Evidence of Coverage:

Your Medicare Prescription Drug Coverage as a Member of Humana Group Medicare PDP Plan

This booklet gives you the details about your Medicare prescription drug coverage for this plan year. It explains how to get coverage for the prescription drugs you need. **This is an important legal document. Please keep it in a safe place.**

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

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 booklet*) 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 and/or pharmacy network may change at any time. You will receive notice when necessary.

2022 Evidence of Coverage

Table of Contents

This list of chapters and page numbers is your starting point. For more help in finding information you need, go to the first page of a chapter. **You will find a detailed list of topics at the beginning of each chapter.**

CHAPTER 1

Getting started as a member

Chapter 1. Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in Humana Group Medicare PDP Plan, which is a Medicare Prescription Drug Plan

You are covered by Original Medicare for your health care coverage, and you have chosen to get your Medicare prescription drug coverage through our plan, Humana Group Medicare PDP Plan.

There are different types of Medicare plans. Humana Group Medicare PDP Plan is a Medicare prescription drug plan (PDP). Like all Medicare health plans, this Medicare PDP is approved by Medicare and run by a private company.

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

This *Evidence of Coverage* booklet tells you how to get your Medicare prescription drug coverage through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

The word "coverage" and "covered drugs" refers to the prescription drug coverage available to you as a member of Humana Group Medicare PDP Plan.

It's important for you to learn what the plan's rules are and what coverage is 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. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

Section 1.3 Legal information about the *Evidence of Coverage*

It's part of our contract with you

This *Evidence of Coverage* is part of our contract with you about how Humana Group Medicare PDP 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 PDP Plan coverage between January 1, 2022 and December 31, 2022.

Each 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 PDP Plan after December 31, 2022. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2022.

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve the Humana Group Medicare PDP Plan each year. You can continue 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 Medicare Part A or Medicare Part B (or you have both Part A and Part B) (section 2.2 tells you about Medicare Part A and Medicare Part B);
- -- *and* -- you live in our geographic service area (section 2.3 below describes our service area);
- -- *and* -- you are a United States citizen or are lawfully present in the United States.

Section 2.2 What are Medicare Part A and Medicare Part B?

As discussed in Section 1.1 above, you have chosen to get your prescription drug coverage (sometimes called Medicare Part D) through our plan. Our plan has contracted with Medicare to provide you with most of these Medicare benefits. We describe the drug coverage you receive under your Medicare Part D coverage in Chapter 3.

When you first signed up for Medicare, you received information about what services are covered under Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally helps cover services provided by hospitals for inpatient services, skilled nursing facilities, or home health agencies.

- Medicare Part B is for most other medical services (such as physician's services, home infusion therapy, and other outpatient services) and certain items (such as durable medical equipment (DME) and supplies).

Section 2.3 Here is the plan service area for Humana Group Medicare PDP Plan

Although Medicare is a Federal program, Humana Group Medicare PDP 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.

Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming.

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

If you plan to move out of the service area, please contact Customer Care. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.) When you move, you will have a Special Enrollment Period that will allow you to 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.

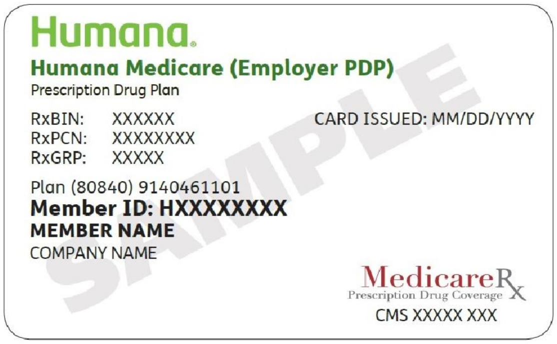
Section 2.4 U.S. Citizen or Lawful Presence

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 PDP Plan if you are not eligible to remain a member on this basis. Humana Group Medicare PDP Plan must disenroll you if you do not meet this requirement.

SECTION 3 What other materials will you get from us?

Section 3.1 Your plan membership card – Use it to get all covered prescription drugs

While you are a member of our plan, you must use your membership card for our plan 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:



Please carry your card with you at all times and remember to show your card when you get covered drugs. If your plan membership card is damaged, lost, or stolen, call Customer Care right away and we will send you a new card. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

You may need to use your red, white, and blue Medicare card to get covered medical care and services under Original Medicare.

Section 3.2 The *Pharmacy Directory*: Your guide to pharmacies in our network

What are "network pharmacies"?

Network pharmacies are all of the pharmacies that have agreed to fill covered prescriptions for our plan members.

Why do you need to know about network pharmacies?

You can use the *Pharmacy Directory* to find the network pharmacy you want to use. An updated *Pharmacy Directory* is located on our website at **www.humana.com**. You may also call Customer Care for updated provider information or to ask us to mail you a *Pharmacy Directory*. Please review the 2022 *Pharmacy Directory* to see which pharmacies are in our network.

If you don't have the *Pharmacy Directory*, you can request a copy from Customer Care. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.) At any time, you can call Customer Care to get up-to-date information about changes in the pharmacy network. 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 PDP 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 PDP 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 4, 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 3.4 *SmartSummary*: Reports with a summary of payments made for your Part D prescription drugs

When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called *SmartSummary*.

SmartSummary tells you the total amount you, others on your behalf, and we have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during each month the Part D benefit is used. The *SmartSummary* provides more information about the drugs you take, such as increases in price and other drugs with lower cost-sharing that may be available. You should consult with your prescriber about these lower cost options. Chapter 4 (*What you pay for your Part D prescription drugs*) gives more information about the *SmartSummary* and how it can help you keep track of your drug coverage.

The *SmartSummary* is also available upon request. To get a copy, please contact Customer Care. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

SECTION 4 Your monthly premium for Humana Group Medicare PDP Plan

Section 4.1 How much is your 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.

In some situations, your plan premium could be <u>less</u>

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. 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 and ask for the *"LIS Rider"*. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

In some situations, your plan premium could be <u>more</u>

In some situations, your plan premium could be more than the amount listed above in Section 4.1. Some members are required to pay a **Part D late enrollment penalty** because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of 63 days or more when they didn't have "creditable" prescription drug coverage. ("Creditable" means the drug coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) For these members, the Part D late enrollment penalty is added to the plan's monthly premium. Their premium amount will be the monthly plan premium plus the amount of their Part D late enrollment penalty.

- If you are required to pay the Part D late enrollment penalty, the cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. Chapter 1, Section 5 explains the Part D late enrollment penalty.

- If you have a Part D late enrollment penalty and do not pay it, you could be disenrolled from the plan.

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA, because, 2 years ago, they had a modified adjusted gross income, above a certain amount, on their IRS tax return. Members subject to an IRMAA will have to pay the standard premium amount and this extra charge, which will be added to their premium. Chapter 1, Section 6 explains the IRMAA in further detail.

SECTION 5 Do you have to pay the Part D "late enrollment penalty"?

Section 5.1 What is the Part D "late enrollment penalty"?

Note: If you receive "Extra Help" from Medicare to pay for your prescription drugs, you will not pay a late enrollment penalty.

The late enrollment penalty is an amount that is added to your Part D premium. You may owe a Part D late enrollment penalty 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 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 your monthly premium. When you first enroll in Humana Medicare Employer Plan, we let you know the amount of the penalty.

Your Part D late enrollment penalty is considered part of your plan premium. If you do not pay your Part D late enrollment penalty, you could be disenrolled for failure to pay your plan premium.

Section 5.2 How much is the Part D late enrollment penalty?

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

- First count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months in which you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is **1%** for every month that you didn't 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 2022, this average premium amount is **$33.37**.

- 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 **$33.37**, which equals **$4.67**, which is rounded up to **$4.70**. 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. If the national average premium (as determined by Medicare) increases, your penalty will increase.
- 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.

Section 5.3 In some situations, you can enroll late and not have to pay the penalty

Even if you have delayed enrolling in a plan offering Medicare Part D coverage when you were first eligible, sometimes you do not have to pay the Part D late enrollment penalty.

You will not have to pay a penalty for late enrollment if you are in any of these situations:

- If you already have prescription drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Medicare calls this "**creditable drug coverage**." Please note:
  - Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the 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.
    - Please note: If you receive a "certificate of creditable coverage" when your health coverage ends, it may not mean your prescription drug coverage was creditable. The notice must state that you had "creditable" prescription drug coverage that expected to pay as much as Medicare's standard prescription drug plan pays.
  - The following are not creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.
  - For additional information about creditable coverage, please look in your *Medicare & You 2022* handbook or call Medicare at 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.

- If you were without creditable coverage, but you were without it for less than 63 days in a row.
- If you are receiving "Extra Help" from Medicare.

Section 5.4 What can you do if you disagree about your Part D late enrollment penalty?

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review of the decision about your late enrollment penalty. 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. If you were paying a penalty before joining our plan, you may not have another chance to request a review or that late enrollment penalty. Call Customer Care to find out more about how to do this. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

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 plan premiums.

SECTION 6 Do you have to pay an extra Part D amount because of your income?

Section 6.1 Who pays an extra Part D amount because of income?

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 an IRMAA. IRMAA is an extra charge added to your premium.

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 and how to pay it. 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.**

Section 6.2 How much is the extra Part D amount?

If your modified adjusted gross income (MAGI) as reported on your IRS tax return is above a certain amount, you will pay an extra amount in addition to your monthly plan premium. For more information on the extra amount you may have to pay based on your income, visit **www.medicare.gov/part-d/costs/premiums/drug-plan-premiums.html**.

Section 6.3 What can you do if you disagree about paying an extra Part D amount?

If you disagree about paying an extra amount because of your income, you can ask Social Security to review the decision. To find out more about how to do this, contact Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

Section 6.4 What happens if you do not pay the extra Part D amount?

The extra amount is paid directly to the government (not your Medicare plan) for your Medicare Part D coverage. If you are required by law to pay the extra amount and you do not pay it, you will be disenrolled from the plan and lose prescription drug coverage.

SECTION 7 More information about your monthly premium

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, many members are required to pay other Medicare premiums. Some plan members (those who aren't eligible for premium-free Part A) pay a premium for Medicare Part A. Most plan members pay a premium for Medicare Part B.

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.

- **If you are required to pay the extra amount and you do not pay it, you will be disenrolled from the plan and lose prescription drug coverage.**
- 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.
- For more information about Part D premiums based on income, go to Chapter 1, Section 6 of this booklet. You can also visit **www.medicare.gov** on the Web or call 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 may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Your copy of the *Medicare & You 2022* handbook gives information about these premiums in the section called "2022 Medicare Costs." This explains how the Medicare Part B and Part D premiums differ for people with different incomes. Everyone with Medicare receives a copy of *Medicare & You* handbook each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of the *Medicare & You 2022* handbook 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 7.1 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 7, Section 7 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 7.2 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 8 Please keep your plan membership record up to date

Section 8.1 How to help make sure that we have accurate information about you

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

The pharmacists in the plan's network need to have correct information about you. **These network providers use your membership record to know what 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 medical or drug insurance coverage you have (such as from your employer, your spouse'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 your designated responsible party (such as a caregiver) changes

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. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

SECTION 9 We protect the privacy of your personal health information

Section 9.1 We make sure that your health information is protected

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.

For more information about how we protect your personal health information, please go to Chapter 6, Section 1.4 of this booklet.

SECTION 10 How other insurance works with our plan

Section 10.1 Which plan pays first when you have other insurance?

