Humana.

Evidence of Coverage for 2026:

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

This document gives the details of Medicare health and drug coverage for this plan year . **This is an important legal document. Keep it in a safe place.**

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

- Our plan premium and cost sharing;
- Our medical and drug benefits;
- How to file a complaint if you're not satisfied with a service or treatment;
- How to contact us
- Other protections required by Medicare law.

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

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

This document is available for free in Spanish.

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

Benefits, premiums and/or member copayments/coinsurance may change on the beginning of each plan year. Our Formulary, pharmacy network, and/or provider network may change at any time. You'll receive notice about changes that may affect you at least 30 days in advance.

2026 Evidence of Coverage

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CHAPTER 1:

Get started as a member

SECTION 1 You're a member of Humana Group Medicare Advantage PPO Plan

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

You're covered by Medicare, and you chose to get your Medicare health and drug coverage through our plan, Humana Group Medicare Advantage PPO Plan . Our plan covers all Part A and Part B services. However, cost sharing and provider access in this plan are different from Original Medicare.

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

Section 1.2 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how Humana Group Medicare Advantage PPO Plan covers your care. Other parts of this contract include your enrollment form, the *Prescription Drug Guide* (formulary), and any notices you get 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 the months you're enrolled in Humana Group Medicare Advantage PPO Plan coverage between January 1, 2026, and December 31, 2026.

Medicare allows us to make changes to our plans we offer each calendar year. This means we can change the costs and benefits of the Humana Group Medicare Advantage PPO Plan after December 31, 2026. We can also choose to stop offering the plan in your service area, after December 31, 2026.

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

SECTION 2 Plan eligibility requirements

Section 2.1 Eligibility requirements

*Y*ou're eligible for membership in our plan as long as you meet all these conditions:

- You have both Medicare Part A and Medicare Part B
- You live in our geographic service area (described in Section 2.2) . People who are incarcerated aren't considered to be living in the geographic service area, even if they're physically located in it.
- You're a United States citizen or lawfully present in the United States

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

Humana Group Medicare Advantage PPO Plan is only available to people who live in our plan service area. To stay a member of our plan, you must continue to reside in the plan service area. The service area is described below:

Where is Humana Group Medicare Advantage PPO Plan available?

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

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

If you move out of our plan's service area, you can't stay a member of this plan. Call Humana Group Medicare Customer Care (TTY users call 711) to see if we have a plan in your new area. When you move, you'll have a Special Enrollment Period to either switch to Original Medicare or enroll in a Medicare health or drug plan in your new location.

If you move or change your mailing address it's also important to call Social Security. Call Social Security, at 1-800-772-1213 (TTY users call 1-800-325-0778).

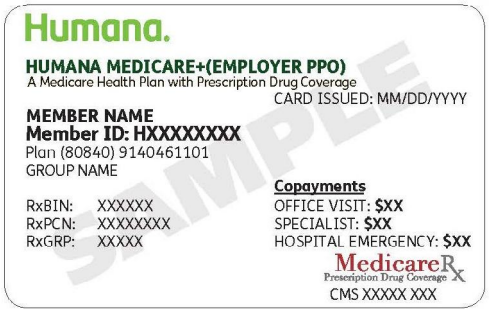
Section 2.3 U.S. citizen or lawful presence

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

SECTION 3 Important membership materials

Section 3.1 Our plan membership card

Use your membership card whenever you get services covered by our plan and for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card, you have one. Sample membership card:



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

If our plan membership card is damaged, lost, or stolen, call Humana Group Medicare Customer Care (TTY users call 711) right away and we'll send you a new card.

Section 3.2 Provider Directory

The *Provider Directory* (**www.Humana.com/SearchResources**) lists our current network providers, durable medical equipment suppliers and pharmacies . **Network providers** are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost-sharing as payment in full.

As a member of our plan, you can choose to get care from out-of-network providers. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and medically necessary. However, if you use an out-of-network provider, your share of the costs for your covered services may be higher. See Chapter 3 for more specific information.

If you don't have a *Provider Directory*, you can ask for a copy (electronically or in paper form) from Humana Group Medicare Customer Care (TTY users call 711). Requested paper *Provider Directories* will be mailed to you within 3 business days.

Section 3.3 Pharmacy Directory

The Pharmacy Directory **www.Humana.com/SearchResources**. lists our network pharmacies. Network pharmacies are pharmacies that agree to fill covered prescriptions for our plan members. Use the Pharmacy Directory to find the network pharmacy you want to use. Go to Chapter 5, Section 2.5 for information on when you can use pharmacies that aren't in our plan's network.

Section 3.4 Drug Guide (Formulary)

Our plan has a *Prescription Drug Guide* (also called the Drug List or formulary). It tells which prescription drugs are covered under the Part D benefit included in Humana Group Medicare Advantage PPO Plan. The drugs on this list are selected by our plan with the help of doctors and pharmacists. The Drug Guide must meet Medicare's requirements . Medicare approved the Humana Group Medicare Advantage PPO Plan Drug Guide. Drugs with negotiated prices under the Medicare Drug Price Negotiation Program will be included on your Drug List unless they have been removed and replaced as described in Chapter 5, Section 6.

The Drug Guide also tells if there are any rules that restrict coverage for a drug.

We'll give you a copy of the Drug Guide. The Drug Guide includes information for the covered drugs most commonly used by our members. However, we also cover additional drugs that aren't included in the Drug Guide. If one of your drugs isn't listed in the Drug Guide, visit our website or call Humana Group Medicare Customer Care (TTY users call 711) to find out if we cover it. To get the most complete and current information about which drugs are covered, visit the **www.Humana.com/SearchResources** or call Humana Group Medicare Customer Care (TTY users call 711).

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

	Your Costs in 2026	
	In-Network	**Out-of-Network**
Deductible	$150.00 except for insulin furnished through an item of durable medical equipment	$150.00 except for insulin furnished through an item of durable medical equipment
Maximum out-of-pocket amount This is the most you'll pay out-of-pocket for covered Part A and Part B services. (Go to Chapter 4 Section 1 for details.)	$3,500.00	**From in-network and out-of-network providers combined:** $3,500.00
Primary care office visits	$20 copayment per visit	$20 copayment per visit
Specialist office visits	$20 copayment per visit	$20 copayment per visit
Inpatient hospital stays	$250 copayment per admission	$250 copayment per admission

	Your Costs in 2026
Part D drug coverage deductible (Go to Chapter 6 Section 4 for details).	$0
Part D drug coverage (Go to Chapter 6 for details, for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	Copayment/Coinsurance during the Initial Coverage Stage: Drug Tier 1: $2 Drug Tier 2: $10 Drug Tier 3: $40 You pay 25% coinsurance with $35 maximum out-of-pocket per prescription per month supply of each covered insulin product on this tier. Drug Tier 4: $75 You pay 25% coinsurance with $35 maximum out-of-pocket per prescription per month supply of each covered insulin product on this tier. Drug Tier 5: $75 You pay 25% coinsurance with $35 maximum out-of-pocket per prescription per month supply of each covered insulin product on this tier. Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs.

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Part D Late Enrollment Penalty (Section 4.3)
- Income Related Monthly Adjusted Amount (Section 4.4)
- Medicare Prescription Payment Plan Amount (Section 4.5)

Section 4.1 Plan premium

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

If you *already* get help from one of these programs, **the information about premiums in this *Evidence of Coverage* may not apply to you** . We have sent you 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, call Humana Group Medicare Customer Care (TTY users call 711) and ask for the LIS Rider.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

You must continue paying your Medicare premiums to remain a member of our plan . This includes your premium for Part B. You may also pay a premium for Part A if you aren't eligible for premium-free Part A.

Section 4.3 Part D Late Enrollment Penalty

Some members are required to pay a Part D **late enrollment penalty.** The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there was a period of 63 days or more in a row when you didn't 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 drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. You'll have to pay this penalty for as long as you have Part D coverage.

When you first enroll in Humana Group Medicare Advantage PPO Plan, we let you know the amount of the penalty. If you don't pay your Part D late enrollment penalty, you could lose your prescription drug benefits.

You don't have to pay the Part D late enrollment penalty if:

- You get Extra Help from Medicare to help pay for your drug costs.
- You went less than 63 days in a row without creditable coverage.
- You had creditable drug coverage through another source (like a former employer, union, TRICARE, or Veterans Health Administration (VA)). Your insurer or human resources department will tell you each year if your drug coverage is creditable coverage. You may get this information in a letter or in a newsletter from our plan. Keep this information, because you may need it if you join a Medicare drug plan later.

    - **Note:** Any letter or notice must state that you had creditable prescription drug coverage that is expected to pay as much as Medicare's standard drug plan pays.
    - **Note:** Prescription drug discount cards, free clinics, and drug discount websites aren't creditable prescription drug coverage.

Medicare determines the amount of the Part D late enrollment penalty. Here is how it works:

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

- Then Medicare determines the amount of the average monthly plan premium for Medicare drug plans in the nation from the previous year (national base beneficiary premium). For 2026, this average premium amount was **$38.99**.

- To calculate your monthly penalty, multiply the penalty percentage by the national base beneficiary premium and round it to the nearest 10 cents. In the example here, it would be 14% times **$38.99**, which equals **$5.46**. This rounds to **$5.50**. This amount would be added **to the monthly plan premium for someone with a Part D late enrollment penalty** .

Three important things to know about this monthly Part D late enrollment penalty:

- **The penalty may change each year** , because the by the national base beneficiary premium can change each year.
- **You'll continue to pay a penalty** every month for as long as you're enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- If you're *under* 65 and enrolled in Medicare, 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 you don't have coverage after your initial enrollment period for aging into Medicare.

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

Important: Don't 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 our premiums.

Section 4.4 Income Related Monthly Adjustment Amount

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

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

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

Section 4.5 Medicare Prescription Payment Plan Amount

If you're participating in the Medicare Prescription Payment Plan, each month you'll pay your plan premium (if you have one) and you'll get a bill from your health or drug plan for your prescription drugs (instead of paying the pharmacy). Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Chapter 2, Section 7 tells more about the Medicare Prescription Payment Plan. If you disagree with the amount billed as part of this payment option, you can follow the steps in Chapter 9 to make a complaint or appeal.

SECTION 5 More information about your monthly plan premium

Section 5.1 How to pay our plan premium.

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

If you think we have wrongfully ended your membership, you can make a complaint (also called a grievance). If you had an emergency circumstance that was out of your control and that made you to not be able to pay your Part D late enrollment penalty, within our grace period, you can make a complaint. For complaints, we'll review our decision again. Go to Chapter 9 to learn how to make a complaint or call Humana Group Medicare Customer Care. (Phone numbers for Humana Group Medicare Customer Care are located in Chapter 2, Section 1 of this booklet.) TTY users call 711. You must make your request no later than 60 calendar days after the date your membership ends.

Section 5.2 Our monthly plan premium won't change during the year

We're not allowed to change our plan's monthly plan premium amount during the year. If the monthly plan premium changes for next year we'll tell you in your *Annual Notice of Change*. However, in some cases, you may be able to stop paying a late enrollment penalty, if you owe one, or you may need to start paying a late enrollment penalty. This could happen if you become eligible for Extra Help or lose your eligibility for Extra Help during the year.

- If you currently pay a Part D late enrollment penalty and become eligible for Extra Help during the year, you'd be able to stop paying your penalty.
- If you lose Extra Help, you may be subject to the Part D late enrollment penalty if you go 63 days or more in a row without Part D or other creditable drug coverage.

Find out more about Extra Help in Chapter 2, Section 7.

SECTION 6 Keep our plan membership record up to date

Your membership record has information from your enrollment form, including your address and phone number. It shows your specific plan coverage including your Primary care Provider.

The doctors, hospitals, pharmacists, and other providers in our plan's network **use your membership record to know what services and drugs are covered and your cost-sharing amounts**. Because of this, it's very important to help us keep your information up to date.

If you have any of these changes, let us know:

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

If any of this information changes, please let us know by calling Humana Group Medicare Customer Care. (Phone numbers for Humana Group Medicare Customer Care are located in Chapter 2, Section 1 of this booklet (TTY users call 711).)

