-296-1500 (local) **http://www.kdheks.gov/**
SPAP	Not Applicable
ADAP	Kansas AIDS Drug Assistance Program (ADAP) Curtis State Office Building, 1000 SW Jackson Suite 210, Topeka, KS 66612 1-785-296-6174 1-785-559-4225 (fax) **http://www.kdheks.gov/sti_hiv/ryan_white_care.htm**
KENTUCKY	
QIO	KEPRO 5201 W. Kennedy Blvd, Suite 900, Tampa, FL 33609 1-888-317-0751 1-855-843-4776 (TTY) 1-833-868-4058 (fax)
SHIP	State Health Insurance Assistance Program (SHIP) 275 East Main Street, 3E-E, Frankfort, KY 40621 1-877-293-7447 (toll free) 1-502-564-6930 (local) **https://www.chfs.ky.gov/agencies/dail/Pages/ship.aspx**

SMO	Department for Medicaid Services (DMS) 275 East Main Street, Frankfort, KY 40621 1-800-635-2570 (toll free) 1-502-564-4321 (local) **http://www.chfs.ky.gov**
SPAP	Not Applicable
ADAP	Kentucky AIDS Drug Assistance Program (KADAP) Kentucky Cabinet for Public Health and Family Services 275 East Main Street HS2E-C, Frankfort, KY 40621 1-800-420-7431 1-502-564-9865 (fax) **https://www.chfs.ky.gov/agencies/dph/dehp/hab/Pages/services.aspx**
LOUISIANA	
QIO	KEPRO 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609 1-888-315-0636 1-855-843-4776 (TTY) 1-833-868-4060 (fax)
SHIP	Senior Health Insurance Information Program (SHIIP) 1702 N. Third Street, Baton Rouge, LA 70802 1-800-259-5300 (toll free) 1-225-342-5301 (local) **http://www.ldi.la.gov/SHIIP/**
SMO	Healthy Louisiana (Medicaid) Healthy Louisiana P.O. Box 629, Baton Rouge, LA 70821-0629 1-888-342-6207 (toll free) 1-855-229-6848 (local) 1-877-252-2447 (Spanish) 1-855-526-3346 (TTY) **https://ldh.la.gov/**
SPAP	Not Applicable
ADAP	Louisiana AIDS Drug Assistance Program (L-DAP) Department of Health & Hospitals Louisiana Health Access Program (LA HAP) 1450 Poydras St Suite 2136, New Orleans, LA 70112 1-504-568-7474 1-504-568-3157 (fax) **http://www.lahap.org**
MAINE	
QIO	KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-319-8452 1-855-843-4776 (TTY) 1-833-868-4055 (fax)
SHIP	Maine State Health Insurance Assistance Program (SHIP) 109 Capitol Street, 11 State House Station, Augusta, ME 04333 1-800-262-2232 (toll free) Maine relay 711 (TTY) **www.maine.gov/dhhs/oads/community-support/ship.html**
SMO	Maine Department of Health and Human Services (Medicaid) 109 Capitol St, Augusta, ME 04333-0011 1-800-977-6740 (toll free) 1-207-287-3707 (local) 1-207-287-3005 (fax) 711 (TTY) **www.maine.gov/dhhs/**

SPAP	Maine Low Cost Drugs for the Elderly or Disabled Program Office of MaineCare Services 242 State Street, Augusta, ME 04333 1-866-796-2463 **https://www.maine.gov/dhhs/oads/home-support/elderly-physically-disabled/index.html**
ADAP	Maine Ryan White Program 40 State House Station, Augusta, ME 04330 1-207-287-3747 1-207-287-3727 (fax) **www.maine.gov/dhhs/mecdc/infectious-disease/hiv-std/contacts/adap.shtml**
MARYLAND	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-396-4646 1-888-985-2660 (TTY) 1-833-868-4057 (fax)
SHIP	Maryland Department of Aging -Senior Health Insurance Assistance Program (SHIP) 301 West Preston Street, Suite 1007, Baltimore, MD 21201 1-800-243-3425 (toll free) 1-410-767-1100 (local) 1-844-627-5465 (out of state) 711 (TTY) **https://aging.maryland.gov/Pages/state-health-insurance-program.aspx**
SMO	Maryland Department of Health and Mental Hygiene 201 W. Preston St., Baltimore, MD 21201-2399 1-877-463-3464 (toll free) 1-410-767-6500 (local) 1-855-642-8573 (TTY) **https://health.maryland.gov/pages/home.aspx**
SPAP	Maryland Senior Prescription Drug Assistance Program Maryland SPDAP c/o Pool Administrators 628 Hebron Avenue, Suite 100, Glastonbury, CT 06033 1-800-551-5995 (toll free) 1-410-767-5000 (local) **www.marylandspdap.com**
ADAP	Prevention and Health Promotion Administration 500 N Calvert St 5th Floor, Baltimore, MD 21202 1-410-767-6535 1-410-333-2608 (fax) **https://phpa.health.maryland.gov/OIDPCS/CHCS/Pages/madap.aspx**
MASSACHUSETTS	
QIO	KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-319-8452 1-855-843-4776 (TTY) 1-833-868-4055 (fax)
SHIP	Serving Health Information Needs of Elders (SHINE) One Ashburton Place, 5 floor, Boston, MA 02108 1-800-243-4636 (toll free) 1-617-727-7750 (local) 1-617-727-9368 (fax) 1-877-610-0241 (toll free TTY) **https://www.mass.gov/orgs/executive-office-of-elder-affairs**