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.

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 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.

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have any questions about who pays first, or you need to update your other insurance information, call Customer Care. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.) You may need to give your plan member ID to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

CHAPTER 2

Important phone numbers and resources

Chapter 2. Important phone numbers and resources

SECTION 1 Humana Group Medicare PDP Plan contacts (how to contact us, including how to reach Customer Care at the plan)

How to contact our plan's Customer Care

For assistance with claims, billing or member card questions, please call or write to Customer Care. We will be happy to help you.

Method	Customer Care - Contact Information
CALL	Customer Care at (800) 585-7417. 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 about your Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs covered under the Part D benefit included in your plan. For more information on asking for coverage decisions about your Part D prescription drugs, see Chapter 7 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).*

You may call us if you have questions about our coverage decision process.

Method	**Coverage Decisions For Part D Prescription Drugs - Contact Information**
CALL	Customer Care at the number located in Section 1 of this chapter. Calls to this number are free. You can call 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**

How to contact us when you are making an appeal about your 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 making an appeal about your Part D prescription drugs, see Chapter 7 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).*

Method	Appeals 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. You can call 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.
FAX	1-800-949-2961 for expedited appeals only.
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 Grievance and Appeal Dept. P.O. Box 14165 Lexington, KY 40512-4165
WEBSITE	**www.humana.com**

How to contact us when you are making a complaint about your Part D prescription drugs

You can make a complaint about us or one of our network 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 Part D prescription drugs, see Chapter 7 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).*

Method	**Complaints About 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
FAX	1-800-949-2961 for expedited grievances only.
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 Grievance and Appeal Dept. P.O. Box 14165 Lexington, KY 40512-4165
MEDICARE WEBSITE	You can submit a complaint about your Humana Group Medicare PDP 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 of a drug you have received

The coverage determination process includes determining requests to pay for our share of the costs of a drug that you have received. For more information on situations in which you may need to ask the plan for reimbursement or to pay a bill you have received from a provider, see Chapter 5 (*Asking us to pay our share of the costs for covered 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 7 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* for more information.

Method	**Payment Requests - Contact Information**
CALL	Call the telephone number located in Section 1 of this chapter. You can call 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**

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 Prescription Drug Plans, 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 booklets 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 PDP Plan: • **Tell Medicare about your complaint:** You can submit a complaint about Humana Group Medicare PDP 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, print it out, and send it to 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.)

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.

The State Health Insurance Assistance Program (SHIP) is independent (not connected with any insurance company or health plan). It is a 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 with your Medicare questions or problems. They 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 understand your Medicare plan choices and answer questions about switching plans.

METHOD TO ACCESS SHIP and OTHER RESOURCES:

- Visit **www.medicare.gov**
- Click on **"Forms, Help, and Resources"** on far right of menu on top
- In the drop down click on **"Phone Numbers & Websites"**
- You now have several options

  - Option #1: You can have a **live chat**
  - Option #2: You can click on any of the **"TOPICS"** in the menu on bottom
  - Option #3: You can select your **STATE** from the dropdown menu and click GO. 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) has a group of doctors and other health care professionals who are paid by the Federal government. This organization is 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 7:00 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 7:00 a.m. to 7:00 p.m., Monday through Friday.
WEBSITE	**www.ssa.gov/**

SECTION 6 Medicaid
(a joint Federal and state program that helps with medical costs for some people with limited income and resources)

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.

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" help people with limited income and resources save money each year:

- **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

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 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.

Some people automatically qualify for "Extra Help" and don't need to apply. Medicare mails a letter to people who automatically qualify for "Extra Help".

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 7:00 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" 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 established a process that allows 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 overpayment 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 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.)

Medicare Coverage Gap Discount Program

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs to Part D members who have reached the coverage gap and are not receiving "Extra Help." For brand name drugs, the 70% discount provided by manufacturers excludes any dispensing fee for costs in the gap. Members pay 25% of the negotiated price and a portion of the dispensing fee for brand name drugs.

If you reach the coverage gap, we will automatically apply the discount when your pharmacy bills you for your prescription and your *SmartSummary* will show any discount provided. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and move you through the coverage gap. The amount paid by the plan (5%) does not count toward your out-of-pocket costs.

You also receive some coverage for generic drugs. If you reach the coverage gap, the plan pays 75% of the price for generic drugs and you pay the remaining 25% of the price. For generic drugs, the amount paid by the plan (75%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap. Also, the dispensing fee is included as part of the cost of the drug.

The Medicare Coverage Gap Discount Program is available nationwide. Because Humana Group Medicare PDP Plan may offer additional gap coverage during the Coverage Gap Stage, your out-of-pocket costs will sometimes be lower than the costs described here. Please go to Chapter 4 for more information about your coverage during the Coverage Gap Stage.

If you have any questions about the availability of discounts for the drugs you are taking or about the Medicare Coverage Gap Discount Program in general, please contact Customer Care. (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)?

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 covered by ADAP 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 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.

For information on eligibility criteria, covered drugs, or how to enroll in the program, please contact the ADAP in your state.

Contact information for your AIDS Drug Assistance Program (ADAP) can be found in "Exhibit A" in the back of this booklet.

What if you get "Extra Help" from Medicare to help pay your prescription drug costs? Can you get the discounts?

No. If you get "Extra Help", you already get coverage for your prescription drug costs during the coverage gap.

What if you don't get a discount, and you think you should have?

If you think that you have reached the coverage gap and did not get a discount when you paid for your brand name drug, you should review your next *SmartSummary*. If the discount doesn't appear on your *SmartSummary*, you should contact us to make sure that your prescription records are correct and up-to-date. If we don't agree that you are owed a discount, you can appeal. You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP) (telephone numbers are in "Exhibit A" in the back of this booklet) or 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.

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 have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

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.

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) get benefits from your (or your spouse's) employer or retiree group as 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'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'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's coverage for your Part D prescription drugs

Chapter 3. Using the plan's coverage for your Part D prescription drugs

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Did you know there are programs to help people pay for their drugs?

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. For more information, see Chapter 2, Section 7.

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"*. Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.

SECTION 1 Introduction

Section 1.1 This chapter describes your coverage for Part D drugs

This chapter explains rules for using your coverage for Part D drugs. The next chapter tells what you pay for Part D drugs (Chapter 4, *What you pay for your Part D prescription drugs*).

In addition to your coverage for Part D drugs through our plan, Original Medicare (Medicare Part A and Part B) also covers some drugs:

- Medicare Part A covers drugs you are given during Medicare-covered stays in the hospital or in a skilled nursing facility.
- Medicare Part B also provides benefits for some drugs. Part B drugs include certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility.

The two examples of drugs described above are covered by Original Medicare. (To find out more about this coverage, see your *Medicare & You* Handbook.) Your Part D prescription drugs are covered under our plan.

Section 1.2 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 your prescription.

- Your prescriber must either accept Medicare or file documentation with CMS showing that he or she is qualified to write prescriptions, or your Part D claim will be denied. You should ask your prescribers the next time you call or visit if they meet this condition. If not, please be aware it takes time for your prescriber to submit the necessary paperwork to be processed.

- 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 of this chapter, *Your drugs need to be in 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 reference books. (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 To have your prescription covered, 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 covered by the plan's *Drug Guide.* (See Chapter 4, Section 1.1 of this booklet for how to access the *Drug Guide*.)

Our network includes pharmacies that offer standard cost-sharing and pharmacies that offer preferred cost-sharing. You may go to either type of network pharmacy to receive your covered prescription drugs. Your cost-sharing may be less at pharmacies with preferred cost-sharing.

Section 2.2 Finding network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Pharmacy Directory,* visit our website **www.humana.com**, or call Customer Care. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

You may go to any of our network pharmacies. If you switch from one network pharmacy to another, and you need a refill of a drug you have been taking, you can ask either to have a new prescription written by a provider or have your prescription transferred to your new network pharmacy.

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 network pharmacy in your area, you can get help from Customer Care (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.) or use the *Pharmacy Directory.* You can also find information on our website at **www.humana.com**.

What if you need a specialized pharmacy?

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies, which is typically the pharmacy that the LTC facility uses. 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 *Pharmacy Directory* or call Customer Care. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

Section 2.3 Using the plan's mail-order services

For certain kinds of drugs, you can use the plan's network mail-order services. Generally, the drugs available through mail-order are drugs that you take on a regular basis, for a chronic or long-term medical condition. The drugs available through our plan's mail-order service 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 HumanaPharmacy Mail Order at 1-800-379-0092.

Usually a mail-order pharmacy order will get 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 (phone numbers are printed on the back cover of this booklet).

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 now or at any time by calling Customer Care (phone numbers are printed on the back cover of this booklet).

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 (phone numbers are printed on the back cover of this booklet).

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. This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allow you to cancel or delay the order before you are billed and it is shipped. It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

To opt out of automatic deliveries of new prescriptions received directly from your health care provider's office, please contact us by calling Customer Care (phone numbers are printed on the back cover of this booklet).

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

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you. Please call the pharmacy to provide your communication preferences. To find contact information for the mail-order pharmacy(s), you can look in your Pharmacy Directory, visit our website (**Humana.com/PlanMaterials**), or call HumanaPharmacy Mail Order at 1-800-379-0092.

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.* (See Chapter 4, Section 1.1 of this booklet for how to access the *Drug Guide.*) Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition. You may order this supply through mail order (see Section 2.3) or you may go to a retail pharmacy.

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs. Your *Pharmacy 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. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

2. For certain kinds of drugs, you can use the plan's network **mail-order services.** The drugs available through our plan's mail-order service are marked as **"mail-order" drugs** in our plan's *Drug Guide*. Our plan's mail-order service requires you to order *at least* a 30-day supply of the drug and *no more than* a 90-day supply. See Section 2.3 for more information about using our mail-order services.

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. If you cannot use a 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 5, 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 (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.) 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 5, Section 2.1 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 5, 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.

In these situations, **please check first with Customer Care** to see if there is a network pharmacy nearby. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.) You may 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.

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 share of the cost) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 5, 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 must meet requirements set by Medicare. Medicare has approved the plan's *Drug Guide*. (See Chapter 4, Section 1.1 of this booklet for how to access the *Drug Guide*.)

The drugs in the *Drug Guide* are only those covered under Medicare Part D (earlier in this chapter, Section 1 explains about Part D drugs).

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. (That is, the Food and Drug Administration has approved the drug 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 both brand name and generic drugs

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Generally, it works just as well as the brand name drug and usually costs less. There are generic drug substitutes available for many brand name drugs.

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. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

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*.

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

Every drug in the plan's *Drug Guide* (see Chapter 4, Section 1.1 of this booklet for how to access the *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 4 (*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 two ways to find out:

1. Search the most current and complete *Drug Guide* by visiting the plan's website **www.humana.com**. (See Chapter 4, Section 1.1 of this booklet for how to access the *Drug Guide.*)

2. 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 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 help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. Whenever 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. We also need to comply with Medicare's rules and regulations for drug coverage and cost-sharing.

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. 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 7, Section 5.4 for information about asking for exceptions.)

Please note that sometimes a drug may appear more than once in our *Drug Guide.* (See Chapter 4, Section 1.1 of this booklet for how to access the *Drug Guide*.) This is because different restrictions or cost-sharing may apply based on factors such as the strength, amount, or form of the drug prescribed by your health care provider (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

Section 4.2 What kinds of restrictions?