It's also important to contact Social Security if you move or change your mailing address. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

SECTION 7 How other insurance works with our plan

Medicare requires us to collect information about any other medical or drug coverage that you have so we can coordinate any other coverage with your benefits under our plan. This is called **Coordination of Benefits** .

Once a year, we'll send you a letter that lists any other medical or drug coverage we know about. Read this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that's not listed, call Humana Group Medicare Customer Care (TTY users call 711). You may need to give our plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

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

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

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

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

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

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

CHAPTER 2:

Phone numbers and resources

SECTION 1 Humana Group Medicare Advantage PPO Plan contacts

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

Humana Group Medicare Customer Care - Contact Information

Call	Humana Group Medicare Customer Care at (866) 371-2104 . Calls to this number are free. We are available Monday through Friday from 8 am to 9 pm, Eastern time. Our phone system may answer your call after hours, and on Saturdays, Sundays, and some holidays. Humana Group Medicare 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 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 ask for a coverage decision or appeal about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical services or part D drugs. An appeal is a formal way of asking us to review and change a coverage decision. For more information on how to ask for coverage decisions about your medical care or Part D drugs, go to Chapter 9

Coverage Decisions and Appeals for Medical Care or Part D drugs - Contact Information

Call	Humana Group Medicare 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 am to 9 pm, Eastern time. Our phone system may answer your call after hours, and on Saturdays, Sundays, and some holidays. Humana Group Medicare 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 hearing or speaking. Calls to this number are free.
Fax	800-949-2961 for expedited coverage decisions only
Write	Humana P.O. Box 14168 Lexington, KY 40512-4168

Method	Coverage Decisions For Part D Prescription Drugs - Contact Information
Call	Humana Group Medicare 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 am to 9 pm, Eastern time. Our phone system may answer your call after hours, and on Saturdays, Sundays, and some holidays. Humana Group Medicare Customer Care also has free language interpreter services available for non-English speakers.
Fax	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 hearing or speaking. Calls to this number are free.
Write	Humana Clinical Pharmacy Review Attn: Medicare Part D Coverage Determinations P.O. Box 33008 Louisville, KY 40232
Website	**www.Humana.com/member/member-rights/pharmacy-authorizations**

Method	**Appeals For Medical Care or Part D prescription drugs - Contact Information**
Call	Humana Group Medicare 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 am to 9 pm, 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. Humana Group Medicare 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 hearing or speaking. Calls to this number are free.
Fax	800-949-2961 for expedited appeals only.
Write	Humana Grievance and Appeal Dept. P.O. Box 14165 Lexington, KY 40512-4165

How to make a complaint about your medical care

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint doesn't 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 how to make a complaint about your medical care, see Chapter 9.

Complaints about Medicare Care - Contact Information

Call	Humana Group Medicare 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 am to 9 pm, 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. Humana Group Medicare 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 hearing or speaking. Calls to this number are free.
Fax	800-949-2961 for expedited grievances only
Write	Humana Grievance and Appeal Dept. P.O. Box 14165 Lexington, KY 40512-4165
Medicare Website	To submit a complaint about your Humana Group Medicare Advantage PPO Plan to Medicare, go to **www.Medicare.gov/my/medicare-complaint**

How to ask us to pay our share of the cost for medical care or a drug you have

If you got a bill or paid for services (like a provider bill) that you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. Go to Chapter 7 for more information.

If you send us a payment request and we deny any part of your request, you can appeal our decision. Go to Chapter 9 for more information.

Payment Requests - Contact Information

Call	Humana Group Medicare 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 am to 9 pm, Eastern time. Our phone system may answer your call after hours, and on Saturdays, Sundays, and some holidays. Humana Group Medicare 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 hearing or speaking. Calls to this number are free.
Write	Humana P.O. Box 14168 Lexington, KY 40512-4168

SECTION 2 Get help from Medicare

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 (CMS). This agency contracts with Medicare Advantage organizations including our plan.

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 hearing or speaking. Calls to this number are free.
Chat Live	Chat live at **www.Medicare.gov/talk-to-someone**
Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044

Website	**www.Medicare.gov** • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. • Find Medicare-participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly "Wellness" visits). • Get Medicare appeals information and forms. • Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. • Look up helpful websites and phone numbers. You can also visit **Medicare.gov** to tell Medicare about any complaints you have about our plan. **To submit a complaint to Medicare** , go to **www.Medicare.gov/my/medicare-complaint** . Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

SECTION 3 State Health Insurance Assistance Program

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. Contact information for your State Health Insurance Assistance Program (SHIP) can be found in "Exhibit A" in the back of this document.

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

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

SECTION 4 Quality Improvement Organization (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare in each state.

The Quality Improvement Organization (QIO) is a group of doctors and other health care professionals 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.

Contact your Quality Improvement Organization (QIO) in any of these situations:

- You have a complaint about the quality of care you have got. Examples of quality-of-care concerns include getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis.
- 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 is 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 determines Medicare eligibility and handles Medicare enrollment. 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, contact Social Security to let them know.

Social Security - Contact Information

Call	1-800-772-1213 Calls to this number are free. Available 8 am to 7 pm, Monday through Friday. Use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	800-325-0778 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. Available 8 am to 7 pm, Monday through Friday.
Website	**www.SSA.gov**

SECTION 6 Medicaid

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

Medicaid offers programs to help people with Medicare pay their Medicare costs, such as their Medicare premiums. These Medicare Savings Programs include:

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

To find out more about Medicaid and Medicare Savings 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 Programs to help people pay for prescription drugs

The Medicare website **(www.Medicare.gov/basics/costs/help/drug-costs)** has information on ways to lower your prescription drug costs. The programs below can help people with limited incomes.

Extra Help from Medicare

Medicare Extra Help and Social Security have a program called that can to pay drug costs for people with limited income and resources. If you qualify, you can get help paying for your Medicare drug plan's monthly plan premium, yearly deductible, and copayments or coinsurance. Extra Help also counts toward your out-of-pocket costs.

If you automatically qualify for Extra help Medicare will mail you a purple letter to let you know. If you don't automatically qualify , you can apply anytime. To see if you qualify for getting Extra Help:

- Visit **https://secure.ssa.gov/i1020start** to apply online
- Call Social Security at 1-800-772-1213, TTY users call 1-800-325-0778.

When you apply for Extra Help, you can also start the application process for a Medicare Savings Program (MSP). These state programs provide help with other Medicare costs. Social Security will send information to your state to initiate an MSP application, unless you tell them not to on the Extra Help application.

If you qualify for Extra Help and you think that you're paying an incorrect amount for your prescription at a pharmacy, our plan has a process to help you get evidence of the right copayment amount. If you already have evidence of the right amount, we can help you share this evidence with 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 get the evidence showing the right copayment level, we'll update our system so you can pay the right amount when you get your next prescription. If you overpay your copayment, we'll pay you back, either by check or a future copayment credit. If the pharmacy didn't collect your copayment and you owe them a debt, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make the payment directly to the state. Call Humana Group Medicare Customer Care if you have questions.

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

Many states offer help paying for prescriptions, drug plan premiums and/or other drug costs. If enrolled in a State Pharmaceutical Assistance Program (SPAP), Medicare Extra Help pays first. The services of SHIP counselors are free. You'll find phone numbers and website URLs in Exhibit A in the back of this document. Contact information can be found in “Exhibit A” in the back of this document.

What if you have Extra Help and coverage from an AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps people living with HIV/AIDS access to life-saving HIV medications. Medicare Part D drugs that are also on the ADAP formulary qualify for prescription cost-sharing help through the ADAP operating in your state.

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

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

State Pharmaceutical Assistance Programs

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

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

Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across **the calendar year** (January - December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs. If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026.** To learn more about this payment option, call Humana Group Medicare Customer Care or visit www.Medicare.gov.

Medicare Prescription Payment Plan - Contact Information

CALL	Humana Group Medicare 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 am to 9 pm, Eastern time. Our phone system may answer your call after hours, and on Saturdays, Sundays, and some holidays. Humana Group Medicare 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 hearing or speaking. Calls to this number are free. Hours of operation are the same as above.
Write	Humana P.O. Box 14168 Lexington, KY 40512-4168
Website	To learn more about this payment option, please visit **Humana.com/RxCostHel**p

SECTION 8 Railroad Retirement Board (RRB)

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 get Medicare through the Railroad Retirement Board, let them know if you move or change your mailing address. For questions about your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board (RRB) - Contact Information

Call	1-877-772-5772 Calls to this number are free. Press "0" to speak with an RRB representative from 9 am to 3:30 pm Monday, Tuesday, Thursday, and Friday, and from 9 am to 12 pm on Wednesday. Press "1" to access the automated RRB HelpLine and get 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 hearing or speaking. Calls to this number are *not* free.
Website	**https://RRB.gov/**

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

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner's) employer or retiree group as a part of this plan, call the employer/union benefits administrator or Humana Group Medicare Customer Care with any questions. You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. You can call 1-800-MEDICARE (1-800-633-4227 TTY users call 1-877-486-2048). With questions about your Medicare coverage under this plan.

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

CHAPTER 3:

Using our plan for your medical services

SECTION 1 How to get medical care as a member of our plan

This chapter explains what you need to know about using our plan to get your medical care covered.

For details on what medical care by our plan covers and how much you pay when you get care, go to the Medical Benefits Chart in Chapter 4.

Section 1.1 Network providers and covered services

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

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

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

Section 1.2 Basic rules for your medical care to be covered by our plan

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

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

- **The care you get is included in plan's Medical Benefits Chart** in Chapter 4.

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

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

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

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

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

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

We list the providers that participate with our plan in our *Provider Directory* **Humana.com/SearchResources.**

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

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

When a specialist or another network provider leaves our plan

We may make changes to the hospitals, doctors and specialists (providers) in our plan's network during the year. If your doctor or specialist leaves our plan, you have these rights and protections:

- Even though our network of providers may change during the year, Medicare requires that you have uninterrupted access to qualified doctors and specialists.
- We'll notify you that your provider is leaving our plan so that you have time to choose a new provider.
    - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited them within the past 3 years.
    - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past 3 months.
- We'll help you choose a new qualified in-network provider for continued care.
- If you're undergoing medical treatment you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.

- We'll give you information about available enrollment periods and options you may have for changing plans.
- When an in-network provider is unavailable or inadequate to meet your medical needs, we'll arrange for any medically necessary covered benefit outside of our provider network at in-network cost sharing. Prior authorization is required for service to be covered.
- If you find ou t your doctor or specialist is leaving our plan, contact us so we can help you choose a new provider to manage your care.
- If you believe we haven't furnished you with a qualified provider to replace your previous provider or that your care isn't being appropriately managed, you have the right to file a quality of care complaint to the QIO, a quality of care grievance to our plan, or both (go to Chapter 9).

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

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

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

- You can get your care from an out-of-network provider; however, in most cases that provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you receive care from a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.
- You don't need to get a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers you may want to ask for a pre-visit coverage decision to confirm that the services you are getting are covered and are medically necessary. (See Chapter 9, Section 4 for information about asking for coverage decisions.) This is important because:

- Without a pre-visit coverage decision, if we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. See Chapter 9 *(If you have a problem or complaint (coverage decisions, appeals, complaints))* to learn how to make an appeal.

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

SECTION 3 How to get services in an emergency, disaster, or urgent need for care

Section 3.1 Get care if you have a medical emergency

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

If you have a medical emergency:

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

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

Covered services in a medical emergency

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

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

After the emergency is over, you're entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us and make plans for additional care. Your follow-up care will be covered by our plan.

What if it wasn't a medical emergency?

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

However, after the doctor says that it wasn't an emergency, the amount of cost-sharing that you pay will depend on whether you get the care from network providers or out-of-network providers.

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

A service that requires immediate medical attention (but isn't an emergency) is an urgently needed service if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits such as annual checkups, aren't considered urgently needed even if you're outside the service area or our plan network is temporarily unavailable.

Our plan covers urgently needed services if you receive the care outside of the United States. See Chapter 4 *(Medical Benefits Chart (what's covered and what you pay))* for more information. If you have already paid for the covered services, we will reimburse you for our share of the cost for covered services. You can send the bill to us for payment. See Chapter 7 *(Asking us to pay our share of a bill for covered medical services or drugs)* for information about what to do if you receive a bill or if you need to ask for reimbursement.
Transportation back to the United States from another country is NOT covered. Pre-scheduled, pre-planned treatments (including treatment for an ongoing condition) and/or elective procedures are NOT covered.