SMO	MassHealth 100 Hancock Street, 6th Floor, Quincy, MA 02171 1-800-841-2900 (toll free) 1-800-497-4648 (TTY) **http://www.mass.gov/masshealth**
SPAP	Massachusetts Prescription Advantage P.O. Box 15153, Worcester, MA 01615 1-800-243-4636 ext. 2 (toll free) **http://www.mass.gov/elders/healthcare/prescription-advantage/**
ADAP	Community Research Initiative of New England 529 Main Street Suite 301, Boston, MA 02129 1-617-502-1700 1-617-502-1703 (fax) **http://crine.org/hdap**
MICHIGAN	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-524-9900 1-888-985-8775 (TTY) 1-833-868-4059 (fax)
SHIP	MMAP, Inc. 6105 West St. Joseph Hwy, Suite 204, Lansing, MI 48917 1-800-803-7174 (toll free) **www.mmapinc.org**
SMO	Michigan Department of Health and Human Services (Medicaid) Capitol View Building, 201 Townsend Street, Lansing, MI 48913 1-800-642-3195 (toll free) 1-517-241-2966 (local) 1-800-649-3777 (TTY) **www.michigan.gov/mdhhs**
SPAP	Not Applicable
ADAP	Michigan AIDS Drug Assistance Program (MIDAP) Michigan Department of Health and Human Services Division of Health, Wellness and Disease Control, 109 Michigan Avenue 9th Floor, Lansing, MI 48913 1-888-826-6565 1-517-335-7723 (fax) **www.michigan.gov/mdch/**
MINNESOTA	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-524-9900 1-888-985-8775 (TTY) 1-833-868-4059 (fax)
SHIP	Minnesota State Health Insurance Assistance Program/Senior LinkAge Line 540 Cedar Street, PO Box 64976, St. Paul, MN 55164 1-800-333-2433 (toll free) **www.health.state.mn.us/ship/**

SMO	Department of Human Services of Minnesota -MinnesotaCare P.O. Box 64838, St. Paul, MN 55164-0838 1-800-657-3672 (toll free) 1-651-297-3862 (local) 1-651-282-5100 (fax) **www.mn.gov/dhs/**
SPAP	Not Applicable
ADAP	Minnesota AIDS Drug Assistance Program P.O. Box 64972, St. Paul, MN 55164 1-651-431-2414 1-651-431-7414 (fax) **www.mn.gov/dhs/**
MISSISSIPPI	
QIO	KEPRO 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609 1-888-317-0751 1-855-843-4776 (TTY) 1-833-868-4058 (fax)
SHIP	MS Dept of Human Services - Division of Aging & Adult Services 200 South Lamar St., Jackson, Jackson, MS 39201 1-844-822-4622 (toll free) 1-601-359-4577 (local) 1-787-919-7291 (TTY) **www.mdhs.ms.gov/adults-seniors/**
SMO	Mississippi Division of Medicaid 550 High Street, Suite 1000, Jackson, MS 39201 1-800-421-2408 (toll free) 1-601-359-6050 (local) 1-601-359-6048 (fax) 1-228-206-6062 (Video Phone) **www.medicaid.ms.gov/**
SPAP	Not Applicable
ADAP	Mississippi AIDS Drug Assistance Program Office of STD/HIV Care and Services Division Post Office Box 1700, Jackson, MS 39215-1700 1-888-343-7373 1-601-362-4782(fax) **http://msdh.ms.gov**
MISSOURI	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-755-5580 1-888-985-9295 (TTY) 1-833-868-4061 (fax)
SHIP	CLAIM 1105 Lakeview Avenue, Columbia, MO 65201 1-800-390-3330 (toll free) 1-573-817-8320 (local) **http://www.missouriclaim.org**

SMO	MO HealthNet (Medicaid) 615 Howerton Court, P.O. Box 6500, Jefferson City, MO 65102-6500 1-855-373-4636 (toll free) 1-573-751-3425 (local) 1-800-735-2966 (TTY) **http://www.dss.mo.gov/fsd/index.htm**
SPAP	Missouri RX Plan P.O. Box 6500, Jefferson City, MO 65102 1-800-375-1406 (toll free) **www.morx.mo.gov/**
ADAP	Missouri AIDS Drug Assistance Program Bureau of HIV, STD, and Hepatitis Missouri Department of Health & Senior Services P.O. Box 570, Jefferson City, MO 65102-0570 1-573-751-6439 1-573-751-6447 (fax) **http://www.health.mo.gov/living/healthcondiseases/communicable/hivaids/casemgmt.php**
MONTANA	
QIO	KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-317-0891 1-855-843-4776 (TTY) 1-833-868-4062 (fax)
SHIP	Montana State Health Insurance Assistance Program (SHIP) 2030 11th Ave, Helena, MT 59601 1-800-551-3191 (toll free) **http://www.dphhs.mt.gov/sltc/aging/SHIP.aspx**
SMO	State of Montana Department of Public Health and Human Services (Medicaid) 1400 Broadway Cogswell Building, P.O. Box 202951, Helena, MT 59601-8005 1-800-362-8312 (toll free) 1-406-444-4455 (local) 1-406-444-1861 (fax) **http://www.dphhs.mt.gov/**
SPAP	Montana Big Sky RX Program P.O. Box 202915, Helena, MT 59620 1-866-369-1233 (toll free- In State) 1-406-444-1233 (local) **http://www.dphhs.mt.gov/MontanaHealthcarePrograms/BigSky.aspx**
ADAP	Montana AIDS Drug Assistance Program Montana Department of Public Health and Human Services Cosswell Bldg. C – 211, 1400 Broadway, Helena, MT 59620-2951 1-406-444-3565 1-406-444-6842 (fax) **http://www.dphhs.mt.gov/publichealth/hivstd/treatmentprogram.aspx**
NEBRASKA	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-755-5580 1-888-985-9295 (TTY) 1-833-868-4061 (fax)