Our plan uses different types of restrictions to help our members use drugs in the most effective ways. The sections below tell you more about the types of restrictions we use for certain drugs.

Restricting brand name drugs when a generic version is available

Generally, a "generic" drug works the same as a brand name drug and usually costs less. **When a generic version of a brand name drug is available, our network pharmacies will provide you the generic version.** We usually will not cover the brand name drug when a generic version is available. However, if your provider has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug. (Your share of the cost may be greater for the brand name drug than for the generic drug.)

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"**. Sometimes the requirement for getting approval in advance helps 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 the amount of the drug that you can have by limiting 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 4.3 Do any of these restrictions apply to your drugs?

The plan's *Drug Guide* includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the *Drug Guide*. For the most up-to-date information, visit our website at **www.humana.com** (see Chapter 4, Section 1.1 of this booklet for how to access the *Drug Guide*) or call Customer Care. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

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. If there is a restriction on the drug you want to take, you should 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 7, Section 5.4 for information about asking for exceptions.)

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

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

We hope that your drug coverage will work well for you. But it's possible that there could be a prescription drug you are currently 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, some of the drugs covered by the plan have extra rules to restrict their use. For example, you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. Or there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period. In some cases, you may want us to waive the restriction for you.

- 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. The plan puts each covered drug into one of four different cost-sharing tiers. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

There are things you can do if your drug is not covered in the way that you'd like it to be covered. Your options depend on what type of problem you have:

- If your drug is not in the *Drug Guide* (see Chapter 4, Section 1.1 of this booklet for how to access 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* (see Chapter 4, Section 1.1 of this booklet for how to access the *Drug Guide*) or is restricted, here are things you can do:

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply). This will give you and your provider time to change to another drug or to file a request to have the drug covered.
- 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 offer a temporary supply of a drug to you when your drug is not in the *Drug Guide* or when it is restricted in some way. Doing this gives you time to talk with your provider about the change in coverage and figure out what to do.

To be eligible for a temporary supply, you must meet the two requirements below:

1. **The change to your drug coverage must be one of the following types of changes:**
   - The drug you have been taking is **no longer in the plan's *Drug Guide;***
   - - or - The drug you have been taking is **now restricted in some way** (Section 4 in this chapter tells about restrictions).
2. **You must be in one of the situations described below:**

- **For those members who are new or who were in the plan last year:**

  We will cover a temporary supply of your drug **during the first 90 days of your membership in the plan if you were new and during the first 90 days of the calendar year if you were in the plan last 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 (LTC) facility and need a supply right away:**

  We will cover one *31 day* supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above long-term care transition 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 2022 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.

<u>One-Time Transition Supply at a Retail or Mail-Order Pharmacy</u>

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.

<u>Transition Supply if you're in a Long-Term Care Facility</u>

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.

<u>Transition Period Extension</u>

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. Contact Customer Care if you believe we need to extend the transition period to make sure you continue to receive your drugs as needed. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

<u>Costs for Temporary Supplies</u>

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 2022 your copayment or coinsurance won't exceed your LIS limit.]

To ask for a temporary supply, call Customer Care. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug. The sections below tell you more about these options.

You can change to another drug

Start by talking with your provider. Perhaps there is a different drug covered by the plan that might 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. (Phone numbers are located in Chapter 2, Section 1 of this booklet.)

You can ask for an exception

You and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be 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 to the rule. 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 allow you to request a formulary exception in advance for next year. We will tell you about any change in the coverage for your drug for next 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 7, Section 5.4 tells 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, start by talking with your provider. Perhaps there is a different drug in a lower cost-sharing tier that might 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. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

You can ask for an exception

For drugs in Cost Sharing Tier 2 - Preferred Brand Drugs or Cost Sharing Tier 3 - 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 7, Section 5.4 tells 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 might make changes to the *Drug Guide*. (See Chapter 4, Section 1.1 of this booklet for how to access the *Drug Guide*.) For example, the plan might:

- **Add or remove drugs from the *Drug Guide***. New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.
- **Move a drug to a higher or lower cost-sharing tier.**
- **Add or remove a restriction on coverage for a drug** (for more information about restrictions to coverage, see Section 4 in this chapter).
- **Replace a brand name drug with a generic drug.**

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 during the year, we post information on our website about those changes. We will update our online *Drug Guide* on a regularly scheduled basis to include any changes that have occurred after the last update. Below we point out the times that you would get direct notice if changes are made to a drug that you are then taking. You can also call Customer Care for more information. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

Do changes to your drug coverage affect you right away?

Changes that can affect you this year: In the below cases, you will be affected by the coverage changes during the current 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 that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, 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.
    - We may not tell you in advance before we make that change -- even if you are currently taking the brand name drug
    - 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 7 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))*.
    - 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) we made. 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.
- **Unsafe drugs and other drugs in the *Drug Guide* that are withdrawn from the market**
    - Once in a while, a drug may be suddenly withdrawn because it has been found to be unsafe or removed from the market for another reason. If this happens, we will immediately remove the drug from the *Drug Guide*. If you are taking that drug, we will let you know of this change 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 instance, we might add a generic drug that is not new to the market to replace a brand name drug 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. 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 be working with your prescriber to switch to a different drug that we cover.
    - Or 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 7 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))*.

Changes to drugs in the *Drug Guide* that will not affect people currently taking the drug: For changes to the *Drug Guide* that are not described above, if you are currently taking the drug, the following types of changes will not affect you until January 1 of the next year if you stay in the plan:

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

If any of these changes happen for a drug you are taking (but not because of a 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 restriction to your use of the drug. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, the changes will affect you, and it is important to check the *Drug Guide* in the new benefit year for any changes to drugs.

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. We won't pay for the drugs that are listed in this section (except for certain excluded drugs covered under our enhanced drug coverage). The only exception: If the requested drug is found upon appeal to be a drug that is not excluded under Part D and we should have paid for or covered it because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to Chapter 7, Section 5.5 in this booklet.)

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 and 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.
    - Generally, 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. If the use is not supported by any of these references, then our plan cannot cover its "off-label use."

Also, by law, these categories of drugs are not covered by Medicare drug plans (Our plan may also cover 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 when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra, and Caverject
- Drugs when 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 may offer additional coverage of some prescription drugs not normally covered in a Medicare prescription drug plan (enhanced drug coverage). The amount you pay when you fill a prescription for these drugs does not count towards qualifying you for the Catastrophic Coverage Stage. (The Catastrophic Coverage Stage is described in Chapter 4, Section 7 of this booklet.)

In addition, if you are receiving **"Extra Help" from Medicare** 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* (see Chapter 4, Section 1.1 of this booklet for how to access the *Drug Guide*). or call Customer Care (Phone numbers for Customer Care are located in Chapter 2, or call Customer Care (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.) for more information. 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 Show your plan membership card when you fill a prescription

Section 8.1 Show your membership card

To fill your prescription, show your plan membership card at the network pharmacy you choose. When you show your plan membership card, the network pharmacy will automatically bill the plan for *our* share of your covered prescription 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 card with you?

If you don't have your plan membership card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary 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 5, Section 2.1 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 Original Medicare?

If you are admitted to a hospital for a stay covered by Original Medicare, Medicare Part A will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital, our plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this chapter that tell about the rules for getting drug coverage.

If you are admitted to a skilled nursing facility for a stay covered by Original Medicare, Medicare Part A will generally cover your prescription drugs during all or part of your stay. If you are still in the skilled nursing facility, and Part A is no longer covering your drugs, our plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this chapter that tell about the rules for getting drug coverage.

Please Note: When you enter, live in, or leave a skilled nursing facility, you are entitled to a Special Enrollment Period. During this time period, you can switch plans or change your coverage. (Chapter 8, *Ending your membership in the plan*, tells when you can leave our plan and join a different Medicare plan.)

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

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

Check your *Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Customer Care. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

What if you're a resident in a long-term care (LTC) facility and become a new member of the plan?

If you need a drug that is not in our *Drug Guide* (see Chapter 4, Section 1.1 of this booklet for how to access the *Drug Guide*). or is restricted in some way, the plan will cover a **temporary supply** of your drug during the first 90 days of your membership. The total supply will be for a maximum of a 31 day supply, or less if your prescription is written for fewer days. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

If you have been a member of the plan for more than 90 days and need a drug that is not in our *Drug Guide* or if the plan has any restriction on the drug's coverage, we will cover one 31-day supply, or less if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If you and your provider want to ask for an exception, Chapter 7, Section 5.4 tells what to do.

Section 9.3 What if you are taking drugs covered by Original Medicare?

Your enrollment in Humana Group Medicare PDP Plan doesn't affect your coverage for drugs covered under Medicare Part A or Part B. If you meet Medicare's coverage requirements, your drug will still be covered under Medicare Part A or Part B, even though you are enrolled in this plan. In addition, if your drug would be covered by Medicare Part A or Part B, our plan can't cover it, even if you choose not to enroll in Part A or Part B.

Some drugs may be covered under Medicare Part B in some situations and through Humana Group Medicare PDP Plan in other situations. But drugs are never covered by both Part B and our plan at the same time. In general, your pharmacist or provider will determine whether to bill Medicare Part B or Humana Group Medicare PDP Plan for the drug.

Section 9.4 What if you have a Medigap (Medicare Supplement Insurance) policy with prescription drug coverage?

If you currently have a Medigap policy that includes coverage for prescription drugs, you must contact your Medigap issuer and tell them you have enrolled in our plan. If you decide to keep your current Medigap policy, your Medigap issuer will remove the prescription drug coverage portion of your Medigap policy and lower your premium.

Each year your Medigap insurance company should send you a notice that tells if your prescription drug coverage is "creditable," and the choices you have for drug coverage. (If the coverage from the Medigap policy is "**creditable**," it means that it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) The notice will also explain how much your premium would be lowered if you remove the prescription drug coverage portion of your Medigap policy. If you didn't get this notice, or if you can't find it, contact your Medigap insurance company and ask for another copy.

Section 9.5 What if you're also getting drug coverage from an employer or retiree group plan?

Do you currently have other prescription drug coverage through your (or your spouse's) employer or retiree group? If so, 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 are currently employed, the prescription drug coverage you get from us will be *secondary* to your employer or retiree 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" and the choices you have for drug coverage.

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 these notices about creditable coverage, because you may need them 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 a notice about creditable coverage from your employer or retiree group plan, you can get a copy from the employer or retiree group's benefits administrator or the employer or union.

Section 9.6 What if you are in Medicare-certified Hospice?

Drugs are never covered by both hospice and our plan at the same time. If you are enrolled in Medicare hospice and require an anti-nausea, laxative, pain medication, or antianxiety drug that is 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 any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover all your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify your revocation or discharge. See the previous parts of this section that tell about the rules for getting drug coverage under Part D. Chapter 4 (What you pay for your Part D prescription drugs) gives more information about drug coverage and what you pay.

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. These reviews are especially important for members who have more than one provider who prescribes their drugs.

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 medical 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 written 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 can help make sure our members safely use their prescription opioid medications, and other medications that are frequently abused. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several doctors or pharmacies, or if you had a recent opioid overdose, 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 is not safe, we may limit how you can get those medications. 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 think that one or more of these limitations should apply to you, we will send you a letter in advance. The letter will have information explaining the limitations we think should apply to you. You will also 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 determination that you are at-risk for prescription drug misuse or with limitation, you and your prescriber have the right to ask us for an appeal. If you choose to appeal, we will review your case and give you a 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 7 for information about how to ask for an appeal.