Section 3.3 Get care during a disaster

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

Visit **www.Humana.com/alert** for information on how to get needed care during a disaster.

If you can't use a network provider during a disaster, our plan will allow you to get care from out-of-network providers at in-network cost-sharing. If you cannot use a network pharmacy during a disaster, you may be able to fill your prescription at an out-of-network pharmacy. Go to Chapter 5, Section 2.5.

SECTION 4 What if you're billed directly for the full cost of covered services

If you paid more than our plan cost-sharing for covered services, or if you get a bill for the full cost of covered medical services, you can ask us to pay our share of the cost of covered services. Go to Chapter 7 for information about what to do.

Section 4.1 If services are not covered by our plan, you must pay the full cost

Humana Group Medicare Advantage PPO Plan covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4. If you get services that aren't covered by our plan, you're responsible for paying the full cost of services.

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

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

SECTION 5 Medical services covered in a clinical research study

Section 5.1 What is a clinical research study

A clinical research study (also called a clinical trial) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically ask for volunteers to participate in the study. When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that's not related to the study) through our plan.

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

If you want to participate in any Medicare-approved clinical research study, you don't need to tell us or get approval from us. The providers that deliver your care as part of the clinical research study don't need to be part of our plan's network (This doesn't apply to covered benefits that require a clinical trial or registry to assess the benefit, including certain benefits requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies. These benefits may also be subject to prior authorization and other plan rules).

While you don't need our plan's permission to be in a clinical research study we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

If you participate in a study not approved by Medicare or our plan, you'll *be responsible for paying all costs for your participation in the study.*

Section 5.2 Who pays for services in a clinical research study

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

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

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

Example of cost sharing in a clinical trial: Let's say you have a lab test that costs **$100** as part of the research study. Your share of the costs for this test is **$20** under Original Medicare, but the test would be **$10** under our plan. In this case, Original Medicare would pay **$80** for the test and you would pay the **$20** copay required under Original Medicare. You would notify our plan that you got a qualified clinical trial service and submit documentation, (like a provider bill) to our plan. Our plan would then directly pay you **$10.** This makes your net payment for the tests **$10,** the same amount you'd pay under our plan's benefits.

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

- Generally, Medicare won't pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were *not* in a study.

- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare won't pay for monthly CT scans done as part of a study if your medical condition would normally require only one CT scan.

- Items and services provided by the research sponsors free of charge for people in the trial.

Get more information about joining a clinical research study

Get more information about joining a clinical research study in the Medicare publication Medicare and Clinical Research Studies available at: **www.Medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf** . You can also call 1-800-MEDICARE (1-800-633-4227), TTY users call 1-877-486-2048.

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

Section 6.1 A religious non-medical health care institution

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

Section 6.2 How to get care from a religious non-medical health care institution

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

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

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

- The facility providing the care must be certified by Medicare.
- Our plan only covers *non-religious* aspects of care.
- If you get services from this institution provided to you in a facility, the following condition applies:
  - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
  - - and - you must get approval in advance from our plan before you're admitted to the facility or your stay won't be covered.

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

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 You won't own some durable medical equipment after making a certain number of payments under our plan

Durable medical equipment (DME) includes items like wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns some DME items, like prosthetics. Other types of DME you must rent.

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

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

If you didn't get ownership of the DME item while in our plan, you'll have to make 13 new consecutive payments after you switch to Original Medicare to own the DME item. The payments you made while enrolled in our plan don't count towards these 13 payments.

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

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You didn't get ownership of the item while in our plan. You then go back to Original Medicare. You'll have to make 13 consecutive new payments to own the item once you rejoin Original Medicare. Any payments you already made (whether to our plan or to Original Medicare) don't count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

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

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

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

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

Original Medicare requires an oxygen supplier to provide you services for five years. During the first 36 months you rent the equipment. For the remaining 24 months, the supplier provides the equipment and maintenance (you're still responsible for the copayment for oxygen). After 5 years you can choose to stay with the same company or go to another company. At this point, the 5-year cycle starts over again, even if you stay with the same company, and you're again required to pay copayments for the first 36 months. If you join or leave our plan, the 5-year cycle starts over.

CHAPTER 4:

Medical Benefits Chart (what's covered and what you pay)

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

The Medical Benefits Chart lists your covered services and shows how much you pay for each covered service as a member of Humana Group Medicare Advantage PPO Plan. This section also gives information about medical services that aren't covered. Also, see exclusions and limitations pertaining to certain supplemental benefits in the Medical Benefits Chart in this chapter.

Section 1.1 Out-of-pocket costs you may pay for covered services

Types of out-of-pocket costs you may pay for covered services include:

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

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program don't pay deductibles, copayments or coinsurance. If you're in one of these programs, be sure to show your proof of Medicaid or QMB eligibility to your provider.

Section 1.2 Our plan deductible

Your combined deductible is $150.00. Until you've paid the combined deductible amount, you must pay the full cost for most of your covered services. After you pay your combined deductible, we'll start to pay our share of the costs for covered medical services and you'll pay your share (your copayment or coinsurance amount) for the rest of the calendar year.

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

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

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

Section 1.3 What's the most you'll pay for Medicare Part A and Part B covered medical services?

Under our plan, there are 2 different limits on what you pay out-of-pocket for covered medical services:

- Your **in-network maximum out-of-pocket amount** is $3,500.00. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from network providers. The amounts you pay for deductibles, copayments, and coinsurance for covered services from network providers count toward this in-network maximum out-of-pocket amount. (The amounts you pay for plan premiums and Part D drugs and services from out-of-network providers don't count toward your in-network maximum out-of-pocket amount.) In addition, amounts you pay for some services don't count toward your in-network maximum out-of-pocket amount. (See the Medical Benefits Chart in Section 2, below) If you pay $3,500.00 for covered Part A and Part B services from network providers, you won't have any out-of-pocket costs for the rest of the year when you see our network providers. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

- Your **combined maximum out-of-pocket amount** is $3,500.00. This is the most you pay during the calendar year for covered Medicare Part A and Part B services you get from both in-network and out-of-network providers. The amounts you pay for deductibles, copayments, and coinsurance for covered services count toward this combined maximum out-of-pocket amount. (The amounts you pay for our plan premiums and for your Part D drugs don't count toward your combined maximum out-of-pocket amount.) In addition, amounts you pay for some services don't count toward your combined maximum out-of-pocket amount. (See the Medical Benefits Chart in Section 2, below.) If you pay $3,500.00 for covered services, you'll have 100% coverage and won't have any out-of-pocket costs for the rest of the plan year for covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.4 Providers aren't allowed to balance bill you

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

Here's how protection from balance billing works:

- If your cost-sharing is a copayment (a set amount of dollars, for example, $15.00), you pay only that amount for any covered services from a network provider. You'll generally have higher copayments when you get care from out-of-network providers.
- If your cost-sharing is a coinsurance (a percentage of the total charges), you never pay more than that percentage. However, your cost depends on which type of provider you see:
  - If you get covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (this is set in the contract between the provider and our plan).
  - If you get covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
  - If you get covered services from an out-of-network provider who doesn't participate with Medicare, then you pay the coinsurance amount multiplied by the Medicare payment rate for non-participating providers.
- If you think a provider has balanced billed you, call Humana Group Medicare Customer Care.

SECTION 2 The Medical Benefits Chart shows your medical benefits and costs

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

- Your Medicare-covered services must be provided according to Medicare coverage guidelines.
- Your services (including medical care, services, supplies, equipment, and Part B drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan can't require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- Some services listed in the Medical Benefits Chart are covered as in-network services *only* if your doctor or other network provider gets approval from us in advance (sometimes called prior authorization) from Humana Group Medicare Advantage PPO Plan.
    - Covered services that need approval in advance to be covered as in-network services are marked in the bulleted section of the Medical Benefits Chart. In addition, the following services not listed in the Benefits Chart require approval in advance:
        - The preauthorization list can be found here: **Humana.com/PAL**
    - You never need approval in advance for out-of-network services from out-of-network providers.
    - While you may not need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.
- If your coordinated care plan provides approval of a prior authorization request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, your medical history, and the treating provider's recommendation.

Other important things to know about our coverage:

- For benefits where your cost-sharing is a coinsurance percentage, the amount you pay depends on what type of provider you get the services from:
  - If you get the covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (as determined in the contract between the provider and our plan).
  - If you get the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
  - If you get the covered services from an out-of-network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You 2026* handbook. View it online at **www.Medicare.gov** or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), TTY users call 1-877-486-2048).
- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you. However, if you're also treated or monitored for an existing medical condition during the visit when you get the preventive service, a copayment will apply for the care you got for the existing medical condition.
- If Medicare adds coverage for any services during 2026, either Medicare or our plan will cover those services.

If you are diagnosed with any of the chronic condition(s) identified below, you are eligible for the Uniform Flexibility Non-Emergency Medical Transportation benefit.

- Cancer
- Chronic Kidney Disease (CKD)
- End Stage Renal Disease (ESRD)

Please go to the Uniform Flexibility Non-Emergency Medical Transportation row in the below Medical Benefits Chart for further detail.

This apple shows preventive services in the benefits chart.

Medical Benefits Chart

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

Covered Service	What you pay
Acupuncture (Medicare-covered) for chronic low back pain Covered services include: Up to 20 combined In & Out of Network visits per year are covered under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • Nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, disease etc); • Not associated with surgery; and • Not associated with pregnancy. Your plan allows services to be received by a provider licensed to perform acupuncture or by providers meeting the Original Medicare provider requirements. Our plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL**.	In Network $20 copayment for each specialist's office visit Out of Network $20 copayment for each specialist's office visit

Covered Service	What you pay
Advanced imaging Covered services include, but are not limited to: • CT scans • MRI • MRA • Our plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL**.	In Network $20 copayment for each primary care physician's office visit $20 copayment for each specialist's office visit $20 copayment for each freestanding radiological facility visit $20 copayment for each outpatient hospital visit Out of Network $20 copayment for each primary care physician's office visit $20 copayment for each specialist's office visit $20 copayment for each freestanding radiological facility visit $20 copayment for each outpatient hospital visit

Covered Service	What you pay
Allergy shots and serum	
Administration and serum related to medically necessary allergy shots.	In Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit Out of Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit

Covered Service	What you pay
Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. Our plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL.**	Emergency In Network $20 copayment per date of service regardless of the number of trips. Limited to Medicare-covered transportation Benefit does not apply to your combined deductible Emergency Out of Network $20 copayment per date of service regardless of the number of trips. Limited to Medicare-covered transportation Benefit does not apply to your combined deductible Non-Emergency In Network $20 copayment per date of service regardless of the number of trips. Limited to Medicare-covered transportation Benefit does not apply to your combined deductible Non-Emergency Out of Network $20 copayment per date of service regardless of the number of trips. Limited to Medicare-covered transportation Benefit does not apply to your combined deductible

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

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

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

Covered Service	What you pay
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs. Our plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL**.	In Network $20 copayment for each specialist's office visit $20 copayment for each outpatient hospital visit Out of Network $20 copayment for each specialist's office visit $20 copayment for each outpatient hospital visit
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	In Network $0 copayment for each primary care physician's office visit Benefit does not apply to your combined deductible Out of Network $0 copayment for each primary care physician's office visit Benefit does not apply to your combined deductible

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

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

Covered Service	What you pay
Chemotherapy drugs	
Medically-necessary chemotherapy services and treatments. Our plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL**.	In Network $0 copayment for each specialist's office visit $0 copayment for each outpatient hospital visit Benefit does not apply to your combined deductible Out of Network $0 copayment for each specialist's office visit $0 copayment for each outpatient hospital visit Benefit does not apply to your combined deductible
Chiropractic services (Medicare-covered)	
Covered services include: • We cover only manual manipulation of the spine to correct subluxation (one or more of the bones of your spine move out of position) Our plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL.**	In Network $15 copayment for each specialist's office visit Out of Network $15 copayment for each specialist's office visit

Covered Service	What you pay
Chronic pain management and treatment services	
Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than 3 months). Services may include pain assessment, medication management, and care coordination and planning.	Cost sharing for this service will vary depending on individual services provided under the course of treatment. <u>In Network</u> $20 copayment for each primary care physician's office visit $20 copayment for each specialist's office visit <u>Out of Network</u> $20 copayment for each primary care physician's office visit $20 copayment for each specialist's office visit

Covered Service	What you pay
Colorectal cancer screening	
The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 45 year and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient got a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or computed tomography colonography . • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.	In Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit $0 copayment for each ambulatory surgical center visit $0 copayment for each outpatient hospital visit Benefit does not apply to your combined deductible Out of Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit $0 copayment for each ambulatory surgical center visit $0 copayment for each outpatient hospital visit Benefit does not apply to your combined deductible

Covered Service	What you pay
Colorectal cancer screening (continued) • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.	