SHIP	Nebraska Senior Health Insurance Information Program (SHIIP) 1033 O Street, Suite 307, Lincoln, NE 68508 1-800-234-7119 (toll free) 1-402-471-2841(local) 1-800-833-7352 (toll free TTY) 1-800-234-7119 (llamada gratuita) **http://www.doi.nebraska.gov/shiip/**
SMO	Nebraska Department of Health and Human Services (Medicaid) P.O. Box 95026, Lincoln, NE 68509 1-855-632-7633 (toll free) 1-402-471-3121 (local) 1-800-833-7352 (TTY) 1-402-471-9209 (fax) **http://www.dhhs.ne.gov/Pages/default.aspx**
SPAP	Not Applicable
ADAP	Nebraska AIDS Drug Assistance Program Nebraska Department of Health & Human Services 301 Centennial Mall South, Lincoln, NE 68509 1-402-471-2101 1-402-553-5527 (fax) **www.dhhs.ne.gov/Pages/Ryan-White.aspx**
NEVADA	
QIO	Livanta BFCC-QIO Program 10820 Guilford Rd, Ste 202, Annapolis Junction, MD 20701 1-877-588-1123 (toll free) 1-833-868-4063 (fax) 1-855-887-6668 (TTY)
SHIP	State Health Insurance Assistance Program (SHIP) 1860 E Sahara Avenue, Suite 205, Las Vegas, NV 89104 1-800-307-4444 (toll free) 1-702-486-3478 (local) **https://adsd.nv.gov/Programs/Seniors/SHIP/SHIP_Prog/**
SMO	Department of Health and Human Services Division of Health Care Financing and Policy, 1100 E. William Street, Carson City, NV 89701 1-800-992-0900 (toll free) 1-702-631-7098 (local) **www.dwss.nv.gov**
SPAP	Nevada Senior Rx Program Nevada Senior Rx Dept of Health and Human Services 3416 Goni Road Suite D-132, Carson City, NV 89706 1-866-303-6323 (toll free) 1-775-687-4210 (local) **http://adsd.nv.gov/Programs/Seniors/SeniorRx/SrRxProg/**
ADAP	Nevada AIDS Drug Assistance Program Office of HIV/AIDS 4126 Technology Way Suite 200, Carson City, NV 89706 1-775-684-5928 1-775-684-4056 (fax) **http://dpbh.nv.gov/Programs/HIV-Ryan/Ryan_White_Part_B_-_Home/**

NEW HAMPSHIRE	
QIO	KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-319-8452 1-855-843-4776 (TTY) 1-833-868-4055 (fax)
SHIP	NH SHIP - ServiceLink Aging and Disability Resource Center 129 Pleasant Street, Concord, NH 03301-3857 1-866-634-9412 (toll free) **https://www.servicelink.nh.gov/medicare/index.htm**
SMO	New Hampshire Medicaid 129 Pleasant Street, Concord, NH 03301 1-844-275-3447 (toll free) 1-603-271-4344 (local) 1-800-735-2964 (toll free TTY) **www.dhhs.nh.gov/**
SPAP	Not Applicable
ADAP	New Hampshire AIDS Drug Assistance Program DHHS- NH CARE Program, 29 Hazen Drive, Concord, NH 03301 1-800-852-3345 ext. 4502 1-603-271-4934 (fax) 1-603-271-4502 **www.dhhs.nh.gov**
NEW JERSEY	
QIO	Livanta BFCC-QIO Program 10820 Guilford Rd, Ste 202, Annapolis Junction, MD 20701 1-866-815-5440 (toll free) 1-833-868-4056 (fax) 1-866-868-2289 (TTY)
SHIP	State Health Insurance Assistance Program (SHIP) P.O. Box 715, Trenton, NJ 08625 0715 1-800-792-8820 (toll free) 1-877-222-3737 (out of state) **http://www.state.nj.us/humanservices/doas/services/ship/index.html**
SMO	NH Family Care P.O. Box 712, Trenton, NJ 08625-0712 1-800-356-1561 (toll free) 1-877-294-4356 (TTY) **http://www.state.nj.us/humanservices/dmahs**
SPAP	New Jersey Senior Gold Prescription Discount Program New Jersey Department of Health and Senior Services Senior Gold Discount Program, P.O. Box 715, Trenton, NJ 08625 1-800-792-9745 (toll free) **http://www.state.nj.us/humanservices/doas/services/seniorgold/**
ADAP	New Jersey AIDS Drug Assistance Program New Jersey ADDP Office, P.O. Box 722, Trenton, NJ 08625-0722 1-877-613-4533 1-609-588-7037 (fax) **http://www.state.nj.us/health/aids**