The DMP may not apply to you if you have certain medical conditions, such as cancer, or sickle cell disease 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.

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

Some members who take medications for different medical conditions and have high drug costs, or are in a DMP to help members use their opioids safely may be able to get services through an MTM program. A pharmacist or other health professional will give you a comprehensive review of all your medications. You can talk about how best to take 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 of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications, with space for you to take notes or write down any follow-up questions. You'll also get a personal medication list that will include all the medications you're taking 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 have your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, keep your medication list 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 you from the program. If you have any questions about these programs, please contact Customer Care. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

CHAPTER 4

What you pay for your Part D prescription drugs

Chapter 4. What you pay for your Part D prescription drugs

? **Did you know there are programs to help people pay for their drugs?**

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs (SPAPs). For more information, see Chapter 2, Section 7.

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*". (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

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 your 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 3, 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 we give you in this chapter, you need to know the basics of what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Here are materials that explain these basics:

- **The plan's *Prescription Drug Guide* (Formulary).** To keep things simple, we call this the "*Drug Guide.*"
  - This *Drug Guide* tells which drugs are covered for you.
  - It also tells which of the four "cost-sharing tiers" the drug is in and whether there are any restrictions on your coverage for the drug.
  - To view the most complete and current Drug Guide information online, visit **www.humana.com/SearchResources**, locate Prescription Drug section, select **www.humana.com/MedicareDrugList** link; under Printable drug lists, click Printable Drug Lists, select future plan year, select Group Medicare under Plan Type and search for GRP49.
  - You may 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.)

- **Chapter 3 of this booklet.** Chapter 3 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 3 also tells which types of prescription drugs are not covered by our plan.

- **The plan's *Pharmacy Directory.*** In most situations you must use a network pharmacy to get your covered drugs (see Chapter 3 for the details). The *Pharmacy Directory* has a list of pharmacies in the plan's network. It also tells you which pharmacies in our network can give you a long-term supply of a drug (such as filling a prescription for a 90-day supply).

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

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 amount that you pay for a drug is called "cost-sharing" and there are three ways you may be asked to pay.

- The **"deductible"** is the amount you must pay for drugs before our plan begins to pay its share.
- **"Copayment"** means that you pay a fixed amount each time you fill a prescription.
- **"Coinsurance"** means that you pay a percent of the total cost of the drug each time you fill a prescription.

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 Humana Group Medicare PDP Plan members?

As shown in the table below, there are "drug payment stages" for your prescription drug coverage under your Humana Group Medicare PDP Plan. How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled. Keep in mind you are always responsible for the plan's monthly premium regardless of the drug payment stage.

Stage 1 ***Yearly Deductible Stage***	***Stage 2*** ***Initial Coverage Stage***	***Stage 3*** ***Coverage Gap Stage***	***Stage 4*** ***Catastrophic Coverage Stage***
Because there is no deductible for the plan, this payment stage does not apply to you.	You begin in this stage when you fill your first prescription of the year. During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost. You stay in this stage until your year-to-date "total drug costs" (your payments plus any Part D plan's payments) total $4,430. (Details are in Section 5 of this chapter.)	You stay in this stage until your year-to-date "out-of-pocket costs" (your payments) reach a total of $7,050. This amount and rules for counting costs toward this amount have been set by Medicare. (Details are in Section 6 of this chapter.)	During this stage, **the plan will pay most of the cost** of your drugs for the rest of the plan year. (Details are in Section 7 of this chapter.)

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**" cost.
- 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.

Our plan will prepare a written summary called the *SmartSummary* when you have had one or more prescriptions filled through the plan during the previous month. The *SmartSummary* provides more information about the drugs you take, such as increases in price and other drugs with lower cost-sharing that may be available. You should consult with your prescriber about these lower cost options. It 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 you 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 any percentage change from first fill for each prescription claim of the same quantity.

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

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 when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.

- **Make sure we have the information we need.** There are times you may pay for prescription drugs when 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, you may give us copies of receipts for drugs that you have purchased. (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 5, Section 2 of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
  - 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.
- **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 and help qualify you for catastrophic coverage. 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. You should 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* in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call Customer Care. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.) Be sure to keep these reports. They are an important record of your drug expenses.

SECTION 4 There is no deductible for Humana Group Medicare PDP Plan

Section 4.1 You do not pay a deductible for your Part D drugs

There is no deductible for Humana Group Medicare PDP 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* (See Section 1.1 of this chapter for how to access the *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*.

Your pharmacy choices

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

- A retail pharmacy that is in our plan's network
- A pharmacy that is not in the plan's network
- The plan's mail-order pharmacy

For more information about these pharmacy choices and filling your prescriptions, see Chapter 3 in this booklet and the plan's *Pharmacy 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.

- **"Copayment"** means that you pay a fixed amount each time you fill a prescription.
- **"Coinsurance"** means that you pay a percent of the total cost of the drug each time you fill a prescription.

As shown in the table below, the amount of the copayment or coinsurance depends on which cost-sharing tier your drug is in. Please note:

- If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay either the full price of the drug or the copayment amount, whichever is lower.

- We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 3, Section 2.5 for information about when we will cover a prescription filled at an out-of-network pharmacy.

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)	**Mail-order cost-sharing**	**Long-term care (LTC) cost-sharing**	**Out-of-network cost-sharing** (coverage is limited to certain situations; see Chapter 3 for details.)*
Cost-Sharing Tier 1 (Generic or Preferred Generic)	$5 copay Member pays 15% in addition to the tier specific cost share	$5 copay Member pays 15% in addition to the tier specific cost share	$5 copay Member pays 15% in addition to the tier specific cost share	$5 copay Member pays 15% in addition to the tier specific cost share
Cost-Sharing Tier 2 (Preferred Brand)	$15 copay Member pays 25% in addition to the tier specific cost share	$15 copay Member pays 25% in addition to the tier specific cost share	$15 copay Member pays 25% in addition to the tier specific cost share	$15 copay Member pays 25% in addition to the tier specific cost share
Cost-Sharing Tier 3 (Non-Preferred Drug)	$25 copay Member pays 50% in addition to the tier specific cost share	$25 copay Member pays 50% in addition to the tier specific cost share	$25 copay Member pays 50% in addition to the tier specific cost share	$25 copay Member pays 50% in addition to the tier specific cost share
Cost-Sharing Tier 4 (Specialty)	$25 copay Member pays 50% in addition to the tier specific cost share	$25 copay Member pays 50% in addition to the tier specific cost share	$25 copay Member pays 50% in addition to the tier specific cost share	$25 copay Member pays 50% in addition to the tier specific cost share

* 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 of a covered drug. However, your doctor can prescribe less than a month's supply of drugs. There may be times when you want to ask your doctor about prescribing less than a month's supply of a drug (for example, when you are trying a medication for the first time that is known to have serious side effects). If your doctor prescribes less than a full month's supply, you will not have to pay for the full month's supply for certain drugs.

The amount you pay when you get less than a full month's supply will depend on whether you are responsible for paying coinsurance (a percentage of the total cost) or a copayment (a flat dollar amount).
If you are responsible for coinsurance, you pay a percentage of the total cost of the drug. You pay the same percentage regardless of whether the prescription is for a full month's supply or for fewer days. However, because the entire drug cost will be lower if you get less than a full month's supply, the amount you pay will be less.

- If you are responsible for a copayment for the drug, your copay will be based on the number of days of the drug that you receive. 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.

  - Here's an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is $30. This means that the amount you pay per day for your drug is $1. If you receive a 7 days' supply of the drug, your payment will be $1 per day multiplied by 7 days, for a total payment of $7.

Daily cost-sharing allows you to make sure a drug works for you before you have to pay for an entire month's supply. You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply of a drug or drugs, if this will help you better plan refill dates for different prescriptions so that you can take fewer trips to the pharmacy. The amount you pay will depend upon the days' supply 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") when you fill your prescription. A long-term supply is up to a 90-day supply. (For details on where and how to get a long-term supply of a drug, see Chapter 3, Section 2.4.)

The table below shows what you pay when you get a long-term (up to a 90-day) supply of a drug.

Please note: If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay either the full price of the drug or the copayment amount, whichever is lower.

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)	**Mail-order cost-sharing**
Cost-Sharing Tier 1 (Generic or Preferred Generic)	$5 copay Member pays 15% in addition to the tier specific cost share	$5 copay Member pays 15% in addition to the tier specific cost share
Cost-Sharing Tier 2 (Preferred Brand)	$15 copay Member pays 25% in addition to the tier specific cost share	$15 copay Member pays 25% in addition to the tier specific cost share
Cost-Sharing Tier 3 (Non-Preferred Drug)	$25 copay Member pays 50% in addition to the tier specific cost share	$25 copay Member pays 50% in addition to the tier specific cost share
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

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 total drug costs for the year reach $4,430

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled and refilled reaches the $4,430 limit for the Initial Coverage Stage.

Your total drug cost is based on adding together what you have paid and what any Part D plan has paid:

- **What you have paid** for all the covered drugs you have gotten since you started with your first drug purchase of the plan year. (See Section 6.2 for more information about how Medicare calculates your out-of-pocket costs.) This includes:
  - The total you paid as your share of the cost for your drugs during the Initial Coverage Stage.
- **What the plan has paid** as its share of the costs for your drugs during the Initial Coverage Stage. (If you were enrolled in a different Part D Plan at any time during the year, the amount that plan paid during the Initial Coverage Stage also counts toward your total drug costs.)

The *SmartSummary* that we send to you will help you keep track of how much you and the plan, as well as any third parties, have spent on your behalf for your drugs during the year. Many people do not reach the $4,430 limit in a year.

We will let you know if you reach this $4,430 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage.

SECTION 6 During the Coverage Gap Stage, the plan provides some drug coverage

Section 6.1 You stay in the Coverage Gap Stage until your out-of-pocket costs reach $7,050

After you leave the Initial Coverage Stage, we will continue to provide some prescription drug coverage in the Coverage Gap. For details about which types of drugs are covered and their cost-shares, see the charts below.

The table below shows what you pay when you get a one-month supply of a drug.

	Standard retail cost-sharing (in-network)	**Mail-order cost-sharing**	**Long-term care (LTC) cost-sharing**	**Out-of-network cost-sharing** (coverage is limited to certain situations; see Chapter 3 for details.)*
Cost-Sharing Tier 1 (Generic or Preferred Generic)	$5 copay Member pays 15% in addition to the tier specific cost share	$5 copay Member pays 15% in addition to the tier specific cost share	$5 copay Member pays 15% in addition to the tier specific cost share	$5 copay Member pays 15% in addition to the tier specific cost share
Cost-Sharing Tier 2 (Preferred Brand)	$15 copay Member pays 25% in addition to the tier specific cost share	$15 copay Member pays 25% in addition to the tier specific cost share	$15 copay Member pays 25% in addition to the tier specific cost share	$15 copay Member pays 25% in addition to the tier specific cost share
Cost-Sharing Tier 3 (Non-Preferred Drug)	$25 copay Member pays 25% in addition to the tier specific cost share	$25 copay Member pays 25% in addition to the tier specific cost share	$25 copay Member pays 25% in addition to the tier specific cost share	$25 copay Member pays 25% in addition to the tier specific cost share
Cost-Sharing Tier 4 (Specialty)	$25 copay Member pays 25% in addition to the tier specific cost share	$25 copay Member pays 25% in addition to the tier specific cost share	$25 copay Member pays 25% in addition to the tier specific cost share	$25 copay Member pays 25% in addition to the tier specific cost share

* 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.

