2026 Transition Policy for Humana PathWays Dual Care (HMO-POS D-SNP) Prescription Drug Coverage

Humana wants to make sure that members like you get the medicine you need in the coming plan year. Starting January 1, 2026, you may not be able to get the drug you get now if:

- The drug is not on our approved list, or
- We need to approve it in advance because:
  - There are limits on the amount you can get
  - You need to try a less costly drug first, or
  - We need to know some facts about your health

If your drug is not on our approved list or we need to approve it in advance, you can keep getting your drug for a little while. This is called a transition supply.

You cannot get a transition supply for some drugs. Examples of these drugs are:

- Drugs where we need to determine Part A or B versus D coverage.
- Drugs that may not be eligible for Part D coverage. We may need to know what you are using your drug for before it can be covered by us.
- Drugs where we may need information to know if it is being used safely.

If you are a new member or an existing member with history of a drug

During your first **90 days** as a member, Humana will cover **30 days'** worth of a drug that Medicare Part D covers. Humana will do this only **one** time per drug *unless* the prescription is written for less than 30 days (in which case Humana will allow multiple fills to provide up to a total of 30 days of medication).

Transition across contract years

For existing members whose drugs will be affected by negative changes in the upcoming year, Humana will provide a transition process at the start of the new contract year. Humana will also extend the transition policy across contract years for members who enroll into a plan with an effective enrollment date of either November 1 or December 1 and need access to a transition supply.

Distinguishing brand new drugs

Humana will apply transition processes to brand new drugs not on our approved drug list or if the drug has limits, if Humana cannot make the distinction between a brand-new drug and on-going history of the drug at point of sale. To determine if the member has history of the drug, members must have at least 108 days of claim history with Humana. Humana will look-back 180 days from the member effective date or the start of the plan year for drug history.

If you are a new member in a long-term care facility

We will help you if you:

- Are new to your plan
- Have both Medicare and full Medicaid benefits
- Ask us to make an exception, **or**
- Make an appeal

During your first **90 days** as a member, we will cover **a 31 day** supply *unless* the prescription is written for less than 31 days (in which Humana will allow multiple fills to provide up to a total of 31 days of medication) of a drug that Medicare Part D covers.

After that, we will cover a **31-day** emergency supply *unless* the prescription is written for less than 31 days (in which case Humana will allow multiple fills to provide up to a total of 31 days of medication) of a drug that Medicare Part D covers. This will let you keep getting your drug while we look at your request to:

- Make an exception, **or**
- Approve your drug in advance

If you change treatment settings

During the plan year, you may change treatment settings because of a change in the level of your care. For instance, you may:

- Move from a hospital or skilled nursing facility to a home setting
- Move from a home setting to a hospital or skilled nursing facility
- Move from one skilled nursing facility to another, so you need to use a new pharmacy
- Stop staying at a skilled nursing facility where Medicare Part A covered your prescription drugs, so you need to use Part D now
- Give up your Hospice status, so you need to use Medicare Parts A and B now
- Leave a long-term psychiatric hospital where your drugs were tailored to you

In such cases, we will cover up to **31 days'** worth of a drug that Medicare Part D covers when you get the drug at a pharmacy.

If you change treatment settings <u>more than once in the same month</u> you may need to ask us to make an exception, **or** approve your drug in advance.

We will look at your request to see if you have a treatment plan, **and** changing it would harm your health.

Transition Member and Prescriber Notices

After you receive a transition fill, we will send you a letter within 3 business days and also send your doctor a letter. Letters are sent for the first transition fill only if you receive your transition supply in multiple fills. The letters will explain that we will not cover more of the drug unless you

receive approval from us.

We suggest you talk with your doctor. Decide if you should:

- Try another drug to treat your health problem. You can review the Prescription Drug Guide to find out which drugs are covered, **or**
- Ask us to make an exception, **or**
- Ask us to approve your drug in advance

If you get the low-income subsidy (LIS, also known as "Extra Help") in 2026

The amount you pay for your 30-day supply will be **no more than** your LIS limit.

If you <u>don't</u> get "Extra Help"

The amount you pay for your 30-day supply will be based on your plan's terms. Refer to your Member Handbook for more information on your plan's terms.

If you need more time

We may extend your transition supply. This will let you keep getting your drug while we look at your appeal, **or** request for an exception.

After you get a transition supply of a Part D drug

We may need to do a medical review of the drug if:

- The drug is not on our approved list, or
- We need to approve it in advance because:
    - There are limits on the amount you can get, **or**
    - You need to try a less costly drug first, **or**
    - We need to know some facts about your health

If we need to know some facts about your health

Your doctor can give us these facts. This will help us work on your request to approve your drug in advance or make an exception if:

- Your drug is not on our approved list, **or**
- We need to approve your drug in advance, **or**
- You have tried other drugs to treat your health problem

To ask for an exception

Ask your doctor to send us a letter. The letter must say that you need this drug to treat your health problem because the drugs we **do** cover:

- Would not work as well to treat your health problem, **or**
- Would harm your health

The letter must explain why the limit we placed on your drug:

- Is not fitting given your health problem, **or**

- Would harm your health

In most cases, we must tell you our decision no more than **72 hours** after we get your doctor's letter. We will grant you a fast request if we find, or your doctor tells us, that waiting for a standard request could harm your life, health, or ability to function. With a fast request, we must tell you our decision no more than **24 hours** after we get your doctor's letter.

If we say no to your request for an exception

You can ask us if we cover another drug for your health problem if:

- Your drug is **not** on our approved list, **or**
- Your drug **is** on our list, but:
    - We need to approve your drug in advance
    - You need to try a less costly drug first, **or**
    - There are limits on the amount you can get

Ask your doctor if this drug is a good choice for you.

You can also ask us to review our decision. You must make this appeal no more than **65 days** after our first decision.

We can help

We can help you and your doctor:

- Ask for an exception
- Make an appeal
- Find another drug for your health problem
- Learn more about your Transition Policy

You and your doctor can also get forms to ask us to:

- Approve your drug in advance
- Make an exception

Just call the customer service number on the back of your Humana member ID card. Or go to our website.

Pharmacy and Therapeutics (P&T) committee

This committee watches over our Part D drug list and related rules. It made these rules for certain Part D drugs. The rules are meant to make sure the drugs:

- Are used per medical guidelines
- Have been proven safe and effective for the health problem they are treating
- Are prescribed per the maker's guidelines

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- U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building Washington, D.C. 20201. **800-368-1019**, **800-537-7697 (TDD)**.

California members:

You can also file a civil rights complaint with the California Dept. of Health Care Services, Office of Civil rights by calling **916-440-7370 (TTY: 711)**, emailing **Civilrights@dhcs.ca.gov**, or by mail at: Deputy Director, Office of Civil Rights, Department of Health Care Services, P.O. Box 997413, MS 0009, Sacramento, CA 95899-7413. Complaint forms available at: **http://www.dhcs.ca.gov/Pages/Language_Access.aspx**.

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