NEW MEXICO	
QIO	KEPRO 5201 W. Kennedy Blvd., Suite 900, Tampa FL 33609 1-888-315-0636 1-855-843-4776 (TTY) 1-833-868-4060 (fax)
SHIP	New Mexico ADRC 2550 Cerrillos Road, Santa Fe, NM 87505 1-800-432-2080 (toll free) 1-505-476-4846 (local) **www.nmaging.state.nm.us/**
SMO	Department of Human Services of New Mexico P.O. Box 2348, Santa Fe, NM 87504-2348 1-888-997-2583 (toll free) 1-505-827-3100 (local) 1-800-432-6217 (Spanish) 1-855-227-5485 (TTY) **www.newmexico.gov/**
SPAP	Not Applicable
ADAP	New Mexico AIDS Drug Assistance Program, HIV Services Program 1190 S St. Francis Dr. Suite 2-1200, Santa Fe, NM 87502 1-505-476-3628 1-505-827-0561 (fax) **www.nmhealth.org/about/phd/idb/hats/**
NEW YORK	
QIO	Livanta BFCC-QIO Program 10820 Guilford Rd, Ste 202, Annapolis Junction, MD 20701 1-866-815-5440 1-833-868-4056 (fax) 1-866-868-2289 (TTY)
SHIP	Health Insurance Information Counseling and Assistance Program (HIICAP) 2 Empire State Plaza, Albany, NY 12223-1251 1-800-701-0501 (toll free) **https://aging.ny.gov/health-insurance-information-counseling-and-assistance**
SMO	New York State Department of Health (SDOH) (Medicaid), Office of Medicaid Management 800 North Pearl Street, Albany, NY 12204 1-800-541-2831 (toll free) 1-518-473-3782 (local) **www.omig.ny.gov**
SPAP	New York State Elderly Pharmaceutical Insurance Coverage (EPIC) EPIC P.O. Box 15018, Albany, NY 12212-5018 1-800-332-3742 (toll free) **www.health.state.ny.us/nysdoh/epic/faq.htm**
ADAP	New York AIDS Drug Assistance Program HIV Uninsured Care Programs Empire Station P.O. Box 2052, Albany, NY 12220 1-800-542-2437 (or 1-844-682-4058 (toll-free)) 1-518-459-0121 (TDD) **www.health.ny.gov/diseases/aids/general/resources/adap**

NORTH CAROLINA	
QIO	KEPRO 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609 1-888-317-0751 1-855-843-4776 (TTY) 1-833-868-4058 (fax)
SHIP	Seniors' Health Insurance Information Program (SHIIP) 325 N. Salisbury Street, Raleigh, NC 27603 1-855-408-1212 (toll free) 1-919-807-6900 (local) 1-919-807-6901 (fax) **http://www.ncdoi.com/SHIIP/Default.aspx**
SMO	North Carolina, Division of Health Benefits (Medicaid) 2501 Mail Service Center, Raleigh, NC 27699-2501 1-800-662-7030 (toll free) 1-919-855-4100 (local) 1-919-733-6608 (fax) **https://www.dma.ncdhhs.gov/**
SPAP	North Carolina HIV SPAP 1902 Mail Service Center, Raleigh, NC 27699 1-877-466-2232 (toll free) 1-919-733-7301 (local) **https://epi.dph.ncdhhs.gov/cd/hiv/hmap.html**
ADAP	North Carolina AIDS Drug Assistance Program NC Department of Health and Human Services Division of Public Health Epidemiology Section Communicable Disease Branch 1907 Mail Service Center, Raleigh, NC 27699-1902 1-877-466-2232 (toll free) (in state) 1-919-733-0490 (fax) 1-877-466-2232 (toll free) **http://epi.publichealth.nc.gov/cd/hiv/hmap.html**
NORTH DAKOTA	
QIO	KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-317-0891 1-855-843-4776 (TTY) 1-833-868-4062 (fax)
SHIP	Senior Health Insurance Counseling (SHIC) North Dakota Insurance Department, 600 East Boulevard Ave. Bismarck, ND 58505-0320 1-888-575-6611 (toll free) 1-701-328-2440 (local) 1-701-328-4880 (fax) 1-800-366-6888 (TTY) **www.nd.gov/ndins/shic**
SMO	North Dakota Department of Human Resources 600 East Blvd. Ave, Dept. 325, Bismarck, ND 58505-0250 1-800-755-2604 (toll free) 1-701-328-7068 (local) 1-701-328-1544 (fax) 1-800-366-6888 (TTY) **www.nd.gov/dhs/**
SPAP	Not Applicable