The table below shows what you pay when you get a *long-term* 90-day supply of a drug.

	Standard retail cost-sharing (in-network)	**Mail-order cost-sharing**
Cost-Sharing Tier 1 (Generic or Preferred Generic)	$5 copay Member pays 15% in addition to the tier specific cost share	$5 copay Member pays 15% in addition to the tier specific cost share
Cost-Sharing Tier 2 (Preferred Brand)	$15 copay Member pays 25% in addition to the tier specific cost share	$15 copay Member pays 25% in addition to the tier specific cost share
Cost-Sharing Tier 3 (Non-Preferred Drug)	$25 copay Member pays 25% in addition to the tier specific cost share	$25 copay Member pays 25% in addition to the tier specific cost share
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

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

Medicare has rules about what counts and what does not count as your out-of-pocket costs. When you reach an out-of-pocket limit of $7,050, you leave the Coverage Gap Stage and move on to the Catastrophic Coverage Stage.

Section 6.2 How Medicare calculates your out-of-pocket costs for prescription drugs

Here are Medicare's rules that we must follow when we keep track of your out-of-pocket costs for your drugs. These payments **are included** in your out-of-pocket costs.

When you add up your out-of-pocket costs, **you can include** 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 3 of this booklet):

- The amount you pay for drugs when you are in any of the following drug payment stages:
  - The Initial Coverage Stage
  - The Coverage Gap 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 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 of the payments made by the Medicare Coverage Gap Discount Program are included. 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 $7,050 in out-of-pocket costs within the calendar year, you will move from the Coverage Gap Stage to the Catastrophic Coverage Stage.

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

When you add up your out-of-pocket costs, you **are not allowed to include** any of these types of payments for prescription drugs:

- The amount you pay for your monthly premium.
- 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.
- 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 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. Call Customer Care to let us know. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

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

- **We will help you**. The *SmartSummary* we send to you includes the current amount of your out-of-pocket costs (Section 3 in this chapter tells about this report). When you reach a total of $7,050 in out-of-pocket costs for the year, this report will tell you that you have left the Coverage Gap 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 7 During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs

Section 7.1 Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $7,050 limit for the plan year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the plan year.

During this stage, the plan will pay most of the cost for your drugs.

- **Your share** of the cost for a covered drug will be either coinsurance or a copayment, whichever is the *larger* amount:
  - -*either* - coinsurance of 5% of the cost of the drug;
  - -*or* - $3.95 catastrophic cost-sharing amount for a generic drug or a drug that is treated like a generic and $9.85 catastrophic cost-sharing amount for all other drugs.
- Our plan pays the rest of the cost.

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

Section 8.1 Our plan may have separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccine

Our plan provides benefits for a number of Part D vaccines.

There are two parts to our coverage of vaccinations:

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

What do you pay for a Part D vaccination?

What you pay for a Part D vaccination depends on three things:

1. **The type of vaccine** (what you are being vaccinated for).
    - Some vaccines are considered Part D drugs. You can find these vaccines listed in the plan's *Drug Guide.* (See Section 1.1 of this chapter for how to access the *Drug Guide*.)
    - Other vaccines are considered medical benefits. They are covered under Original Medicare.
2. **Where you get the vaccine medication.**
3. **Who gives you the vaccine.**

What you pay at the time you get the Part D vaccination can vary depending on the circumstances. For example:

- Sometimes when you get your vaccine, you will have to pay the entire cost for both the vaccine medication and for getting the vaccine. You can ask our plan to pay you back for our share of the cost.

- Other times, when you get the vaccine medication or the vaccine, you will pay only your share of the cost.

To show how this works, here are three common ways you might get a Part D vaccine. Remember you are responsible for all of the costs associated with vaccines (including their administration) during the Coverage Gap Stage of your benefit.

Situation 1: You buy the Part D vaccine at the pharmacy and you get your vaccine at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to administer a vaccination.)

- You will have to pay the pharmacy the amount of your coinsurance or copayment for the vaccine itself and 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 vaccination, you will pay for the entire cost of the vaccine and its administration.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 5 of this booklet (*Asking us to pay our share of the costs for covered drugs*).
- You will be reimbursed the amount you paid less your normal coinsurance or copayment for the vaccine (including administration) 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 at your pharmacy, and then take it to your doctor's office where they give you the vaccine.

- You will have to pay the pharmacy the amount of your coinsurance or copayment for the vaccine itself.
- When your doctor gives you the vaccine, you will 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 5 of this booklet.
- You will be reimbursed the amount charged by the doctor for administering the vaccine 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.)

Section 8.2 You may want to call Customer Care before you get a vaccination

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call Customer Care first whenever you are planning to get a vaccination. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
- We can tell you how to keep your own cost down by using providers and pharmacies in our network.
- If you are not able to use a network provider and pharmacy, we can tell you what you need to do to get payment from us for our share of the cost.

CHAPTER 5

Asking us to pay our share of the costs for covered drugs

Chapter 5. Asking us to pay our share of the costs for covered drugs

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

Section 1.1 If you pay our plan's share of the cost of your covered drugs, you can ask us for payment

Sometimes when you get a prescription drug, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our plan to pay you back (paying you back is often called "reimbursing" you).

Here are examples of situations in which you may need to ask our plan to pay you back. All of these examples are types of coverage decisions (for more information about coverage decisions, go to Chapter 7 of this booklet).

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

   If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, 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. (We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to Chapter 3, Section 2.5 to learn more.)

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

2. **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 look up your 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.

3. **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 in the plan's *Prescription Drug Guide* (Formulary); 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 4, 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.

4. If you are retroactively enrolled in our plan

Sometimes a person's enrollment in the plan is retroactive. (Retroactive 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 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 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.)

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 7 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has information about how to make an appeal.

SECTION 2 How to ask us to pay you back

Section 2.1 How and where to send us your request for payment

Send us your request for payment, along with your receipt documenting the payment you have made. It's a good idea to make a copy of your 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.
- Either download a copy of the form from our website (**www.humana.com**) 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:

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

Contact Customer Care if you have any questions. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.) If you don't know what you should have paid, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

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 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 drug is covered and you followed all the rules for getting the drug, we will pay for our share of the cost. We will mail your reimbursement of our share of the cost to you. (Chapter 3 explains the rules you need to follow for getting your Part D prescription drugs covered.) We will send payment within 30 days after your request was received.
- If we decide that the 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 that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

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

If you think we have made a mistake in turning down your request for payment or you don't agree with 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.

For the details on how to make this appeal, go to Chapter 7 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*). The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 7. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then after you have read Section 4, you can go to Section 5.5 in Chapter 7 for a step-by-step explanation of how to file an appeal.

SECTION 4 Other situations in which you should save your receipts and send copies to us

Section 4.1 In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs

There are some situations when you should let us know about payments you have made for your drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your out-of-pocket costs correctly. This may help you to qualify for the Catastrophic Coverage Stage more quickly.

Here are two situations when you should send us copies of receipts to let us know about payments you have made for your drugs:

1. **When you buy the drug for a price that is lower than our price**

   Sometimes when you are in the Deductible Stage OR Coverage Gap Stage you can buy your drug **at a network pharmacy** for a price that is lower than our price.

   - For example, a pharmacy might offer a special price on the drug. Or you may have a discount card that is outside our benefit that offers a lower price.
   - Unless special conditions apply, you must use a network pharmacy in these situations and your drug must be in our *Drug Guide*. (See Chapter 4, Section 1.1 of this booklet for how to access the *Drug Guide*.)
   - Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
   - **Please note:** If your plan has a Deductible OR Coverage Gap Stage, we may not pay for any share of these drug costs while you are in them. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

2. **When you get a drug through a patient assistance program offered by a drug manufacturer**

   Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside the plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.

   - Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.

- **Please note:** Because you are getting your drug through the patient assistance program and not through the plan's benefits, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

Since you are not asking for payment in the two cases described above, these situations are not considered coverage decisions. Therefore, you cannot make an appeal if you disagree with our decision.

CHAPTER 6

Your rights and responsibilities

Chapter 6. Your rights and responsibilities

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

Section 1.1 We must provide information in a way that works for you (in languages other than English, in braille, in large print, or other alternate formats, etc.)

To get information from us in a way that works for you, please call Customer Care. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

Our plan has people and free interpreter services available to answer questions from disabled and 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 (phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet).

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. Contact information is included in this *Evidence of Coverage* or with this mailing, or you may contact 1-800-457-4708 for additional information.

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 drugs

As a member of our plan, you 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 Part D drugs within a reasonable amount of time, Chapter 7, Section 7 of this booklet tells what you can do. (If we have denied coverage for your prescription drugs and you don't agree with our decision, Chapter 7, Section 4 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.

- The laws that protect your privacy give you rights related to getting 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. In most situations, if we 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 first.* Written permission can be given by you or by someone you have given legal power to make decisions for you.

- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.

    - For example, 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.

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 healthcare 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. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

Notice of Privacy Practices for your personal health information

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

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

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

What is personal and health information?
Personal and health information includes both medical information and personal information, like your name, address, telephone number, or Social Security number. The term "information" in this notice includes any personal and health information. This includes information created or received by a health care provider or health plan. The information relates to your physical or mental health or condition, providing health care to you, or the payment for such health care.

How do we protect your information?
We have a responsibility to protect the privacy of your information in all formats including electronic, written and oral information. We have safeguards in place to protect your information in various ways including:

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

How do we use and disclose your information?
We use and disclose your information:

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

We have the right to use and disclose your information:

- To a doctor, a hospital, or other health care provider so you can receive medical care
- For payment activities, including claims payment for covered services provided to you by health care providers and for health plan premium payments
- For health care operation activities. Including processing your enrollment, responding to your inquiries, coordinating your care, improving quality, and determining premiums
- For performing underwriting activities. However, we will not use any results of genetic testing or ask questions regarding family history.
- To your plan sponsor to permit them to perform plan administration functions such as eligibility, enrollment and disenrollment activities. We may share summary level health information about you with your plan sponsor in certain situations. For example, to allow your plan sponsor to obtain bids from other health plans. Your detailed health information will not be shared with your plan sponsor. We will ask your permission or your plan sponsor has to certify they agree to maintain the privacy of your information.
- To contact you with information about health-related benefits and services, appointment reminders, or treatment alternatives that may be of interest to you if you have not opted out as described below, we will not contact you.
- To your family and friends if you are unavailable to communicate, such as in an emergency
- To your family and friends or any other person you identify. This applies if the information is directly relevant to their involvement with your 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 if the claim has been received and paid.
- To provide payment information to the subscriber for Internal Revenue Service substantiation
- To public health agencies if we believe that there is a serious health or safety threat
- To appropriate authorities when there are issues about abuse, neglect, or domestic violence
- In response to a court or administrative order, subpoena, discovery request, or other lawful process
- For law enforcement purposes, to military authorities and as otherwise required by law

- To help with disaster relief efforts
- For compliance programs and health oversight activities
- To fulfill our obligations under any workers' compensation law or contract
- To avert a serious and imminent threat to your health or safety or the health or safety of others
- For research purposes in limited circumstances
- 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?
We will not use or disclose your information for any reason that is not described in this notice, without your written permission. You may cancel your permission at any time by notifying us in writing. The following uses and disclosures will require your written permission:

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

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

What are my rights concerning my information?