Covered Service	What you pay
Dental services (Medicare-covered)	
In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. In addition, we cover: • Surgery of the jaw or related structures • Setting fractures of the jaw or facial bones • Extraction of teeth to prepare the jaw for radiation treatments or neoplastic disease • Services that would be covered when provided by a doctor Our plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL**.	In Network $20 copayment for each specialist's office visit Out of Network $20 copayment for each specialist's office visit

Covered Service	What you pay
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	In Network $0 copayment for each primary care physician's office visit Benefit does not apply to your combined deductible Out of Network $0 copayment for each primary care physician's office visit Benefit does not apply to your combined deductible

Covered Service	What you pay
Diabetes screening	
We cover this screening (includes fasting glucose tests) if you have any of these risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. You may be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test.	In Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit Benefit does not apply to your combined deductible Out of Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit Benefit does not apply to your combined deductible

Covered Service	What you pay

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

Covered Service	What you pay
Diabetes self-monitoring supplies (continued) • For Continuous Glucose Monitors, see Durable medical equipment (DME) and related supplies. • For people with diabetes who have severe diabetic foot disease: one pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts, or one pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. Our plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL**.	

Covered Service	What you pay
Diabetes self-management training	
For all people who have diabetes (insulin and non-insulin users) covered services include: • Diabetes self-management training is covered under certain conditions Our plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL**.	In Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit $0 copayment for each outpatient hospital visit Benefit does not apply to your combined deductible Out of Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit $0 copayment for each outpatient hospital visit Benefit does not apply to your combined deductible

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

Covered Service	What you pay
Diagnostic Colonoscopy	
Colonoscopy services performed due to past or present history (such as gastrointestinal symptoms or disease, polyps, or cancer) or physical symptoms such as rectal bleeding or pain. Our plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL**.	In Network $20 copayment for each specialist's office visit $0 copayment for each ambulatory surgical center visit $0 copayment for each outpatient hospital visit Out of Network $20 copayment for each specialist's office visit $0 copayment for each ambulatory surgical center visit $0 copayment for each outpatient hospital visit

Covered Service	What you pay
Durable medical equipment (DME) and related supplies (For a definition of durable medical equipment, see Chapter 12 as well as Chapter 3, Section 7 of this document.) Covered items include, but aren't limited to wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, walkers, CPAP and Continuous Glucose Monitors*.	In Network 20% coinsurance at a durable medical equipment provider 20% coinsurance at a pharmacy Durable medical equipment received from a pharmacy do not apply to your combined deductible Continuous Glucose Monitors 20% coinsurance from a durable medical equipment provider 20% coinsurance at a pharmacy Continuous glucose monitors received from a pharmacy do not apply to your combined deductible

Covered Service	What you pay
Durable medical equipment (DME) and related supplies (continued)	
We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at **www.Humana.com/SearchResources** Our plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL**. *Preferred Continuous Glucose Monitors (CGMs) are covered at pharmacies. Preferred CGMs are Dexcom & Freestyle Libre. Non-preferred CGMs are not covered through a pharmacy unless your doctor provides adequate information that the use of an alternate brand is medically necessary. All CGMs will continue to be available through durable medical equipment providers (DME).	Cost sharing for covered Part B Insulin furnished through a covered item of durable medical equipment will be no more than $35 for a one-month (up to 30-day) supply and if your plan has a deductible, it does not apply to Part B Insulin. Plan requires prior authorization for durable medical equipment and related supplies. Call 1-800-523-0023, (TTY # 711) Out of Network 20% coinsurance at a durable medical equipment provider 20% coinsurance at a pharmacy Durable medical equipment received from a pharmacy do not apply to your combined deductible Continuous Glucose Monitors 20% coinsurance from a durable medical equipment provider 20% coinsurance at a pharmacy Continuous glucose monitors received from a pharmacy do not apply to your combined deductible

Covered Service	What you pay
Durable medical equipment (DME) and related supplies (continued)	
	Cost sharing for covered Part B Insulin furnished through a covered item of durable medical equipment will be no more than $35 for a one-month (up to 30-day) supply and if your plan has a deductible, it does not apply to Part B Insulin. Plan requires prior authorization for durable medical equipment and related supplies. Call 1-800-523-0023, (TTY # 711)

Covered Service	What you pay
Emergency care	
Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's is quickly getting worse. Cost-sharing for necessary emergency services you get out-of-network is the same as when you get these services in-network. You are covered for emergency care worldwide. If you have an emergency outside of the U.S. and its territories, you will be responsible to pay for the services rendered upfront. You must submit to Humana for reimbursement; for more information please see Chapter 7. We may not reimburse you for all out-of-pocket expenses. This is because our contracted rates may be lower than provider rates outside of the U.S. and its territories. You are responsible for any costs exceeding our contracted rates as well as any applicable member cost-share.	<u>In Network</u> $80 copayment for emergency services in an emergency room Benefit does not apply to your combined deductible <u>Out of Network</u> $80 copayment for emergency services in an emergency room Benefit does not apply to your combined deductible Worldwide Coverage: $80 copayment for emergency services, and $20 copayment for urgent care services outside of the U.S. and its territories. Benefit does not apply to your combined deductible or combined maximum out-of-pocket You do not pay the emergency room visit cost share if you are admitted to the same hospital within 24 hours for the same condition, even if you are at a hospital outside of the United States

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

Covered Service	What you pay
Health and wellness education programs **Additional Telehealth Services** Use a phone, computer, tablet or other video technology for diagnosis and treatment of certain non-emergency medical care when your regular healthcare provider is not available. While this benefit is not intended to replace your regular healthcare provider, a virtual visit can sometimes be another option when your regular healthcare provider's office is not available or open. You are not required to use this benefit, and you can contact your regular healthcare provider's office to request an appointment. When you have an emergency, such as a life-threatening injury, illness or major trauma, call 911 or go to your nearest emergency room. Humana is not responsible for the availability or ongoing participation of any provider. Provider availability may change. Always make sure your provider is in the network before you receive care. If you want the name of the provider or need a provider directory you may access **www.Humana.com/SearchResources** or call Humana Group Medicare Customer Care. Covered services include but are not limited to: • Primary care physician services • Specialist services • Behavioral health and substance abuse services • Urgently needed care You have the option of getting these services either through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service via telehealth.	$0 copayment for each primary care physician - virtual visit $20 copayment for each specialist - virtual visit $0 copayment for each behavioral health and substance abuse - virtual visit $0 copayment for each urgent care - virtual visit Benefit does not apply to your combined deductible

Covered Service	What you pay
Health Education	
Work toward wellness with Wellness Coaching • Get support and guidance, develop a personalized action plan, and experience ongoing (year-round) one-on-one interactions with a professional coach to reinforce healthy changes and set goals for a healthier lifestyle • Stop smoking with help from a wellness coach. The Wellness Coaching comprehensive tobacco and vaping cessation program provides ongoing one-on-one coaching to assist in smoking cessation.	In Network $0 copayment Benefit does not apply to your combined deductible or combined maximum out-of-pocket Wellness Coaching is available in all states.
Contact Wellness Coaching at 1-877-567-6450 (TTY: 711) Monday - Friday, 8 a.m. - 6 p.m., Eastern time for further details or to take advantage of this benefit.	Out of Network The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.
Smoking Cessation Program	
For eligible members, services include a 3 month's supply of nicotine replacement therapy products in coordination with Wellness Coaching. Contact Wellness Coaching at 1-877-567-6450 (TTY: 711) Monday-Friday, 8 a.m. - 6 p.m., Eastern time for further details or to take advantage of this benefit.	In Network $0 copayment Benefit does not apply to your combined deductible or combined maximum out-of-pocket Available in all states.
	Out of Network The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.

Covered Service	What you pay
Post-Discharge Personal Home Care	
With the Personal Home Care (PHC) benefit you will be eligible to receive services for a minimum of 4 hours per day up to a maximum of 8 hours per discharge from an inpatient hospitalization or skilled nursing facility stay. PHC includes certain in-home support services to assist individuals with disabilities and/or medical conditions in performing activities of daily living (ADLs). Personal home care services must be initiated within 30 days of discharge event and utilized within 60 days of discharge. Examples of ADLs: Assistance with: • Bathing, Dressing, or Grooming • Toileting • Eating or Drinking • Changing Positions • Walking Independently Prior authorization rules may apply. Call Humana Customer Care for further details or to take advantage of this benefit after your discharge.	In Network $0 copayment Benefit does not apply to your combined deductible or combined maximum out-of-pocket Personal Home Care is not available in Puerto Rico or U.S. territories. Out of Network The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.

Covered Service	What you pay
Post-Discharge Transportation You are covered for 12 one-way trip(s) to plan-approved locations per inpatient facility discharge by rideshare services, car, van, or wheelchair access vehicle. There is a maximum allowed travel distance of 50 miles per trip. Benefit must be utilized within 60 days of inpatient discharge event. Benefit is subject to transportation provider availability within the plan service area. Please contact Humana Customer Care for information on how to arrange transportation. Humana Customer Care will confirm your benefits and guide you to the transportation provider to plan your trip.	In Network $0 copayment Benefit does not apply to your combined deductible or combined maximum out-of-pocket Post-Discharge Transportation is available in all states. Out of Network The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.
SilverSneakers® Fitness SilverSneakers® is a fitness program for seniors that is included at no additional charge with qualifying Medicare health plans. Members have access to thousands of fitness locations across the country that may include weights and machines plus group exercise classes led by trained instructors at select locations. Access online education on SilverSneakers.com, watch workout videos on SilverSneakers On-Demand ™ or download the SilverSneakers GO ™ fitness app, for additional workout ideas. Any fitness center services that usually have an extra fee are not included in your membership.	In Network $0 copayment Benefit does not apply to your combined deductible or combined maximum out-of-pocket SilverSneakers® Fitness is available in all states. Out of Network The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.