ADAP	North Dakota AIDS Drug Assistance Program, North Dakota Department of Health 2635 E. Main Avenue P.O. Box 5520, Bismarck, ND 58506-5520 1-701-328-2378 1-701-328-0338 1-800-472-2180 (toll free) **www.ndhealth.gov/HIV**
OHIO	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-524-9900 1-888-985-8775 (TTY) 1-833-868-4059 (fax)
SHIP	Ohio Senior Health Insurance Information Program (OSHIIP) 50 West Town Street, 3rd floor Suite 300, Columbus, OH 43215 1-800-686-1578 (toll free) 1-614-644-3745 (TTY) **www.insurance.ohio.gov**
SMO	Ohio Department of Medicaid (ODM) 50 West Town Street, Suite 400, Columbus, OH 43215 1-800-324-8680 (toll free) 1-614-466-1213 (local) **www.medicaid.ohio.gov/**
SPAP	Not Applicable
ADAP	Ohio HIV Drug Assistance Program (OHDAP) Ohio Department of Health HIV Care Services Section Ohio HIV Drug Assistance Program (OHDAP), 246 N. High Street, Columbus, OH 43215 1-800-777-4775 **https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/Ryan-White-Part-B-HIV-Client-Services/AIDS-Drug-Assistance-Program/**
OKLAHOMA	
QIO	KEPRO 5201 W. Kennedy Blvd, Suite 900, Tampa, FL 33609 1-888-315-0636 1-855-843-4776 (TTY) 1-833-868-4060 (fax)
SHIP	Oklahoma Medicare Assistance Program (MAP) Five Corporate Plaza 3625 NW 56th St., Suite 100, Oklahoma City, OK 73112 1-800-763-2828 (toll free) (in state only) 1-405-521-6628 (local) (out of state only) **https://www.ok.gov/oid/Consumers/Information_for_Seniors/index.html**
SMO	Oklahoma Health Care Authority (OHCA) (Medicaid) 4345 N. Lincoln Blvd., Oklahoma City, OK 73105 1-800-522-0310 (toll free) 1-405-522-7300 (local) 1-405-522-7100 (fax) **http://www.okhca.org/**
SPAP	Not Applicable

ADAP	Oklahoma AIDS Drug Assistance Program HIV/STD Services Division Oklahoma State Department of Health 1000 N.E. Tenth St., Mail Drop 0308, Oklahoma City, OK 73117-1299 1-405-271-4636 1-405-271-5149 (fax) **https://www.ok.gov/health/Prevention_and_Preparedness/HIV_STD_Service/index.html**
OREGON	
QIO	KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-305-6759 1-855-843-4776 (TTY) 1-833-868-4064 (fax)
SHIP	Senior Health Insurance Benefits Assistance (SHIBA) P.O. Box 14480, Salem, OR 97309 1-800-722-4134 (toll free) 1-503-947-7979 (local) **https://healthcare.oregon.gov/shiba/pages/index.aspx**
SMO	Oregon Health Authority 500 Summer Street NE,E-15, Salem, OR 97301 1-800-375-2863 (toll free) 1-503-947-2340 (local) 1-503-947-5461 (fax) 1-503-945-6214 (TTY) **www.oregon.gov/oha**
SPAP	Not Applicable
ADAP	Oregon AIDS Drug Assistance Program (ADAP) CAREAssist Program 800 NE Oregon Street Suite 1105, Portland, OR 97232 1-971-673-0144 1-971-673-0177 (fax) **http://www.public.health.oregon.gov/DiseasesConditions/HIVSTDViralHepatitis/HIVCareTreatment**
PENNSYLVANIA	
QIO	Livanta BFCC-QIO Program 10820 Guilford Rd, Ste 202, Annapolis Junction, MD 20701 1-888-396-4646 1-888-985-2660 (TTY) 1-833-868-4057 (fax)
SHIP	APPRISE 555 Walnut Street, 5th Floor, Harrisburg, PA 17101-1919 1-800-783-7067 (toll free) 1-717-783-1550 (local) **www.aging.state.pa.us**
SMO	Pennsylvania Department of Human Services (Medicaid) 625 Forster St, Harrisburg, PA 17120 1-800-692-7462 (toll free) 1-800-451-5886 (TTY) **www.dhs.pa.gov**
SPAP	Pharmaceutical Assistance Contract for the Elderly (PACE) PACE/Pacenet Program, P.O. Box 8806, Harrisburg, PA 17105 1-800-225-7223 (toll free) 1-717-651-3600 (local) **https://www.aging.pa.gov/aging-services/prescriptions/Pages/default.aspx**