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

- Access - You have the right to review and obtain a copy of your information that may be used to make decisions about you. You also may receive a summary of this health information. If you request copies, we may charge you a fee for the labor for copying, supplies for creating the copy (paper or electronic), and postage.
- Adverse Underwriting Decision - If we decline your application for insurance, you have the right to be provided a reason for the denial.

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

- Amendment - You have the right to request an amendment of information we maintain about you if you believe that the information is wrong or incomplete. We may deny your request if we did not create the information, we do not maintain the information, or the information is correct and complete. If we deny your request, we will give you a written explanation of the denial.

- Disclosure - You have the right to receive a listing of instances in which we or our business associates have disclosed your information. This does not apply to treatment, payment, health plan operations, and certain other activities. We maintain this information and make it available to you for six years. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee.

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

- Restriction - You have the right to ask to limit how your information is used or disclosed. We are not required to agree to the limit, but if we do, we will abide by our agreement. You also have the right to agree to or terminate a previously submitted limitation.

What types of communications can I opt out of that are made to me?

- Appointment reminders
- Treatment alternatives or other health-related benefits or services
- Fundraising activities

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

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

- Contacting us at 1-866-861-2762
- Accessing our Website at **www.humana.com** and going to the Privacy Practices link

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

- Send completed request form to:
  Humana Inc.
  Privacy Office 003/10911
  101 E. Main Street
  Louisville, KY 40202

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

You may also submit a written complaint to the U.S. Department of Health and Human Services, Office for Civil Rights (OCR). We will give you the appropriate OCR regional address on request. You can also e-mail your complaint to **OCRComplaint@hhs.gov**. If you elect to file a complaint, your benefits will not be affected and we will not punish or retaliate against you in any way.

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

We follow all federal and state laws, rules, and regulations addressing the protection of personal and health information. In situations when federal and state laws, rules, and regulations conflict, we follow the law, rule, or regulation which provides greater protection.

We are required by law to abide by the terms of this notice currently in effect.

What will happen if my information is used or disclosed inappropriately?
We are required by law to provide individuals with notice of our legal duties and privacy practices regarding personal and health information. If a breach of unsecured personal and health information occurs, we will notify you in a timely manner.

The following affiliates and subsidiaries also adhere to our privacy programs and procedures:

Arcadian Health Plan, Inc.
CarePlus Health Plans, Inc.
Cariten Health Plan, Inc.
CHA HMO, Inc.
CompBenefits Company
CompBenefits Dental, Inc.
CompBenefits Insurance Company
DentiCare, Inc.
Emphesys Insurance Company

HumanaDental Insurance Company
Humana Benefit Plan of Illinois, Inc.
Humana Benefit Plan of South Carolina, Inc.
Humana Benefit Plan of Texas, Inc.
Humana Employers Health Plan of Georgia, Inc.
Humana Health Benefit Plan of Louisiana, Inc.
Humana Health Company of New York, Inc.
Humana Health Insurance Company of Florida, Inc.
Humana Health Plan of California, Inc.
Humana Health Plan of Ohio, Inc.
Humana Health Plan of Texas, Inc.
Humana Health Plan, Inc.
Humana Health Plans of Puerto Rico, Inc.
Humana Insurance Company
Humana Insurance Company of Kentucky
Humana Insurance Company of New York
Humana Insurance of Puerto Rico, Inc.
Humana Medical Plan, Inc.
Humana Medical Plan of Michigan, Inc.
Humana Medical Plan of Pennsylvania, Inc.
Humana Medical Plan of Utah, Inc.
Humana Regional Health Plan, Inc.
Humana Wisconsin Health Organization Insurance Corporation
Go365 by Humana for Healthy Horizons
Managed Care Indemnity, Inc.
The Dental Concern, Inc.

<u>Effective 9/2013</u>

A more complete picture of your health

Humana has developed programs that have the ability to deliver your electronic healthcare history to authorized healthcare providers. These healthcare providers can view your medical claims, pharmacy claims, laboratory claims and results and radiology claims and results via various information exchange programs. In addition, some of the medical information systems used by your healthcare providers may download your information to provide a more complete view of your health condition. For privacy reasons, records from psychiatric, substance abuse, or HIV-related treatment will not be shared.

The benefit of this information exchange is that healthcare providers receive a complete view of the healthcare services you have received. This information is available to a broad range of healthcare providers, including but not limited to:

- Primary Care Providers
- Medical Specialists
- Hospitals
- Urgent Care Centers
- Dental Providers
- Emergency Medical Service (EMS) Providers
- Selected Alternative and Complementary Medical Practices

<u>For all residents outside of Massachusetts (MA) and New Mexico (NM):</u>
You may use any of the methods listed below to decline your participation in the information sharing program *.

1. Log in to MyHumana - the secure section of **www.humana.com**
   - Select "My Profile" option located in the upper right-hand corner of the webpage.
   - Select the "Communications Preferences" option within the dropdown list.
   - Within the "Privacy and Sharing" section, select "No" to "Primary Care Physician (PCP) and Treating Healthcare Providers."
   - Click the "Save Changes" button at the bottom of the webpage.
2. Call the automated response line at 1-800-733-9203.
3. For TTY service, call 711. Our hours are Monday - Friday, 8 a.m. - 8 p.m. and Saturday, 8 a.m. - 3 p.m., Eastern time.

<u>For all Massachusetts (MA) and New Mexico (NM) residents:</u>
You may use any of the methods listed below to participate in the Payer-based Health Record information sharing program *.

1. Log in to MyHumana - the secure section of **www.humana.com**
   - Select "My Profile" option located in the upper right-hand corner of the webpage.
   - Select the "Communications Preferences" option within the dropdown list.
   - Within the "Privacy and Sharing" section, select "Yes" to "Primary Care Physician (PCP) and Treating Healthcare Providers."
   - Click the "Save Changes" button at the bottom of the webpage.
2. Call the automated response line at 1-800-733-9203.
3. For TTY service, call 711. Our hours are Monday - Friday, 8 a.m. - 8 p.m. and Saturday, 8 a.m. - 3 p.m., Eastern time.

* There may be cases where Humana must exchange your health information to comply with regulatory requests and/or contractual agreements executed between Humana and a treating healthcare provider.

If you have any questions about how Humana protects your privacy, please access **www.humana.com/about/legal/privacy**. If you do not have computer access, you can receive a copy of your Notice of Privacy Practices by calling the customer service phone number located on the back of your Humana ID card.

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

As a member of our plan, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

If you want any of the following kinds of information, please call Customer Care. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet):

- **Information about our plan**. This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's Star ratings, including how it has been rated by plan members and how it compares to other Medicare prescription drug plans.

- **Information about our network pharmacies**

For example, you have the right to get information from us about the pharmacies in our network.

  - For a list of the pharmacies in the plan's network, see the *Pharmacy Directory.*

  - For more detailed information about our pharmacies, you can call Customer Care (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.) or visit our website at **www.humana.com**.

- **Information about your coverage and the rules you must follow when using your coverage.**

  - To get the details on your Part D prescription drug coverage, see Chapters 3 and 4 of this booklet plus the plan's *Prescription Drug Guide* (Formulary) (See Chapter 4, Section 1.1 of this booklet for how to access the *Drug Guide*.) These chapters, together with the Prescription *Drug Guide* (Formulary), tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.

  - If you have questions about the rules or restrictions, please call Customer Care. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

- **Information about why something is not covered and what you can do about it.**

  - If a Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the drug from an out-of-network pharmacy.

- If you are not happy or if you disagree with a decision we make about what Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 7 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 7 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)

- If you want to ask our plan to pay our share of the cost for a Part D prescription drug, see Chapter 5 of this booklet.

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

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.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.

- **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 as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to 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**.

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

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

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

If you have any problems or concerns about your covered services or care, Chapter 7 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints.

What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Customer Care. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

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, 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**. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, 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**. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare**.
  - You can visit the Medicare website to read or download the publication "Your 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

Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Care. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.) We're here to help.

- ***Get familiar with your covered drugs and the rules you must follow to get these covered drugs.*** *Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered drugs.*
  - Chapters 3 and 4 give the details about your coverage for Part D prescription drugs.

- ***If you have any other prescription drug coverage in addition to our plan, you are required to tell us.*** *Please call Customer Care to let us know. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)*
  - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered drugs from our plan. This is called "**coordination of benefits**" because it involves coordinating the drug benefits you get from our plan with any other drug benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 10.)
- ***Tell your doctor and pharmacist that you are enrolled in our plan.*** *Show your plan membership card whenever you get your 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 your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. 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. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- ***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.
  - For most of your drugs covered by the plan, you must pay your share of the cost when you get the drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost) Chapter 4 tells what you must pay for your Part D prescription drugs.
  - If you get any drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
  - If you disagree with our decision to deny coverage for a drug, you can make an appeal. Please see Chapter 7 of this booklet for information about how to make an appeal.
  - If you are required to pay a late enrollment penalty, you must pay the penalty to remain a member of the plan.

- If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a member of the plan.

- ***Tell us if you move.*** *If you are going to move, it's important to tell us right away. Call Customer Care. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)*

  - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.

  - **If you move *within* our service area, we still need to know** so we can keep your membership record up-to-date and know how to contact you.

  - If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.

- ***Call Customer Care (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.) for help if you have questions or concerns.*** *We also welcome any suggestions you may have for improving our plan and our rights and responsibilities statement.*

  - For more information on how to reach us, including our mailing address, please see Chapter 2.

CHAPTER 7

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

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

BACKGROUND

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 types of problems, you need to use the **process for coverage decisions and appeals.**
- For other types of problems, you need to use the **process for making complaints.**

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Which one do you use? That depends on the type of problem you are having. The guide in Section 3 will help you identify the right process to use.

Section 1.2 What about the legal terms?

There are technical 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 keep things simple, this chapter explains the legal rules and procedures using 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 "coverage determination" or "at-risk 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 for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and 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 You can get help from government organizations that are not connected with us

Section 2.1 Where to get more information and personalized assistance

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

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program** (SHIP). This government program has trained counselors in every state. 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 in "Exhibit A" at the end of this booklet.

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from 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 visit the Medicare website **www.medicare.gov**.

SECTION 3 To deal with your problem, which process should you use?

Section 3.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

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.

To figure out which part of this chapter will help with your specific problem or concern, **START HERE**	
Is your problem or concern about your benefits or coverage? (This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)	
Yes. **My problem is about benefits or coverage.** Go on to the next section of this chapter, **Section 4, "A guide to the basics of coverage decisions and appeals".**	**No.** **My problem is not about benefits or coverage.** Skip ahead to **Section 7** 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

The process for coverage decisions and appeals deals with problems related to your benefits and coverage for prescription drugs, including problems related to payment. This is the process you use for issues such as whether a drug is covered or not and the way in which the drug is covered.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs.

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 a 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 and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review we give you our decision. Under certain circumstances, which we discuss later, you can request an expedited or "fast coverage decision" or fast appeal of a coverage decision. In limited circumstances a request for a 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.