Covered Service	What you pay
Post-Discharge Well Dine™ Meal Program After your inpatient stay in either the hospital or a nursing facility, you are eligible to receive 2 meals per day for 14 days, at no cost to you. 28 nutritious meals will be delivered to your home. These meals can be ordered by your care manager or may be ordered directly from the meal order vendor. The request must be completed within 30 days of your inpatient stay. Call Humana Customer Care for further details or to take advantage of this benefit after your discharge.	In Network $0 copayment Benefit does not apply to your combined deductible or combined maximum out-of-pocket Well Dine™ Meal Program is available in all states. Out of Network The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.
Hearing services (Medicare-covered) Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when you get them from by a physician, audiologist, or other qualified provider. Our plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL.**	In Network $20 copayment for each specialist's office visit Out of Network $20 copayment for each specialist's office visit

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

Covered Service	What you pay
Hearing services (Routine) (continued) Costs associated with excluded items are the responsibility of the member and not covered by the plan. Provider availability may change. Always make sure your provider is in the TruHearing network before you receive care by scheduling appointments through TruHearing.	
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months If you are pregnant, we cover: • Up to 3 screening exams during a pregnancy	In Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit Benefit does not apply to your combined deductible Out of Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit Benefit does not apply to your combined deductible

Covered Service	What you pay
Home health agency care Before you get home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week.) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies Our plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL**.	In Network $0 copayment for each home health visit Plan requires prior authorization for home health services. Call 1-800-523-0023, (TTY# 711) Out of Network $0 copayment for each home health visit Plan requires prior authorization for home health services. Call 1-800-523-0023, (TTY# 711)

Covered Service	What you pay
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but aren't limited to: • Professional services, including nursing services, furnished in accordance with our plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier Our plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL**.	In Network – Medical Supplies 20% coinsurance at a medical supply provider 20% coinsurance at a pharmacy Medical supplies received from a pharmacy do not apply to your combined deductible In Network - Medicare Part B Covered Drugs $0 copayment for Medicare Part B drugs at a pharmacy $0 copayment for administration of drugs at a primary care physician's office $0 copayment for administration of drugs at a specialist's office Medicare Part B covered drugs received from a pharmacy do not apply to your combined deductible In Network - Physician/Practitioner services, including doctor's office visits $20 copayment for each primary care physician's office visit

Covered Service	What you pay
Home infusion therapy (continued)	Out of Network – Medical Supplies 20% coinsurance at a medical supply provider 20% coinsurance at a pharmacy Medical supplies received from a pharmacy do not apply to your combined deductible Out of Network – Medicare Part B Covered Drugs $0 copayment for Medicare Part B drugs at a pharmacy $0 copayment for administration of drugs at a primary care physician's office $0 copayment for administration of drugs at a specialist's office Medicare Part B covered drugs received from a pharmacy do not apply to your combined deductible Out of Network – Physician/Practitioner services, including doctor's office visits $20 copayment for each primary care physician's office visit

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

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

Covered Service	What you pay
Immunizations	
Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you're at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you're at risk and meet Medicare Part B coverage rules	In Network $0 copayment for all places of treatment Benefit does not apply to your combined deductible Out of Network $0 copayment for all places of treatment
We also cover some vaccines under our Part D prescription drug benefit. Go to Chapter 6, Section 7 for more information.	Benefit does not apply to your combined deductible

Covered Service	What you pay
Inpatient hospital care	
Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. You are covered for unlimited number of days for medically necessary services. Covered services include, but aren't limited to: • Semi-private room (or a private room if medically necessary) • Meals, including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational and speech language therapy • Inpatient substance abuse services	Your inpatient benefits will begin on day one each time you are admitted or transferred to a specific facility type, including Inpatient Rehabilitation facilities, Long Term Acute Care (LTAC) facilities, Inpatient Acute Care facilities, and Inpatient Psychiatric facilities. <u>In Network</u> $250 copayment per admission $0 copayment for physician services while inpatient at a hospital Plan requires prior authorization for inpatient services. Call 1-800-523-0023, (TTY# 711)

Covered Service	What you pay
Inpatient hospital care (continued)	
• Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If Humana Group Medicare Advantage PPO Plan provides transplant services at a location outside the pattern of care for transplants in your community and you choose to get transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion. If you are sent outside of your community for a transplant, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. Travel and lodging reimbursement requires a minimum of 100 miles one way to transplant center and is limited to **$10,000** per transplant. ○ All transplant services must receive prior authorization. Call 1-866-421-5663 (TTY# 711) Monday-Friday 8:30 am-5 pm EST. Additional details on transplant travel and lodging can be found at **https://provider.humana.com/patient-care/transplant-resources/transplant-services-questions.** • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need.	Out of Network $250 copayment per admission $0 copayment for physician services while inpatient at a hospital Plan requires prior authorization for inpatient services. Call 1-800-523-0023, (TTY# 711)

Covered Service	What you pay
Inpatient hospital care (continued) • Physician services • Prior authorization is required for inpatient hospital care **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you're not sure if you're an inpatient or an outpatient, ask the hospital staff. Get more information in the Medicare fact sheet called *Medicare Hospital Benefits*. This fact sheet is available on the Web at **www.Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf** or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	

Covered Service	What you pay
Inpatient services in a psychiatric hospital	
• Covered services include mental health care services that require a hospital stay. • 190-day lifetime limit for inpatient services in a psychiatric hospital. ○ The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital. • The benefit days used under the Original Medicare program will count toward the 190-day lifetime reserve days when enrolling in a Medicare Advantage plan. Prior authorization is required for inpatient mental health care.	Your inpatient benefits will begin on day one each time you are admitted or transferred to a specific facility type, including Inpatient Rehabilitation facilities, Long Term Acute Care (LTAC) facilities, Inpatient Acute Care facilities, and Inpatient Psychiatric facilities. <u>In Network</u> $250 copayment per admission in an inpatient hospital $250 copayment per admission in an inpatient psychiatric hospital $0 copayment for physician services at an inpatient psychiatric hospital Plan requires prior authorization for inpatient mental health care services. Call 1-800-523-0023, (TTY# 711)

Covered Service	What you pay
Inpatient services in a psychiatric hospital (continued)	Out of Network $250 copayment per admission in an inpatient hospital $250 copayment per admission in an inpatient psychiatric hospital $0 copayment for physician services at an inpatient psychiatric hospital Plan requires prior authorization for inpatient mental health care services. Call 1-800-523-0023, (TTY# 711)

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

Covered Service	What you pay
Laboratory services • Covered services include, but aren't limited to: • Blood tests • Tissue specimen tests • Screening tests • Urinalysis Our plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL**.	In Network $20 copayment for each primary care physician's office visit $20 copayment for each specialist's office visit $20 copayment for each urgent care center visit $20 copayment for each freestanding laboratory visit $20 copayment for each outpatient hospital visit Benefit does not apply to your combined deductible Out of Network $20 copayment for each primary care physician's office visit $20 copayment for each specialist's office visit $20 copayment for each urgent care center visit $20 copayment for each freestanding laboratory visit $20 copayment for each outpatient hospital visit Benefit does not apply to your combined deductible

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

Covered Service	What you pay
Medical supplies Coverage for certain non-durable health care materials ordered by a provider. Covered items include, but are not limited to: • Catheters • Cotton swabs • IV set-ups and supplies • Surgical supplies including bandages and dressings • General supplies	In Network 20% coinsurance at a medical supply provider 20% coinsurance at a pharmacy Medical supplies received from a pharmacy do not apply to your combined deductible Out of Network 20% coinsurance at a medical supply provider 20% coinsurance at a pharmacy Medical supplies received from a pharmacy do not apply to your combined deductible
Medicare Diabetes Prevention Program (MDPP) MDPP services are covered for eligible people under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	In Network $0 copayment Benefit does not apply to your combined deductible Out of Network $0 copayment Benefit does not apply to your combined deductible

Covered Service	What you pay
Medicare Part B drugs These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you get physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • The Alzheimer's drug, Leqembi®, (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan • Clotting factors you give yourself by injection if you have hemophilia • Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Keep in mind, Medicare Part D drug coverage covers immunosuppressive drugs if Part B doesn't cover them • Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug • Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision	In Network Medicare Part B Insulin Drugs $0 copayment for administration of drugs at a primary care physician's office $0 copayment for administration of drugs at a specialist's office $0 copayment for administration of drugs at a outpatient hospital $0 copayment for Medicare Part B insulin drugs at a pharmacy Benefit does not apply to your combined deductible Other Medicare Part B Drugs $0 copayment for administration of drugs at a primary care physician's office $0 copayment for administration of drugs at a specialist's office

Covered Service	What you pay
Medicare Part B drugs (continued)	
• Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B • Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv®, and the oral medication Sensipar® • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Retacrit®, Epogen®, Procrit®, Aranesp® (in polysorbate)) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) Our plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL**. You may also have to try a different drug first before we will agree to cover the drug you are requesting. This is called "step therapy." Contact the plan for details.	$0 copayment for administration of drugs at a outpatient hospital $0 copayment for other Medicare Part B drugs at a pharmacy Other Medicare Part B covered drugs received from an outpatient hospital or pharmacy do not apply to your combined deductible Out of Network Medicare Part B Insulin Drugs $0 copayment for administration of drugs at a primary care physician's office $0 copayment for administration of drugs at a specialist's office $0 copayment for administration of drugs at a outpatient hospital $0 copayment for Medicare Part B insulin drugs at a pharmacy Benefit does not apply to your combined deductible

Covered Service	What you pay
Medicare Part B drugs (continued)	
The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: **Humana.com/PAL** We also cover some vaccines under our Part B and Part D prescription drug benefit. Chapter 5 explains the Part D drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D drugs through our plan is explained in Chapter 6.	Other Medicare Part B Drugs $0 copayment for administration of drugs at a primary care physician's office $0 copayment for administration of drugs at a specialist's office $0 copayment for administration of drugs at a outpatient hospital $0 copayment for other Medicare Part B drugs at a pharmacy Other Medicare Part B covered drugs received from an outpatient hospital or pharmacy do not apply to your combined deductible

Covered Service	What you pay
Nuclear medicine • Covered services include, but aren't limited to: • PET scans • NOPR • SPECT Our plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL**.	In Network $20 copayment for nuclear medicine at a freestanding radiological facility $20 copayment for nuclear medicine at an outpatient hospital Out of Network $20 copayment for nuclear medicine at a freestanding radiological facility $20 copayment for nuclear medicine at an outpatient hospital

Covered Service	What you pay
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	In Network $0 copayment for each primary care physician's office visit Benefit does not apply to your combined deductible Out of Network $0 copayment for each primary care physician's office visit Benefit does not apply to your combined deductible
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications. • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments Our plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL**.	In Network $20 copayment for each specialist's office visit $20 copayment for each outpatient hospital visit Out of Network $20 copayment for each specialist's office visit $20 copayment for each outpatient hospital visit

Covered Service	What you pay
Outpatient Basic Radiological Services	
Covered services include, but aren't limited to: • Radiologic examination • X-rays Our plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL**.	In Network $20 copayment for each primary care physician's office visit $20 copayment for each specialist's office visit $20 copayment for each urgent care center visit $20 copayment for each freestanding radiological facility visit $20 copayment for each outpatient hospital visit Out of Network $20 copayment for each primary care physician's office visit $20 copayment for each specialist's office visit $20 copayment for each urgent care center visit $20 copayment for each freestanding radiological facility visit $20 copayment for each outpatient hospital visit

Covered Service	What you pay
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but aren't limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need • Diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical problem. • Other outpatient diagnostic tests Our plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL**.	<u>In Network</u> $20 copayment for each primary care physician's office visit $20 copayment for each specialist's office visit $20 copayment for each urgent care center visit $20 copayment for each freestanding radiological facility visit $20 copayment for each outpatient hospital visit <u>Out of Network</u> $20 copayment for each primary care physician's office visit $20 copayment for each specialist's office visit $20 copayment for each urgent care center visit $20 copayment for each freestanding radiological facility visit $20 copayment for each outpatient hospital visit

Covered Service	What you pay
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, you should ask the hospital staff. Get more information in the Medicare fact sheet called *Medicare Hospital Benefits*. This fact sheet is available on the Web at **www.Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf** or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. Our plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL**.	In Network $0 copayment for each outpatient hospital visit Out of Network $0 copayment for each outpatient hospital visit

Covered Service	What you pay
Outpatient mental health care	
Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws. Our plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL**.	In Network $20 copayment for each primary care physician's office visit $20 copayment for each specialist's office visit $20 copayment for each urgent care center visit $20 copayment for each outpatient hospital visit Out of Network $20 copayment for each primary care physician's office visit $20 copayment for each specialist's office visit $20 copayment for each urgent care center visit $20 copayment for each outpatient hospital visit

Covered Service	What you pay
Outpatient rehabilitation services	
Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs). Prior authorization is required for physical, occupational, and speech therapies. Our plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL**.	In Network $20 copayment for each specialist's office visit $20 copayment for each comprehensive outpatient rehabilitation facility (CORF) visit $20 copayment for each outpatient hospital visit Out of Network $20 copayment for each specialist's office visit $20 copayment for each comprehensive outpatient rehabilitation facility (CORF) visit $20 copayment for each outpatient hospital visit

Covered Service	What you pay
Outpatient substance use disorder services You are covered for outpatient mental health services for treatment to prevent alcohol and drug abuse. Our plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL**.	In Network $20 copayment for each primary care physician's office visit $20 copayment for each specialist's office visit $20 copayment for each urgent care center visit $20 copayment for each outpatient hospital visit Out of Network $20 copayment for each primary care physician's office visit $20 copayment for each specialist's office visit $20 copayment for each urgent care center visit $20 copayment for each outpatient hospital visit