ADAP	Pennsylvania AIDS Drug Assistance Program (ADAP) Pennsylvania Department of Health Special Pharmaceutical Benefits Program 625 Forster Street, H&W Bldg, Rm 611 Harrisburg, PA 17120 1-800-922-9384 1-888-656-0372 (fax) **www.health.pa.gov/My%20Health/Diseases%20and%20Conditions/E-H/HIV%20And%20AIDS%20Epidemiology/Pages/Special-Pharmaceutical-Benefits-Program.aspx#.V1IcIKPD9es**
PUERTO RICO	
QIO	Livanta BFCC-QIO Program 10820 Guilford Rd, Ste 202, Annapolis Junction, MD 20701 1-866-815-5440 1-833-868-4056 (fax) 1-866-868-2289 (TTY) **www.bfccqioarea1.com/**
SHIP	State Health Insurance Assistance Program (SHIP) P.O. Box 191179, San Juan, PR 00919-1179 1-877-725-4300 (toll free/llamada gratuita) 1-787-721-6121 (local) 1-787-919-7291 (TTY) **https://agencias.pr.gov/agencias/oppea/educacion/Pages/ship.aspx**
SMO	Administración de Seguros de Salud (ASES) P.O. Box 70184, San Juan, PR 00936-8184 1-787-641-4224 (local and toll free/llamada y línea gratuita) 1-787-625-6955 (TTY) 1-787-250-0990 (fax) **www.medicaid.pr.gov**
SPAP	Not Applicable/No corresponde
ADAP	Puerto Rico AIDS Drug, Copays and Coinsurance Assistance Program Departamento de Salud OCASET Programa Ryan White Parte B P.O. Box 70184, San Juan, PR 00936-8184 1-787-765-2929 1-787-766-7015 (fax) **www.salud.gov.pr/Dept-de-Salud/Pages/Unidades-Operacionales/Secretaria-Auxiliar-de-Salud-Familiar-y-Servicios-Integrados/Division%20Central%20de%20Asuntos%20de%20SIDA%20y%20Enfermedades%20Transmisibles/Programa-Ryan-White.aspx**
RHODE ISLAND	
QIO	KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-319-8452 1-855-843-4776 (TTY) 1-833-868-4055 (fax)
SHIP	Senior Health Insurance Program (SHIP) Rhode Island Department of Human Services, Division of Elderly Affairs 57 Howard Ave, Louis Pasteur Bldg. 2nd Floor, Cranston, RI 02920 1-888-884-8721 (local) 1-401-462-0740 (TTY) **www.dea.ri.gov/**

SMO	Executive Office of Health and Human Services Louis Pasteur Building, 57 Howard Avenue, Cranston, RI 02920 1-401-462-5274 (local) 1-855-697-4347 (toll free) 1-800-745-5555 (TTY) **http://www.ohhs.ri.gov/contact/**
SPAP	Rhode Island Pharmaceutical Assistance for the Elderly (RIPAE) Attn: RIPAE, Rhode Island Department of Elderly Affairs 74 West Road 2nd Floor, Hazard Building, Cranston, RI 02920 1-401-462-3000 (local) 1-401-462-0740 (local) 1-401-462-0740 (TTY) **http://www.oha.ri.gov/**
ADAP	Rhode Island AIDS Drug Assistance Program (ADAP) Executive Office of Health & Human Services, Virks Building 3 West Road, Suite 227, Cranston, RI 02920 1-401-462-3295 1-401-462-3297 (fax) **www.health.ri.gov/diseases/hivaids/about/stayinghealthy/**
SOUTH CAROLINA	
QIO	KEPRO 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609 1-888-317-0751 1-855-843-4776 (TTY) 1-833-868-4058 (fax)
SHIP	(I-CARE) Insurance Counseling Assistance and Referrals for Elders 1301 Gervais Street, Suite 350, Columbia, SC 29201 1-800-868-9095 (toll free) 1-803-734-9900 (local) 1-803-734-9886 (fax) **https://aging.sc.gov/**
SMO	South Carolina Department of Health and Human Services (Medicaid) P.O. Box 8206, Columbia, SC 29202-8206 1-888-549-0820 (toll free) 1-803-898-2500 (local) 1-888-842-3620 (TTY) **www.scdhhs.gov**
SPAP	Not Applicable
ADAP	South Carolina AIDS Drug Assistance Program (ADAP) SC Drug Assistance Program/Direct Dispensing Program 3rd Floor, Mills Jarrett Box 101106, Columbia, SC 29211 1-800-856-9954 (toll free) **http://www.scdhec.gov/Health/DiseasesandConditions/InfectiousDiseases/HIVandSTDs/AIDSDrugAssistancePlan**

SOUTH DAKOTA	
QIO	KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-317-0891 1-855-843-4776 (TTY) 1-833-868-4062 (fax)
SHIP	Senior Health Information and Insurance Education (SHIINE) 2300 W. 46th St., Sioux Falls, SD 57105 1-800-536-8197 (toll free) 1-605-336-7471 (fax) **www.shiine.net**
SMO	Department of Social Services of South Dakota 700 Governors Drive, Richard F. Kneip Bldg., Pierre, SD 57501-2291 1-800-597-1603 (toll free) 1-605-773-3165 (local) 1-800-305-9673 (Spanish) **https://dss.sd.gov/**
SPAP	Not Applicable
ADAP	South Dakota AIDS Drug Assistance Program (ADAP) Ryan White Part B CARE Program South Dakota Department of Health 615 E. 4th St., Pierre, SD 57501-1700 1-800-592-1861 1-605-773-5509 (fax) 1-605-773-3737 **https://doh.sd.gov/diseases/infectious/ryanwhite**
TENNESSEE	
QIO	KEPRO 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609 1-888-317-0751 1-855-843-4776 (TTY) 1-833-868-4058 (fax)
SHIP	Tennessee Commission on Aging & Disability -TN SHIP 502 Deaderick St, 9th Floor, Nashville, TN 37243-0860 1-877-801-0044 (toll free) 1-615-741-2056 (local) 1-800 848-0299 (toll free TDD) **http://tnmedicarehelp.com/%20or%20http:/www.tn.gov/aging/**
SMO	TennCare (Medicaid) 310 Great Circle Road, Nashville, TN 37243 1-800-342-3145 (toll free) 1-877-779-3103 (toll free TTY) 1-855-259-0701 (Spanish) 1-615-532-7322 (fax) **www.tn.gov/tenncare/**
SPAP	Not Applicable
ADAP	Tennessee HIV Drug Assistance Program (HDAP) TN Department of Health, HIV/STD Program, 710 James Robertson Parkway, 4th Floor, Andrew Johnson Tower, Nashville, TN 37243 1-615-741-7500 1-800-525-2437 (toll free) **www.tn.gov/health**