If we say no to all or part of your Level 1 Appeal, you can ask for a Level 2 Appeal. The Level 2 Appeal is conducted by an Independent Review Organization that is not connected to us. 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 4.2 How to get help when you are asking for a coverage decision or making an appeal

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- **You can call Customer Care.** (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)
- You can get free help from your State Health Insurance Assistance Program (see Section 2 of this chapter).
- **Your doctor or other prescriber can make a request for you**. For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 or Level 2 Appeal on your behalf. To request any appeal after Level 2, your doctor or other prescriber must be appointed as your representative.
- **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.
  - There may be someone who is already legally authorized to act as your representative under State law.
  - If you want a friend, relative, your doctor or other prescriber, or other person to be your representative, call Customer Care (phone numbers are located in Chapter 2, Section 1 of this booklet) 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.
- **You also have the right to hire a lawyer to act for you.** 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 5 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

? Have you read Section 4 of this chapter (*A guide to "the basics" of coverage decisions and appeals*)? If not, you may want to read it before you start this section.

Section 5.1 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 as a member of our plan include coverage for many prescription drugs. Please refer to our plan's *Prescription Drug Guide* (Formulary). (See Chapter 4, Section 1.1 of this booklet for how to access the *Drug Guide*.) To be covered, the 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 reference books. See Chapter 3, Section 3 for more information about a medically accepted indication.)

- **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.

- For details about what we mean by Part D drugs, the *Prescription Drug Guide* (Formulary), rules and restrictions on coverage, and cost information, see Chapter 3 (*Using our plan's coverage for your Part D prescription drugs*) and Chapter 4 (*What you pay for your Part D prescription drugs*).

Part D coverage decisions and appeals

As discussed in Section 4 of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

Legal Terms
An initial coverage decision about your Part D drugs is called a **"coverage determination".**

Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including:
  - Asking us to cover a Part D drug that is not in the plan's *Prescription Drug Guide* (Formulary)
  - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
  - Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier

- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is in the plan's *Prescription Drug Guide* (Formulary) but we require you to get approval from us before we will cover it for you.)
  - *Please note:* 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.
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

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. Use the chart below to help you determine which part has information for your situation:

Which of these situations are you in?

If you are in this situation:	This is what you can do:
If you need a drug that isn't in our *Drug Guide* or need us to waive a rule or restriction on a drug we cover.	You can ask us to make an exception. (This is a type of coverage decision.) Start with **Section 5.2** of this chapter.
If you want us to cover a drug in our *Drug Guide* and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need.	You can ask us for a coverage decision. Skip ahead to **Section 5.4** of this chapter.
If you want to ask us to pay you back for a drug you have already received and paid for.	You can ask us to pay you back. (This is a type of coverage decision.) Skip ahead to **Section 5.4** of this chapter.
If we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for.	You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to **Section 5.5** of this chapter.

Section 5.2 What is an 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. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. 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 in our plan's *Prescription Drug Guide* (Formulary).** We call it the *"Drug Guide"* for short. (See Chapter 4, Section 1.1 of this booklet for how to access the *Drug Guide*.)

Legal Terms
Asking for coverage of a drug that is not in the *Drug Guide* is sometimes called asking for a **"formulary exception".**

- If we agree to make an exception and cover a drug that is not in the *Drug Guide*, you will need to pay the cost-sharing amount that applies to drugs in the Non-Preferred Drug tier. You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

2. **Removing a restriction on our coverage for a covered drug**. There are extra rules or restrictions that apply to certain drugs in our *Prescription Drug Guide* (Formulary) (for more information, go to Chapter 3).

Legal Terms
Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **"formulary exception".**

- The extra rules and restrictions on coverage for certain drugs include:
  - *Being required to use the generic version* of a drug instead of the brand name drug.
  - *Getting plan approval in advance* before we will agree to cover the drug for you. (This is sometimes called "prior authorization".)
  - *Being required to try a different drug first* before we will agree to cover the drug you are asking for. (This is sometimes called "step therapy".)
  - *Quantity limits*. For some drugs, there are restrictions on the amount of the drug you can have.
- If we agree to 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 in 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.

Legal Terms
Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a **"tiering exception".**

- If our drug list 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). This would lower your share of the cost for the drug.
    - If the drug you're taking is a biological product 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 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.
- You cannot ask us to change the cost-sharing tier for any drug in the Specialty tier.
- If we approve your request for a tiering exception 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 5.3 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* (see Chapter 4, Section 1.1 of this booklet for how to access the *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. If you ask us for a tiering exception, 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 for an exception, you can ask for a review of our decision by making an appeal. Section 5.5 tells you how to make an appeal if we say no.

The next section tells you how to ask for a coverage decision, including an exception.

Section 5.4 Step-by-step: How to ask for a coverage decision, including an exception

<u>Step 1:</u> **You ask us to make a coverage decision about the drug(s) or payment you need.** If your health requires a quick response, you must ask us to make a **"fast coverage decision". You cannot ask for a fast coverage decision if you are asking us to pay you back for a drug you already bought.**

What to do

- **Request the type of coverage decision you want.** Start by calling, writing or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can also access the coverage decision process through our website. For the details, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision about your Part D prescription drugs*. Or if you are asking us to pay you back for a drug, go to the section called, *Where to send a request that asks us to pay for our share of the cost for a drug you have received*.

- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.

- **If you want to ask us to pay you back for a drug,** start by reading Chapter 5 of this booklet: *Asking us to pay our share of the costs for covered drugs*. Chapter 5 describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.

- **If you are requesting an exception, provide the "supporting statement".** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "supporting statement".) 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. See Sections 5.2 and 5.3 for more information about exception requests.

- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.

- **To submit a coverage determination request online,** please go to: **Humana.com/member/member-rights/pharmacy-authorizations.** Fill out the Coverage Determination Request Form. You'll need to send us supporting documentation from the prescribing doctor to show medical need. Your information will be sent to us securely.

If your health requires it, ask us to give you a "fast coverage decision"

Legal Terms
A "fast coverage decision" is called an **"expedited coverage determination".**

- When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard coverage decision means we will give you an answer within 72 hours after we receive your doctor's statement. A fast coverage decision means we will answer within 24 hours after we receive your doctor's statement.

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

  - You can get a fast coverage decision *only* if you are asking for a *drug you have not yet received.* (You cannot ask for a fast coverage decision if you are asking us to pay you back for a drug you have already bought.)

  - 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 or other prescriber 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 or other prescriber's support), we will decide whether your health requires that we give you a fast coverage decision.

- If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).

- This letter will tell you that if your doctor or other prescriber asks for the fast coverage decision, we will automatically give a fast coverage decision.

- The letter will also tell how you can file a complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. It tells how to file a "fast" complaint, which means you would get our answer to your complaint within 24 hours of receiving the complaint. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see Section 7 of this chapter.)

<u>Step 2:</u> We consider your request and we give you our answer.

Deadlines for a "fast coverage decision"

- If we are using the fast deadlines, we must give you our answer **within 24 hours.**
  - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor's statement supporting your request. 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. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **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

- If we are using the standard deadlines, we must give you our answer **within 72 hours.**
  - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. 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. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.

- **If our answer is yes to part or all of what you requested:**
  - If we approve your request for coverage, 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. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **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.

Step 3: If we say no to your coverage request, you decide if you want to make an appeal.

- If we say no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made.

Section 5.5 **Step-by-step: How to make a Level 1 Appeal** (how to ask for a review of a coverage decision made by our plan)

Legal Terms
An appeal to the plan about a Part D drug coverage decision is called a plan **"redetermination".**

<u>Step 1:</u> **You contact us and make your Level 1 Appeal.** If your health requires a quick response, you must ask for a **"fast appeal".**

What to do

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact us.**
  - For details on how to reach us by phone, fax, mail, or on our website, for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called, *How to contact us when you are making an appeal about your Part D prescription drugs.*
- **If you are asking for a standard appeal, make your appeal by submitting a written request.**
- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown in Chapter 2, Section 1** *(How to contact our plan when you are making an appeal about your Part D prescription drugs).*
- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had 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 have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
  - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal"

Legal Terms
A "fast appeal" is also called an **"expedited redetermination".**

- 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 5.4 of this chapter.

Step 2: **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"

- If we are using the fast deadlines, 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 it.
  - 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. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals 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"

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal for a drug you have not received yet. 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 you believe your health requires it, you should ask for "fast" appeal.
  - 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. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.

- **If our answer is yes to part or all of what you requested:**
  - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we receive your appeal.
  - If we approve a 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 your appeal 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 and how you can appeal our decision.
- If you are requesting that we pay you back 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 give you a decision within 14 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. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **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 our decision.

<u>Step 3:</u> **If we say no to your appeal, you decide if you want to continue with the appeals process and make another appeal.**

- If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal.
- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

Section 5.6 Step-by-step: How to make a Level 2 Appeal

If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the "Independent Review Organization" is the **"Independent Review Entity".** It is sometimes called the **"IRE".**

Step 1: To make a Level 2 Appeal, 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.
- When you make an appeal to the Independent Review Organization, we will send the information we have 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 does a review of your appeal and gives you an answer.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with us.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

Deadlines for "fast appeal" at Level 2

- If your health requires it, ask the Independent Review Organization for a "fast appeal".
- If the review 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.
- **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.

Deadlines for "standard appeal" at Level 2

- If you have a standard appeal at Level 2, 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 received yet. 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.
- **If the Independent Review Organization says yes to part or all of what you requested:**
    - If the Independent Review Organization approves a 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 approves a 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 your appeal, it means the organization agrees with our decision not to approve your request. (This is called "upholding the decision". It is also called "turning down your appeal".)

If the Independent Review Organization "upholds the decision" you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. 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. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

Step 3: If the dollar value of the coverage you are requesting meets the requirement, 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 your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 6 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 6 Taking your appeal to Level 3 and beyond

Section 6.1 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	**A judge (called 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**. What you asked for in the appeal has been approved. 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 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. If the Administrative Law Judge or attorney adjudicator says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your 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**. What you asked for in the appeal has been approved. 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 might 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 you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice 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.

This is the last step of the appeals process.

MAKING COMPLAINTS

SECTION 7 How to make a complaint about quality of care, waiting times, customer service or other concerns

? If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you.* Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.

Section 7.1 What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only*. This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

IF YOU HAVE ANY OF THESE KINDS OF PROBLEMS, YOU CAN "MAKE A COMPLAINT"

Quality of your medical care

- Are you unhappy with the quality of the care you have received?

Respecting your privacy

- Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?

Disrespect, poor customer service, or other negative behaviors

- Has someone been rude or disrespectful to you?
- Are you unhappy with how our Customer Care has treated you?
- Do you feel you are being encouraged to leave the plan?

Waiting times

- Have you been kept waiting too long by pharmacists? Or by our Customer Care or other staff at the plan?

Examples include waiting too long on the phone or when getting a prescription.

Cleanliness

- Are you unhappy with the cleanliness or condition of a pharmacy?

Information you get from us

- Do you believe we have not given you a notice that we are required to give?
- Do you think written information we have given you is hard to understand?

Timeliness (These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals)

The process of asking for a coverage decision and making appeals is explained in sections 4-6 of this chapter. If you are asking for a coverage decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked us to give you a "fast coverage decision" or a "fast appeal", and we have said we will not, you can make a complaint.
- If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.
- When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.
- When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 7.2 The formal name for "making a complaint" is "filing a grievance"

Legal Terms

- What this section calls a **"complaint"** is also called a **"grievance".**
- Another term for **"making a complaint"** is **"filing a grievance".**
- Another way to say **"using the process for complaints"** is **"using the process for filing a grievance".**

Section 7.3 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.
- Phone numbers are located in Chapter 2, Section 1 of this booklet. (TTY users should call 711.) We are available Monday through Friday from 8 a.m. to 9 p.m. Eastern time.
- **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. (Phone numbers for Customer Care are located in chapter 2, section 1 of this booklet.) (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 (phone numbers for customer care are located in chapter 2, section 1 of this booklet) 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.