Covered Service	What you pay
Outpatient surgery, including services provided at hospital facilities and ambulatory surgical centers **Note:** If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient. • Prior authorization is required for abdominoplasty, balloon sinuplasty, blepharoplasty, breast procedures, otoplasty, elective outpatient cardiac catheterizations, penile implant, rhinoplasty, obesity, oral surgeries, and surgery for obstructive sleep apnea Our plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL**.	In Network $20 copayment for each primary care physician's office visit $20 copayment for each specialist's office visit $20 copayment for each urgent care center visit $0 copayment for each ambulatory surgical center visit $0 copayment for each outpatient hospital visit Out of Network $20 copayment for each primary care physician's office visit $20 copayment for each specialist's office visit $20 copayment for each urgent care center visit $0 copayment for each ambulatory surgical center visit $0 copayment for each outpatient hospital visit

Covered Service	What you pay
Partial hospitalization services and Intensive outpatient services *Partial hospitalization* is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center , that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization. *Intensive outpatient service* is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a federally qualified health center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization. Prior authorization is required for partial hospitalization services Our plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL**.	In Network $20 copayment for partial hospitalization at an outpatient hospital $20 copayment for intensive outpatient services at an outpatient hospital Out of Network $20 copayment for partial hospitalization at an outpatient hospital $20 copayment for intensive outpatient services at an outpatient hospital

Covered Service	What you pay
Physical exams (Routine)	
In addition to the Annual Wellness Visit or the *Welcome to Medicare* physical exam, you are covered for the following exam once per year: • Comprehensive preventive medicine evaluation and management, including an age and gender appropriate history, examination, and counseling/anticipatory guidance/risk factor reduction interventions • **Note**: Any lab or diagnostic procedures that are ordered are not covered under this benefit and you pay your plan cost-sharing amount for those services separately.	In Network $0 copayment for each primary care physician's office visit Benefit does not apply to your combined deductible Out of Network $0 copayment for each primary care physician's office visit Benefit does not apply to your combined deductible

Covered Service	What you pay
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical care or surgery services you get in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment • Certain telehealth services including consultation, diagnosis, and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare ○ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if:	<u>In Network</u> $20 copayment for each primary care physician's office visit $20 copayment for each specialist's office visit <u>Out of Network</u> $20 copayment for each primary care physician's office visit $20 copayment for each specialist's office visit

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

Covered Service	What you pay
Physician/Practitioner services, including doctor's office visits (continued) • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) • Physician/practitioner urgently needed services furnished in an office setting Our plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL.**	
Podiatry services (Medicare-covered) Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) Our plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL**.	In Network $20 copayment for each specialist's office visit Out of Network $20 copayment for each specialist's office visit

Covered Service	What you pay
Pre-exposure prophylaxis (PrEP) for HIV prevention	
If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: • FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, we also cover the fee for injecting the drug. • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to 8 HIV screenings every 12 months. A one-time hepatitis B virus screening.	In Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit Benefit does not apply to your combined deductible Out of Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit Benefit does not apply to your combined deductible

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

Covered Service	What you pay
Prosthetic and orthotic devices and related supplies	
Devices (other than dental) that replace all or part of a body part or function. These include, but aren't limited to: testing, fitting, or training in the use of prosthetic and orthotic devices; as well as colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – go to Vision Care later in this table for more detail. • Prior authorization is required for prosthetic devices Our plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL**.	In Network 20% coinsurance from a prosthetics provider Plan requires prior authorization for prosthetic devices and related supplies. Call 1-800-523-0023, (TTY# 711) Out of Network 20% coinsurance from a prosthetics provider Plan requires prior authorization for prosthetic devices and related supplies. Call 1-800-523-0023, (TTY# 711)

Covered Service	What you pay
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease. Our plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL.**	In Network $20 copayment for each specialist's office visit $20 copayment for each comprehensive outpatient rehabilitation facility (CORF) visit $20 copayment for each outpatient hospital visit Out of Network $20 copayment for each specialist's office visit $20 copayment for each comprehensive outpatient rehabilitation facility (CORF) visit $20 copayment for each outpatient hospital visit

Covered Service	What you pay
Radiation therapy	
Covered services include: • Radiation (radium and isotope) therapy including technician materials and supplies • Prior authorization is required for radiation therapy	In Network $20 copayment for each specialist's office visit $20 copayment for each freestanding radiological facility visit $20 copayment for each outpatient hospital visit Out of Network $20 copayment for each specialist's office visit $20 copayment for each freestanding radiological facility visit $20 copayment for each outpatient hospital visit

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

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

Covered Service	What you pay
Screening for Hepatitis C Virus infection	
We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965. If you were born between 1945-1965 and aren't considered high risk, we pay for a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	In Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit Benefit does not apply to your combined deductible Out of Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit Benefit does not apply to your combined deductible

Covered Service	What you pay
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs	
We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	In Network $0 copayment for each primary care physician's office visit Benefit does not apply to your combined deductible Out of Network $0 copayment for each primary care physician's office visit Benefit does not apply to your combined deductible

Covered Service	What you pay
Services to treat kidney disease	
Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to 6 sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3), or when your provider for this service is temporarily unavailable or inaccessible • Inpatient dialysis treatments (if you're admitted to a hospital for special care). • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments). • Home dialysis equipment and supplies. • Certain home support services (such as when medically necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply). Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B Drugs, go to **Medicare Part B drugs** in this table. Our plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL**.	**Kidney Disease Education Services** In Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit $0 copayment for each outpatient hospital visit Benefit does not apply to your combined deductible Out of Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit $0 copayment for each outpatient hospital visit Benefit does not apply to your combined deductible

Covered Service	What you pay
Services to treat kidney disease(continued)	**Renal Dialysis Services** In Network $20 copayment for each dialysis center visit $20 copayment for each outpatient hospital visit Out of Network $20 copayment for each dialysis center visit $20 copayment for each outpatient hospital visit

Covered Service	What you pay
Skilled nursing facility (SNF) care	
(For a definition of skilled nursing facility, go to the chapter titled "Definitions of Important Words". Skilled nursing facilities are sometimes called SNFs.) You are covered for medically necessary days 1-100 for each benefit period. Prior hospital stay is not required. Covered services include but aren't limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of our plan of care (this includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services • Generally, you get SNF care from network facilities. Under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment.	Per benefit period, you pay: <u>In Network</u> $0 copayment at a skilled nursing facility per day, days 1-20 $75 copayment at a skilled nursing facility per day, days 21-100 $0 copayment for physician services at a skilled nursing facility Plan requires prior authorization for skilled nursing facility care services. Call 1-800-523-0023, (TTY# 711) <u>Out of Network</u> $0 copayment at a skilled nursing facility per day, days 1-100 $75 copayment at a skilled nursing facility per day, days 21-100 $0 copayment for physician services at a skilled nursing facility Plan requires prior authorization for skilled nursing facility care services. Call 1-800-523-0023, (TTY# 711)

Covered Service	What you pay
Skilled nursing facility (SNF) care (continued) • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital • Prior authorization is required for inpatient skilled nursing care A new skilled nursing benefit period will begin on day one when you first enroll in a Humana Medicare Advantage plan, or you have been discharged from a skilled nursing facility (or not received inpatient skilled level of care) for **60** consecutive days. Our plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL**.	

Covered Service	What you pay
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)	
Smoking and tobacco, use cessation counseling is covered for outpatient an hospitalized patients who meet these criteria: • Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • Are competent and alert during counseling • A qualified physician or other Medicare-recognized practitioner provides counseling We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year.)	If you use tobacco, but do not have signs or symptoms of tobacco-related disease: In Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit Benefit does not apply to your combined deductible Out of Network $0 copayment for each primary care physician's office visit $0 copayment for each specialist's office visit Benefit does not apply to your combined deductible

Covered Service	What you pay
Supervised Exercise Therapy (SET)	
SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, compromising a therapeutic exercise-training program for PAD patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider. Our plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL**.	In Network $20 copayment for each specialist's office visit $20 copayment for each outpatient hospital visit Out of Network $20 copayment for each specialist's office visit $20 copayment for each outpatient hospital visit

Covered Service	What you pay
Transportation (Routine)	
Coverage for non-emergent transportation of a patient to plan-approved facilities. Members must schedule trips at least 72 hours (3 business days) in advance of their appointment. Contact Humana Customer Care for information on how to arrange transportation. Customer Care will confirm your benefits and guide you to the transportation provider to plan your trip. Humana is not responsible for the availability or ongoing participation of any provider.	In Network $0 copayment for plan approved location up to 24 one-way trip(s) per year by rideshare services, car, van, wheelchair access vehicle. This benefit is not to exceed 60 miles per trip. Benefit does not apply to your combined deductible Out of Network The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.

Covered Service	What you pay
Transportation (Uniform Flexibility Non-Emergency Medical Transportation)	
If you are diagnosed with any of the chronic condition(s) identified below, you are eligible for the Uniform Flexibility Non-Emergency Medical Transportation benefit. • Cancer • Chronic Kidney Disease (CKD) • End Stage Renal Disease (ESRD) This benefit offers unlimited one-way trips to all health-related, plan-approved locations per calendar year, up to 60 miles per trip. Please contact Customer Care for information on how to arrange transportation. Customer Care will confirm your benefits and guide you to the transportation provider to plan your trip. If you use a wheelchair, or have any other special needs, please notify the vendor when you schedule your service. Members must schedule trips with the transportation provider at least 72 hours (3 business days) in advance of their appointment.	In Network $0 copayment Benefit does not apply to your combined deductible or combined maximum out-of-pocket Out of Network The in-network provider must be used for this service. If you choose to utilize another provider, you are responsible for all charges.

Covered Service	What you pay
Urgently needed services	
A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside the service area of our plan, or even if you are inside the service area, it's unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits, (like annual checkups), aren't considered urgently needed even if outside the service area or our plan network is temporarily unavailable.	In Network $20 copayment for each primary care physician's office visit $20 copayment for each specialist's office visit $20 copayment for each urgent care center visit Benefit does not apply to your combined deductible
You are covered for urgently needed services worldwide. If you have an urgent need for care while outside of the U.S. and its territories, you will be responsible to pay for the services rendered upfront. You must submit proof of payment to Humana for reimbursement. For more information please see the chapter titled "*Asking us to pay our share of a bill you have received for covered medical services or drugs*". We may not reimburse you for all out of pocket expenses. This is because our contracted rates may be lower than provider rates outside of the U.S. and its territories. You are responsible for any costs exceeding our contracted rates as well as any applicable member cost-share.	Out of Network $20 copayment for each primary care physician's office visit $20 copayment for each specialist's office visit $20 copayment for each urgent care center visit Benefit does not apply to your combined deductible

Covered Service	What you pay
Vision services (Medicare-covered)	
Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. • For people who are at high risk for glaucoma, we cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year. • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. If you have 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. Our plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL**.	In Network $20 copayment for each specialist's office visit $20 copayment for eyeglasses and contact lenses following cataract surgery Out of Network $20 copayment for each specialist's office visit $20 copayment for eyeglasses and contact lenses following cataract surgery

Covered Service	What you pay
Vision services (Routine): Exam, Frames and Eyeglass Lens or Contact Lens Benefit	
Vision benefit through **Humana Medicare Insight Network** includes: Routine exam (includes refraction*) and an allowance for contact lenses or eyeglasses (lenses and frames), including lens options such as ultraviolet protection and "scratch-resistant" coating, fitting for eyeglasses (lenses and frames). • Contact lenses will include conventional or disposable. • The benefit can only be used one time. Any remaining benefit dollars do not "roll over" to a future plan years. Benefit does not include contact lens fitting *Refraction is only covered in conjunction with a comprehensive routine eye exam OR A refraction exam may be covered (1 per calendar year) when completed during a comprehensive eye exam and performed by a Humana network medical provider Please inform the network provider that you are part of the **Humana Medicare Insight Network**. When using an out-of-network provider, you will be responsible for costs above the plan approved amount. The provider locator for the Humana Medicare Insight Network for routine vision can be found at **Humana.com** or call Humana Customer Care.	In Network $0 copayment for routine exam (includes refraction) up to 1 per year. $100 combined maximum benefit coverage amount per year for contact lenses, eyeglasses (lenses and frames), including lens options such as ultraviolet protection and scratch resistant coating, fitting for eyeglasses (lenses and frames). Benefit does not apply to your combined deductible or combined maximum out-of-pocket Out of Network $175 combined maximum benefit coverage amount per year for routine exam (includes refraction). $0 copayment for routine exam (includes refraction) up to 1 per year. $100 combined maximum benefit coverage amount per year for contact lenses, eyeglasses (lenses and frames), including lens options such as ultraviolet protection and scratch resistant coating, fitting for eyeglasses (lenses and frames).