TEXAS	
QIO	KEPRO 5201 W. Kennedy Dr., Suite 900, Tampa, FL 33609 1-888-315-0636 1-855-843-4776(TTY) 1-833-868-4060 (fax)
SHIP	Texas Department of Aging and Disability Services (HICAP) 1100 West 49th Street, Austin, TX 78756-3199 1-800-252-9240 (toll free) 1-800-735-2989 (toll free TTY) **https://hhs.texas.gov/services/health/medicare**
SMO	Texas Health and Human Services Commission (HHSC) Medicaid Program 4900 N. Lamar Blvd., Austin, TX 78751-2316 1-800-252-8263 (toll free) 1-512-424-6500 (local) 1-512-424-6597 (TTY) **http://www.hhsc.state.tx.us**
SPAP	Texas Kidney Health Care Program (KHC) Department of State Health Services MC 1938 P.O. Box 149347, Austin, TX 78714 1-800-222-3986 (toll free) 1-512-776-7150 (local) **http://www.dshs.state.tx.us/kidney/default.shtm**
ADAP	Texas AIDS Drug Assistance Program (ADAP) Texas HIV Medication Program, ATTN: MSJA, MC 1873 P.O Box 149347, Austin, TX 78714 1-800-255-1090 (toll free) 1-512-533-3178 (fax) **http://www.dshs.state.tx.us/hivstd/default.shtm**
UTAH	
QIO	KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-317-0891 1-855-843-4776 (TTY) 1-833-868-4062 (fax)
SHIP	Senior Health Insurance Information Program (SHIP) 195 North 1950 West, Salt Lake City, UT 84116 1-800-541-7735 (toll free) 1-801-538-3910 (local) 1-801-538-4395 (fax) **https://daas.utah.gov/seniors/**
SMO	Utah Department of Health Medicaid Martha S. Hughes Cannon Building 288 North 1460 West, Salt Lake City, UT 84116 1-800-662-9651 (toll free) 1-801-538-6155 (local) 1-866-608-9422 (Spanish) 1-801-538-6805 (fax) **https://medicaid.utah.gov/**
SPAP	Not Applicable

ADAP	Utah AIDS Drug Assistance Program (ADAP) Utah Department of Health Bureau of Epidemiology 288 North 1460 West Box 142104, Salt Lake City, UT 84114-2104 1-801-538-6191 1-801-538-9913 (fax) **http://health.utah.gov**
VERMONT	
QIO	KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-319-8452 1-855-843-4776 (TTY) 1-833-868-4055 (fax)
SHIP	State Health Insurance Assistance Program (SHIP) 476 Main Street Suite #3, Winooski VT 05404 1-800-642-5119 (toll free) 1-(802) 865-0360 (local) **www.vermont4a.org/**
SMO	Agency of Human Services of Vermont Center Building 280 State Drive, Waterbury, VT 05671 1-800-250-8427 (toll free) 1-802-871-3008 (local) 1-802-879-5962 (fax) **www.humanservices.vermont.gov/**
SPAP	VPharm 312 Hurricane Lane, Suite 201, Williston, VT 05495 1-800-250-8427 (toll free) **www.greenmountaincare.org/prescription**
ADAP	Vermont Medication Assistance Program (VMAP) Vermont Department of Health, Vermont Medication Assistance Program 108 Cherry Street- PO BOX 70, Burlington, VT 05402 1-802-951-4005 1-802-863-7314 **www.healthvermont.gov/prevent/aids/aids_index.aspx**
VIRGINIA	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-396-4646 1-888-985-2660 (TTY) 1-833-868-4057 (fax)
SHIP	Virginia Insurance Counseling and Assistance Program (VICAP) 1610 Forest Avenue, Suite 100, Henrico, VA 23229 1-800-552-3402 (toll free) 1-804-662-9333 (local) 1-804-552-3402 (toll free TTY) **www.vda.virginia.gov**
SMO	Department of Medical Assistance Services 600 East Broad Street, Suite 1300, Richmond, VA 23219 1-804-786-7933 (local) 1-855-242-8282 (toll free) 1-888-221-1590 (TTY) **www.dmas.virginia.gov/**