Option for Fast Review of your Grievance

You may request a fast review, and we will respond within 24 hours upon receipt, if your grievance concerns one of the following circumstances:

- We've extended the timeframe for making an organization determination/ reconsiderations, and you believe you need a decision faster.
- We denied your request for a fast review of a 72-hour organization/coverage decision.
- We denied your request for a fast review of a 72-hour appeal.

It's best to call Customer Care if you want to request fast review of your grievance. If you mail your request, we'll call you to let you know we received it.

- **Whether you call or write, you should contact Customer Care right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.

- **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**.

Legal Terms
What this section calls a **"fast complaint"** is also called an **"expedited grievance".**

<u>Step 2:</u> **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. If your health condition requires us to answer quickly, we will do that.

- **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 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 let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 7.4 You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received by using the step-by-step process outlined above.

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization**. If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).
    - 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.
    - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in "Exhibit A" in the back of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or you can make your complaint to both at the same time**. If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

Section 7.5 You can also tell Medicare about your complaint

You can submit a complaint about Humana Group Medicare PDP 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 have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 8

Ending your membership in the plan

Chapter 8. Ending your membership in the plan

SECTION 1 Introduction

Section 1.1 This chapter focuses on ending your membership in our plan

Ending your membership in Humana Group Medicare PDP Plan may be voluntary (your own choice) or involuntary (not your own choice):

- You might leave our plan because you have decided that you want to leave.
- There are also limited situations where you do not choose to leave, but 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, you must continue to get your Part D prescription drugs through our plan 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 PDP Plan may be eligible to end their membership at other times of the year. This is known as a Special Enrollment Period.

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you may be eligible to end your membership during a Special Enrollment Period. 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).
- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.

  Note: If you're in a drug management program, you may not be able to change plans

- **What can you do?** 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. This means you can choose any of the following types of plans:
  - Another Medicare prescription drug plan.
  - Original Medicare *without* a separate Medicare prescription drug plan.
    - **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.
    - -- *or* -- A Medicare health plan. A Medicare health plan is a plan offered by a private company that contracts with Medicare to provide all of the Medicare Part A (Hospital) and Part B (Medical) benefits. Some Medicare health plans also include Part D prescription drug coverage.
    - If you enroll in most Medicare health plans, you will automatically be disenrolled from Humana Group Medicare PDP Plan when your new plan's coverage begins. However, if you choose a Private Fee-for-Service plan without Part D drug coverage, a Medicare Medical Savings Account plan, or a Medicare Cost Plan, you can enroll in that plan and keep Humana Group Medicare PDP Plan for your drug coverage. If you do not want to keep our plan, you can choose to enroll in another Medicare prescription drug plan or to drop Medicare prescription drug coverage.

  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 Part D late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) See Chapter 1, Section 5 for more information about the late enrollment penalty.

- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plan.

Section 2.2 Where can you get more information about when you can end your membership?

If you have any questions or would like more information on when you can end your membership:

- You can **call Customer Care.** (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)

- You can find the information in the ***Medicare & You 2022*** handbook.
  - Everyone with Medicare receives a copy of the *Medicare & You 2022* handbook each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare website **www.medicare.gov**. Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **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 3 How do you end your membership in our plan?

Section 3.1 Usually, you end your membership by enrolling in another plan

Usually, to end your membership in our plan, you simply enroll in another Medicare 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. However, there are two situations in which you will need to end your membership in a different way:

- If you want to switch from our plan to Original Medicare *without* a Medicare prescription drug plan, you must ask to be disenrolled from our plan.
- If you join a Private Fee-for-Service plan without prescription drug coverage, a Medicare Medical Savings Account Plan, or a Medicare Cost Plan, enrollment in the new plan will not end your membership in our plan. In this case, you can enroll in that plan and keep Humana Group Medicare PDP Plan for your drug coverage. If you do not want to keep our plan, you can choose to enroll in another Medicare prescription drug plan or ask to be disenrolled from our plan.

If you are in one of these two situations and want to leave our plan, there are two ways you can ask to be disenrolled:

  - You can make a request in writing to us. Contact Customer Care or your benefit administrator if you need more information on how to do this. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.)
  - -- *or* -- you can contact 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.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for a continuous period of 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) See Chapter 1, Section 5 for more information about the late enrollment penalty.

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 prescription drug plan.	• Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from Humana Group Medicare PDP Plan when your new plan's coverage begins.
• A Medicare health plan.	• Enroll in the Medicare health plan. With most Medicare health plans, you will automatically be disenrolled from Humana Medicare Employer PDP when your new plan's coverage begins. However, if you choose a Private Fee-For-Service plan without Part D drug coverage, a Medicare Medical Savings Account plan, or a Medicare Cost Plan, you can enroll in that new plan and keep Humana Group Medicare PDP Plan for your drug coverage. If you want to leave our plan, you must either enroll in another Medicare prescription drug plan or ask to be disenrolled. To ask to be disenrolled, you must send us a written request (contact Customer Care (Phone numbers are located in Chapter 2, Section 1 of this booklet.) if you need more information on how to do this) or contact 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.
• Original Medicare *without* a separate Medicare prescription drug plan. • **Note:** If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a late enrollment penalty if you join a Medicare drug plan later. See Chapter 1, Section 5 for more information about the late enrollment penalty.	• **Send us a written request to disenroll.** Contact Customer Care if you need more information on how to do this. (Phone numbers are located in Chapter 2, Section 1 of this booklet.) • 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 PDP Plan when your coverage in Original Medicare begins.

SECTION 4 Until your membership ends, you must keep getting your drugs through our plan

Section 4.1 Until your membership ends, you are still a member of our plan

If you leave Humana Group Medicare PDP Plan, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your prescription drugs through our plan.

- **You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy, including through our mail-order pharmacy services.

SECTION 5 Humana Group Medicare PDP 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 PDP Plan must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A or Part B (or both).
- If you move out of our service area.
- If you are away from our service area for more than 12 months.
    - If you move or take a long trip, you need to call Customer Care to find out if the place you are moving or traveling to is in our plan's area. (Phone numbers are located in Chapter 2, Section 1 of this booklet.)
- 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 about 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 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 prescription drugs. (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.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan and you will lose prescription drug coverage.

Where can you get more information?

- If you have questions or would like more information on when we can end your membership, you can call **Customer Care** for more information. (Phone numbers are located in Chapter 2, Section 1 of this booklet.)

Section 5.2 We cannot ask you to leave our plan for any reason related to your health

Humana Group Medicare PDP Plan is not allowed to ask you to leave our plan for any reason related to your health.

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). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

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. You can also look in Chapter 7, Section 7 for information about how to make a complaint.

CHAPTER 9

Legal notices

Chapter 9. Legal notices

SECTION 1 Notice about governing law

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

SECTION 2 Notice about non-discrimination

Our plan must obey laws that protect you from discrimination or unfair treatment. **We don't discriminate** based on race, ethnicity, national origin, color, religion, sex, gender, age, 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 prescription drug 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.

If you have a disability and need help with access to care, please call us at Customer Care. (Phone numbers for Customer Care are located in Chapter 2, Section 1 of this booklet.) 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 prescription drugs for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Humana Medicare Employer PDP, as a Medicare prescription drug plan sponsor, 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 7.

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 7 What to do if you have a problem or complaint (coverage decisions, appeals, complaints) in this *Evidence of Coverage.*

CHAPTER 10

Definitions of important words

Chapter 10. Definitions of important words

Allowed Amount - The payment amount determined and permitted by a plan sponsor for a covered medical service or supply.

Appeal - An appeal is something you do if you disagree with our decision to deny a request for coverage of prescription drugs or payment for drugs you already received. For example, you may ask for an appeal if we don't pay for a drug you think you should be able to receive. Chapter 7 explains appeals, including the process involved in making an appeal.

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 where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $7,050 in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) - The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

Coinsurance - An amount you may be required to pay as your share of the cost for prescription drugs after you pay any applicable deductibles. Coinsurance is usually a percentage (for example, 20%).

Complaint- The formal name for "making a complaint" is "filing a grievance". The complaint process is used for certain types of problems *only*. This includes problems related to quality of care, waiting times, and the customer service you receive. See also "Grievance" in this list of definitions.

Copayment (or "copay") - An amount you may be required to pay as your share of the cost for a prescription drug. A copayment is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a prescription drug.

Cost-Sharing - Cost-sharing refers to amounts that a member has to pay when drugs are received. Cost-sharing includes any combination of the following three types of payments: (1) any "deductible" amount a plan may impose before drugs are covered; (2) any fixed "copayment" amount that a plan requires when a specific drug is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a drug, that a plan requires when a specific drug is received. 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.

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 booklet. Chapter 7 explains how to ask us for a coverage decision.

Covered Drugs - The term we use to mean all of the prescription drugs 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.

Customer Care - A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Customer Care.

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. This means you pay **$1** for each day's supply when you fill your prescription.

Deductible - The amount you must pay for prescriptions before our plan begins to pay.

Disenroll or Disenrollment - The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Dispensing Fee - A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs such as the pharmacist's time to prepare and package the prescription.

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, 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.

***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 your plan sponsor's 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 your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Extra Help - A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

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 us or one of our network pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

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 $4,430.

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. For example, 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.

List of Covered Drugs (Formulary or "*Drug Guide*") - A list of prescription drugs covered 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. (See Chapter 4, Section 1.1 of this booklet for how to access the *Drug Guide*.)

Low Income Subsidy (LIS) - See "Extra Help".

Medicaid (or Medical Assistance) - A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

Medically Accepted Indication - A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 3, Section 3 for more information about a medically accepted indication.

Medically Necessary - 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). People with Medicare can get their Medicare health coverage through Original Medicare or a Medicare Advantage Plan.

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 HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. If you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. 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.** Everyone who has Medicare Part A and Part B is eligible to join any Medicare Advantage health plan that is offered in their area.

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.

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, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

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 network pharmacy is a pharmacy where members of our plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Original Medicare ("Traditional Medicare" or "Fee-for-service" Medicare) - Original Medicare is offered by the government, and not a private health plan like 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 doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. As explained in this *Evidence of Coverage*, most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Pocket Costs – See the definition for "cost-sharing" above. A member's cost-sharing requirement to pay for a portion of 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 (LTC) services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan. If you would like to know if PACE is available in your state, please contact Consumer Care (phone numbers are located in Chapter 2, Section 1 of this booklet).

Part C - see "Medicare Advantage (MA) Plan".

Part D - The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Part D Drugs - Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

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. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive "Extra Help" from Medicare to pay your prescription drug plan costs, you will not pay a late enrollment penalty.

Preferred Cost-Sharing - Preferred cost-sharing means lower cost-sharing for certain covered Part D drugs at certain network pharmacies.

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. (See Chapter 4, Section 1.1 of this booklet for how to access the *Drug Guide*.)

Prior Authorization - Approval in advance to get certain drugs that may or may not be on our formulary. Some drugs are covered only if your doctor or other network provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the formulary.

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. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

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.

Service Area - A geographic area where a prescription drug plan accepts members if it limits membership based on where people live. The plan may disenroll you if you permanently move out of the plan's service area.

Special Enrollment Period - A set time when members can change their health or drug plans 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.

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.

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/**