Covered Service	What you pay
Vision services (Routine): Exam, Frames and Eyeglass Lens or Contact Lens Benefit continued	Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. Benefit does not apply to your combined deductible or combined maximum out-of-pocket *Benefit is limited to one time use per year.
Welcome to Medicare preventive visit Our plan covers the one-time *Welcome to Medicare* preventive visit. The visit includes a review of your health, as well as education and counseling about preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the *Welcome to Medicare* preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you want to schedule your *Welcome to Medicare* preventive visit. Note: Any lab or diagnostic procedures that are ordered are not covered under this benefit and you pay your plan cost-sharing amount for those services separately.	In Network $0 copayment for each primary care physician's office visit Benefit does not apply to your combined deductible Out of Network $0 copayment for each primary care physician's office visit Benefit does not apply to your combined deductible

Covered Service	What you pay
Wigs (medically necessary)	
Coverage for medically necessary wigs related to ongoing treatment. Our plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: **Humana.com/PAL**. • 1 combined In & Out of Network item limit per plan year • $400 combined In & Out of Network maximum benefit coverage amount per year	In Network $0 copayment from prosthetics provider $0 copayment from durable medical equipment provider Out of Network $0 copayment from prosthetics provider $0 copayment from durable medical equipment provider

SECTION 3 Services that aren't covered by our plan

This section tells you what services are excluded from Medicare coverage and therefore, aren't covered by our plan.

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

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

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

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

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

Services not covered by Medicare	Covered only under specific conditions
Routine chiropractic care	Manual manipulation of the spine to correct a subluxation is covered
Routine dental care, such as cleanings, fillings or dentures	Not covered under any condition
Routine foot care	Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes)
Services considered not reasonable and necessary, according to Original Medicare standards	Not covered under any condition
Services provided to veterans in Veterans Affairs (VA) facilities	When emergency services are received at VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts
Purchase, instead of rental, of durable medical equipment that Original Medicare does not allow to be purchased outright.	Not covered under any condition
Limitations and Exclusions - See additional directional documents	

Hearing Mandatory Supplemental Benefit Exclusions include, but not limited to, the following:

- Any fees for exams, tests, evaluations or any services in excess of the stated maximums.
- Any expenses which are covered by Medicare or any other government program or insurance plan, or for which you are not legally required to pay.
- Services provided for clearance/consultation by a provider.
- Any refitting fees for lost or damaged hearing aids.
- Any fees for any services rendered by a non-network hearing aid provider. In-network hearing aid providers reserve the right to only service devices purchased from in-network providers.
- Hearing aids and provider visits to service hearing aids (except as specifically described in the Covered Benefits), ear molds, hearing aid accessories, return fees, warranty claim fees, and hearing aid batteries (beyond the covered limit).

Vision Mandatory Supplemental Benefit Exclusions include, but not limited to, the following:

- Any benefits received at a non-network optical provider.
- Any expense arising from the completion of forms.
- Any service not specifically listed in your supplemental benefit.
- Orthoptic or vision training.
- Subnormal vision aids and associated testing.
- Any expense incurred before your effective date or after the date this supplemental benefit terminates.
- Services provided by someone who ordinarily lives in your home or who is a family member.
- Charges exceeding the allowance for the service.
- Treatment resulting from any intentionally self-inflicted injury or bodily illness.
- Medical or surgical treatment of eye, eyes or supporting structures.
- Services or materials provided by any other group benefit plans providing vision care.
- Corrective vision treatment of an experimental nature.
- Non-prescription items.
- Pre and post-operative services.
- Any expenses incurred while you qualify for any workers' compensation or occupational disease act or law, whether or not you applied for coverage.
- Services that are:
    - Free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law.
    - Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid).
    - Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
- Any loss caused or contributed by war or any act of war, whether declared or not; any act of international armed conflict; or any conflict involving armed forces of any international authority.
- Your failure to keep an appointment.
- Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
- Prescription drugs or pre-medications, whether dispensed or prescribed.
- Any service that we determine is not a visual necessity; does not offer a favorable prognosis; does not have uniform professional endorsement; or is deemed to be experimental or investigational in nature.
- Any examination or material required by an employer as a condition of employment or safety eyewear.
- Pathological treatment.
- These benefits are offered on a calendar year basis. Any amount unused at the end of the year will expire.

- Frames and lenses.
- Contact lenses or exams for the fitting of contact lenses.
- Standard contact lens fit and follow-up.
- Refitting or change in lens design after initial fitting.
- Aniseikonic lenses.
- Prisms (not covered with allowance, but may be available at a discounted rate off retail price; check with provider for details).
- Athletic or industrial lenses.
- Any service we consider cosmetic.
- Plano lenses.
- Non-prescription sunglasses.
- Two pair of glasses in lieu of bifocals.
- Solutions and/or cleaning products for glasses or contact lenses.
- Costs associated with securing materials.
- Orthokeratology.
- Routine maintenance of materials.
- Artistically painted lenses.
- Replacement of lenses or eyeglass frames furnished under this supplemental benefit that are lost or broken, unless otherwise available under the supplemental benefit.

The plan will not cover the excluded services listed above. Even if you receive the services at an emergency facility, the excluded services are still not covered.

CHAPTER 5:

Using plan coverage for Part D drugs

SECTION 1 Basic rules for our plan's Part D coverage

Go to the Medical Benefits Chart in Chapter 4 for Medicare Part B drug benefits and hospice drug benefits.

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

- You must have a provider (a doctor, dentist or other prescriber) write you a prescription that's valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists .
- You generally must use a network pharmacy to fill your prescription. (Go to Section 2.) *or you can fill your prescriptions at a network pharmacy or through our plan's mail-order service.*
- Your drug must be in our plan's Drug Guide (go to Section 3, in this chapter).
- 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 FDA or supported by certain references. (Go to Section 3 for more information about a medically accepted indication.)
- Your drug may require approval from our plan based on certain criteria before we agree to cover it. (Go to Section 4 of this chapter for more information.)

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

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

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

Section 2.1 Network pharmacies

Find a network pharmacy in your area

To find a network pharmacy, go to your *Provider Directory,* visit our website **www.Humana.com/FindCare**, and/or call Humana Group Medicare Customer Care .

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

If your pharmacy leaves the network

If the pharmacy you use leaves the plan's network, you'll have to find a new pharmacy that's in our network. To find another pharmacy in your area, get help from Humana Group Medicare Customer Care or use the *Provider Directory*. You can also find information on our website at **www.Humana.com/FindCare.**

Specialized pharmacies

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. If you have difficulty getting Part D drugs in an LTC facility, call Humana Group Medicare 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 restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. To locate a specialized pharmacy, go to your *Provider Directory* or call Humana Group Medicare Customer Care.

Section 2.2 Our plan's mail-order service

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

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

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

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

New prescriptions the pharmacy gets directly from your doctor's office. The pharmacy will automatically fill and deliver new prescriptions it gets 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 can ask for automatic delivery of all new prescriptions at any time by calling Humana Group Medicare Customer Care.

If you get a prescription automatically by mail that you don't 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 don't want the pharmacy to automatically fill and ship each new prescription, contact us by calling Humana Group Medicare Customer Care.

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

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

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

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

Section 2.3 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. Our plan offers 2 ways to get a long-term supply (also called an extended supply) of maintenance drugs in our plan's Drug Guide. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

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

2. You can also get maintenance drugs through our mail-order program. Go to Section 2.3 for more information.

Section 2.4 Using a pharmacy that's not in our plan's network

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you aren't able to use a network pharmacy. We also have network pharmacies outside of our service area where you can get prescriptions filled as a member of our plan. **Please check first with Humana Group Medicare Customer Care** to see if there's a network pharmacy nearby.

We cover prescriptions filled at an out of network pharmacy only in these circumstances:

- **If you need a prescription because of a medical emergency**
  - We'll 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'll have to pay the full cost (rather than paying just your copayment or coinsurance) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a paper claim form. If the prescription is covered, it will be covered at an out-of-network rate. If you go to an out-of-network pharmacy, you may be responsible for paying the difference between what we would pay for a prescription filled at a network pharmacy and what the out-of-network pharmacy charged for your prescription. (Chapter 7, Section 2.1 explains how to ask the plan to pay you back.)
- **If you need coverage while you're traveling away from our plan's service area**
  - If you take a prescription drug on a regular basis and you're 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're traveling outside of our plan's service area but within the United States and territories and become ill, or run out of your prescription drugs, call Humana Group Medicare Customer Care to find a network pharmacy in your area where you can fill your prescription. If a network pharmacy is not available, we'll 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'll have to pay the full cost (rather than paying just your copayment or coinsurance) when you fill your prescription.
  - **If the prescription is covered, it will be covered at an out-of-network rate** . You may be responsible for paying the difference between what we would pay for a prescription filled at an in-network pharmacy and what the out-of-network pharmacy charged for your prescription. You can ask us to reimburse you for our share of the cost by submitting a paper claim form. (Chapter 7, Section 2 explains how to ask the plan to pay you back.)
- **Please recognize, however, that multiple non-emergency occurrences of out-of-network pharmacy claims will result in claim denials. In addition, we can't pay for any lost or stolen medications or prescriptions that are filled by pharmacies outside the United States and territories, even for a medical emergency, for example on a cruise ship.**

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

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

If you must use an out-of-network pharmacy, you'll generally have to pay the full cost (rather than your normal cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Go to Chapter 7, Section 2.1 for information on how to ask our plan to pay you back.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost we would cover at an in-network pharmacy.

SECTION 3 Your drugs need to be in our plan's Drug Guide

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

Our plan has a *Prescription Drug Guide* (formulary). In this *Evidence of Coverage*, **we call it the Drug Guide.**

The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare. The Drug Guide only shows drugs covered under Medicare Part D.

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

- Approved by the FDA 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 Micromedex DRUGDEX Information System.

The Drug Guide includes brand name drugs, generic drugs, and biological products (which may include biosimilars).

A brand name drug is a prescription drug sold under a trademarked name owned by the drug manufacturer. Biological products are drugs that are more complex than typical. On the Drug Guide, when we refer to drugs, this could mean a drug or a biological product.

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

Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

Go to Chapter 12 for definitions of types of drugs that may be on the Drug Guide.

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 Humana Group Medicare Customer Care.

Drugs that aren't in the Drug Guide

Our plan doesn't cover all prescription drugs.

- In some cases, the law doesn't allow any Medicare plan to cover certain types of drugs. (For more information, go to Section 7).
- In other cases, we decided not to include a particular drug in the Drug Guide.
- In some cases, you may be able to get a drug that's not on the Drug Guide. (For more information, go to Chapter 9.)

Section 3.2 Five (5) cost-sharing tiers for drugs in the Drug Guide

Every drug in our plan's Drug Guide is in one of f ive (5) cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug:

- **Tier 1: Preferred Generic** - Generic or brand drugs that are available at the lowest cost share for this plan.
- **Tier 2: Generic** - Generic or brand drugs that Humana offers at a higher cost to you than Tier 1 Preferred Generic drugs.
- **Tier 3: Preferred Brand** - Generic or brand drugs that Humana offers at a lower cost than Tier 4 Non-Preferred Drug.
- **Tier 4: Non-Preferred Drug** - Generic or brand drugs that Humana offered at a higher cost than Tier 3 Preferred Brand drugs.
- **Tier 5: Specialty** - Some injectables and other higher-cost drugs.

To find out which cost-sharing tier your drug is in, look it up in our plan's Drug Guide. The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6.

Section 3.3 How to find out if a specific drug is in the Drug Guide

To find out if a drug is in our Drug Guide, you have these options:

1. Check the most recent Drug Guide we provided electronically. (The Drug Guide includes information for the covered drugs most commonly used by our members. We cover additional drugs that aren't included in the Drug Guide. If one of your drugs isn't listed visit our website or contact Humana Group Medicare Customer Care to find out if we cover it.)