SPAP	Virginia HIV SPAP HCS Unit, 1st Floor James Madison Building 109 Governor Street, Richmond, VA 23219 1-855-362-0658 (toll free) **http://166.67.66.226/epidemiology/DiseasePrevention/Programs/ADAP/**
ADAP	Virginia AIDS Drug Assistance Program (ADAP) Virginia Department of Health, HCS Unit, James Madison Building 1st Floor, 109 Governor Street, Richmond, VA 23219 1-855-362-0658 1-804-864-8050 **www.vdh.virginia.gov/epidemiology/DiseasePrevention/Programs/ADAP/forms.htm**
WASHINGTON	
QIO	KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-305-6759 1-855-843-4776 (TTY) 1-833-868-4064 (fax)
SHIP	Statewide Health Insurance Benefits Advisors (SHIBA) P.O. Box 40255, Olympia, WA 98504-0255 1-800-562-6900 (toll free) 1-360-586-0241 (TTY) **www.insurance.wa.gov/shiba**
SMO	Washington State Health Care Authority (Medicaid) Cherry Street Plaza 626 8th Avenue SE, P.O. Box 45531, Olympia, WA 98501 1-800-562-3022 (toll free) **www.hca.wa.gov/**
SPAP	Not Applicable
ADAP	Washington State AIDS Drug Assistance Program (ADAP) Early Intervention Program (EIP) Client Services, P.O. Box 47841, Olympia, WA 98504 1-877-376-9316 (in Washington state) 1-360-664-2216 (fax) 1-360-236-3426 **http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/HIVAIDS/HIVCareClientServices/ADAPandEIP**
WEST VIRGINIA	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-396-4646 1-888-985-2660 (TTY) 1-833-868-4057 (fax)

SHIP	West Virginia State Health Insurance Assistance Program (WV SHIP) 1900 Kanawha Blvd. East, Charleston, WV 25305 1-877-987-4463 (toll free) 1-304-558-3317 (local) 1-304-558-0004 (fax) **www.wvship.org**
SMO	West Virginia Department of Health & Human Resources Medicaid 350 Capitol Street, Room 251, Charleston, WV 25301-3709 1-800-642-8589 (toll free) 1-304-558-1700 (local) **www.dhhr.wv.gov/bms**
SPAP	Not Applicable
ADAP	West Virginia AIDS Drug Assistance Program (ADAP) Jay Adams, HIV Care Coordinator, P.O. Box 6360, Wheeling, WV 26003 1-304-232-6822 **http://oeps.wv.gov/rwp/pages/default.aspx**
WISCONSIN	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-524-9900 1-888-985-8775 (TTY) 1-833-868-4059 (fax)
SHIP	WI State Health Ins. Assist. Program (SHIP) 1 West Wilson Street, Madison, WI 53703 1-800-242-1060 (toll free) 711 or 1-800-947-3529 (TTY) **www.dhs.wisconsin.gov/benefit-specialists/ship.htm**
SMO	Wisconsin Department of Health Services 1 West Wilson Street, Madison, WI 53703 3445 1-800-362-3002 (toll free) 1-608-266-1865 (local) 1-800-947-3529 (TTY) **www.dhs.wisconsin.gov**
SPAP	Wisconsin SeniorCare P.O. Box 6710, Madison, WI 53716 1-800-657-2038 (toll free) **www.dhs.wisconsin.gov/seniorcare/**
ADAP	Wisconsin AIDS Drug Assistance Program (ADAP) Division of Public Health, Attn: ADAP, P.O. Box 2659, Madison, WI 53701 1-800-991-5532 1-608-266-1288 (fax) 1-608-267-6875 **www.dhs.wisconsin.gov/aids-hiv/resources/overviews/AIDS_HIV_drug_reim.htm**

WYOMING	
QIO	KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-317-0891 (toll free) 1-855-843-4776 (TTY) 1-833-868-4062 (fax)
SHIP	Wyoming State Health Insurance Information Program (WSHIIP) 106 W Adams, Riverton, WY 82501 1-800-856-4398 (toll free) 1-307-856-6880 (local) **www.wyomingseniors.com**
SMO	Wyoming Department of Health 2300 Capital Ave, Suite 401, Hathaway Bldg., Cheyenne, WY 82002 1-866-571-0944 (toll free) 1-307-777-7656 (local) 1-307-777-7439 (fax) **www.health.wyo.gov/**
SPAP	Not Applicable
ADAP	Wyoming AIDS Drug Assistance Program (ADAP) Wyoming Department of Health, Communicable Disease Unit 6101 Yellowstone Rd. Suite 510, Cheyenne, WY 82002 1-307-777-5856 1-307-777-5279 **www.health.wyo.gov/publichealth/communicable-disease-unit/hivaids/**

Important

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- **California residents:** You may also call the California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

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Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-320-1235 (TTY: 711). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-320-1235 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-877-320-1235（听障专线：711）。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-877-320-1235（聽障專線：711）。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-320-1235 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-320-1235 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-877-320-1235 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-320-1235 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다 . 통역 서비스를 이용하려면 전화 1-877-320-1235 (TTY: 711) 번으로 문의해 주십시오 . 한국어를 하는 담당자가 도와 드릴 것입니다 . 이 서비스는 무료로 운영됩니다 .

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-320-1235 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بخطتنا الصحية أو خطة الأدوية الموصوفة لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-877-320-1235 (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

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Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-320-1235 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-320-1235 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-320-1235 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

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