2. Visit our plan's website **www.Humana.com/FindCare**. The Drug Guide on the website is always the most current

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

4. Use our plan's "Real-Time Benefit Tool" by visiting **www.Humana.com/FindCare** and logging into MyHumana to search for drugs on the Drug Guide to get an estimate of what you'll pay and see if there are alternative drugs on the Drug Guide that could treat the same condition.

SECTION 4 Drugs with restrictions on coverage

Section 4.1 Why some drugs have restrictions

For certain prescription drugs, special rules restrict how and when our plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective way. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug Guide.

If a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option.

Note that sometimes a drug may appear more than once in our Drug Guide. This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your health care provider, and different restrictions or cost sharing may apply to the different versions of the drug (for example, 10 mg versus 100 mg; one per day versus 2 per day; tablet versus liquid).

Section 4.2 Types of restrictions

If there's a restriction for your drug, it usually means that you or your provider have to take extra steps for us to cover the drug. Call Humana Group Medicare Customer Care to learn what you or your provider can do to get coverage for the drug. **If you want us to waive the restriction for you, you 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. (Go to Chapter 9).

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from our plan based on specific criteria before we agree to cover the drug for you. This is called **prior authorization**. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you don't get this approval, your drug might not be covered by our plan. Our plan's step therapy criteria can be obtained by calling Humana Group Medicare Customer Care or on our website.

Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before our plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, our plan may require you to try Drug A first. If Drug A doesn't work for you, our plan will then cover Drug B. This requirement to try a different drug first is called **step therapy**. Our plan's step therapy criteria can be obtained by calling Humana Group Medicare Customer Care (TTY users call 711) or on our website.

Quantity limits

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

SECTION 5 What you can do if one of your drugs isn't covered the way you would like

There are situations where a prescription drug you take, or that you and your provider think you should take, isn't on our Drug Guide or has restrictions. For example:

- The drug might not be covered at all. Or a generic version of the drug may be covered but the brand name version you want to take isn't covered.
- The drug is covered, but there are extra rules or restrictions on coverage .
- The drug is covered, but in a cost-sharing tier that makes your cost-sharing more expensive than you think it should be.
- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.1 to learn what you can do.

If your drug isn't in the Drug Guide or is restricted, here are options for what you can do:

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

You may be able to get a temporary supply

Under certain circumstances, our plan must provide a temporary supply of a drug you 're already taking. This temporary supply gives you time to talk with your provider about the change.

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

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

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

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

- **For members who've been in our plan for more than *90 days*, and live in a long-term care facility and need a supply right away:**

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

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

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

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

- You transfer from one skilled nursing facility to another.

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

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

Policies for Temporary Drug Supplies During the Transition Period

We consider the first 90 days of the 2026 plan year a transition period if you're a new member, you changed plans, or there were changes in your drug coverage. As described above, there are several ways we make sure you can get a temporary supply of your drugs, if needed, during the transition period. During the first 90 days, you can get a temporary supply if you have a current prescription for a drug that's not in our Drug Guide or requires prior authorization because of restrictions. The conditions for getting a temporary supply are described below.

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

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

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

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

Transition Period Extension

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

Costs for Temporary Supplies

Your copayment or coinsurance for a temporary drug supply will be based on your plan's approved drug cost-sharing tiers. [If you're eligible for the low-income subsidy (LIS) in 2026, your copayment or coinsurance won't exceed your LIS limit.]

For questions about a temporary supply, call Humana Group Medicare Customer Care .

During the time when you're using a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You have 2 options:

Option 1. You can change to another drug

Talk with your provider about whether a different drug covered by our plan that may work just as well for you. Call Humana Group Medicare 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.

Option 2. You can ask for an exception

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

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

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

Section 5.1 What to do if your drug is in a cost-sharing tier you think is too high?

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

You can change to another drug

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

You can ask for an exception

For drugs in Cost Sharing Tier 2 - Generic, Cost Sharing Tier 3 -Preferred Brand, or Cost Sharing Tier 4 - Non-Preferred Drugs, you and your provider can ask our 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 ask for an exception to the rule.

If you and your provider want to ask for an exception, go to Chapter 9, Section 6.4 for what to do. It explains the procedures and deadlines 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 Our Drug Guide can change during the year

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

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

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

Information on changes to drug coverage

When changes to the Drug Guide occur we post information on our website about those changes. We also update our online Drug Guide regularly. Sometimes you'll get direct notice if changes are made to a drug that you take.

Changes to drug coverage that affect you during this plan year

- **Adding new drugs to the Drug Guide and immediately removing or making changes to a like drug on the Drug Guide .**

- When adding a new version of a drug to the Drug Guide, we may immediately remove a like drug from the Drug Guide, move the like drug to a different cost-sharing tier, add new restrictions, or both. The new version of the drug will be on the same or a lower cost-sharing tier and on the same or lower cost-sharing tier and with the same or fewer restrictions.

- We'll make these immediate changes only if we add a new generic version of a brand name or add certain new biosimilar versions of an original biological product that was already on the Drug Guide.

- We may make these changes immediately and tell you later, even if you take the drug that we remove or make changes to. If you take the like drug at the time we make the change, we'll tell you about any specific change we made.

- **Adding drugs to the Drug Guide and removing or making changes to a like drug on the Drug Guide.**

  - When adding another version of a drug to the Drug Guide we may remove a like drug from the Drug Guide move it to a different cost-sharing tier, add new restrictions, or both. The new version of the drug will be on the same or a lower cost-sharing tier and on the same or lower cost-sharing tier and with the same or fewer restrictions.

  - We'll make these changes only if we add a new generic version of a brand name drug or add certain new biosimilar versions of an original biological product that was already on the Drug Guide.

  - We'll tell you at least 30 days before we make the change, or tell you about the change and cover an 30-day fill of the version of the drug you take.

- **Removing unsafe drugs and other drugs on the Drug Guide that are withdrawn from the market.**

  - Sometimes a drug can be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug Guide If you take that drug, we'll tell you after we make the change.

- **Making other changes to drugs on the Drug Guide**

  - We may make other changes once the year has started that affect drugs you are taking. For example, we based on FDA boxed warnings or new clinical guidelines recognized by Medicare.

  - We'll tell you at least 30 days before we make these changes, or tell you about the change and cover an additional 30-day fill of the drug you are taking.

If we make changes to any of the drugs you take, talk with your prescriber about the options that would work best for you, including changing to a different drug to treat your condition, or asking for a coverage decision to satisfy any new restrictions on the drug you take. You or your prescriber can ask us for an exception to continue covering the drug or version of the drug you take. For more information on how to ask for a coverage decision, including an exception, go to Chapter 9.

Changes to the Drug Guide that don't affect you during this plan year

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

In general, changes that won't affect you during the current plan year are:

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

If any of these changes happen for a drug you take (except for market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), the change won't affect your use or what you pay as your share of the cost until January 1 of the next year.

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

SECTION 7 Types of drugs we don't cover

Some kinds of prescription drugs are excluded. This means Medicare doesn't pay for these drugs.

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

Here are 3 general rules about drugs that Medicare drug plans won't cover under Part D:

- Our plan's Part D drug coverage can't cover a drug that would be covered under Medicare Part A or Part B.
- Our plan can't cover a drug purchased outside the United States or its territories.
- Our plan can't cover *off-label* use of a drug when the use isn't supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System . Off-label use is any use of the drug other than those indicated on a drug's label as approved by the FDA.

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

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

We may offer additional coverage of some prescription drugs (enhanced drug coverage) not normally covered in a Medicare prescription drug plan, listed below. The amount you pay for these drugs does not count toward qualifying you for the Catastrophic Coverage Stage. (The Catastrophic Coverage Stage is described in Chapter 6, Section 7.)
Replacements for lost or stolen prescription drugs are not covered under your plan.

If you get **Extra Help** to pay for your prescriptions, Extra Help won't pay for drugs that aren't normally covered. (Go to our plan's Drug Guide or call Humana Group Medicare Customer Care for more information. If you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Contact your state Medicaid program to determine what drug coverage may be available to you. (Find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

SECTION 8 How to fill a prescription

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

If you don't have our plan membership information, with you or the pharmacy can call our plan to get the information, or you can ask the pharmacy to look up our plan enrollment information.

If the pharmacy can't 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. Go to Chapter 7, Section 2 for information about how to ask our plan for reimbursement.)

SECTION 9 Part D drug coverage in special situations

Section 9.1 In a hospital or a skilled nursing facility for a stay covered by our plan?

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

Section 9.2 As a resident in a long-term care (LTC) facility

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

Check your *Provider Directory* **www.Humana.com/FindCare** to find out if your LTC facility's pharmacy or the one it uses is part of our network. If it isn't, or if you need more information or help, call Humana Group Medicare Customer Care . If you're in an LTC facility, we must ensure you're able to routinely get your Part D benefits through our network of LTC pharmacies.

If you're a resident in an LTC facility and need a drug that's not on our Drug List or restricted in some way, go to Section 5 for information about a temporary or emergency supply.

Section 9.3 If you also have drug coverage from an employer or retiree group plan

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

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

Special note about creditable coverage:

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

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

Keep any notices about creditable coverage because you may need these notices later to show that you maintained creditable coverage. If you didn't get a creditable coverage notice, ask for a copy from the employer or retiree plan's benefits administrator or the employer or union.

Section 9.4 If you're in a Medicare-certified hospice

Hospice and our plan don't cover the same drug at the same time. If you're enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea drugs, laxatives, pain medication or antianxiety drugs) that aren't covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must get 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 getting these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

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

SECTION 10 Programs on drug safety and managing medications

We conduct drug use reviews to help make sure our members get safe and appropriate care.

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

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

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

Section 10.1 Drug Management Program (DMP) to help members safely use opioid medications

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

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

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

You won't be placed in our DMP if you have certain medical conditions, such as cancer-related pain or sickle cell disease, you're getting hospice, palliative, or end-of-life care, or live in a long-term care facility.

Section 10.2 Medication Therapy Management (MTM) and other programs to help members manage medications

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

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

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

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

If we have a program that fits your needs, we'll automatically enroll you in the program and send you information. If you decide not to participate, notify us and we'll withdraw. For questions about these programs, call Humana Group Medicare Customer Care .

CHAPTER 6:

What you pay for Part D drugs

SECTION 1 What you pay for Part D drugs?

If you're 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, call Humana Group Medicare Customer Care (TTY users call 711) and ask for the *LIS Rider.*

We use "drug" in this chapter to mean a Part D prescription drug. 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. Some excluded drugs may be covered by our plan.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 5, explains these rules. When you use our plan's "Real-Time Benefit Tool" to look up drug coverage **www.Humana.com/FindCare** the cost you see in the tool shows an estimate of the out-of-pocket costs you're expected to pay. You can also get information provided by the "Real-Time Benefit Tool" by calling Humana Group Medicare Customer Care (TTY users call 711).

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

There are different types of out-of-pocket costs for covered Part D drugs you may be asked to pay:

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

Section 1.2 How Medicare calculates your out-of-pocket costs

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

These payments are included in your out-of-pocket costs

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

- The amount you pay for drugs when you're in any of the following drug payment stages:
  - The Initial Coverage Stage

- Any payments you made during this calendar year as a member of a different Medicare drug plan before you joined our plan.

- Any payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, or by a State Pharmaceutical Assistance Program (SPAP)s, and most charities.

Moving to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $2,100 in out-of-pocket costs within the calendar year, you will move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

These payments aren't included in your out-of-pocket costs

Your out-of-pocket costs **don't include** any of these types of payments:

- Drugs you buy outside the United States and its territories

- Drugs that aren't covered by our plan

- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage

- Non-Part D drugs, including prescription drugs and vaccines covered by Part A or Part B and other drugs excluded from coverage by Medicare

- Prescription drugs and vaccines covered by Part A or Part B

- Payments you make toward drugs covered under our additional coverage but not normally covered in a Medicare Drug Plan

- Payments you make toward drugs not normally covered in a Medicare Drug Plan

- Payments for your drugs that are made by group health plans including employer health plans
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Health Administration (VA)
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation)
- Payments made by drug manufacturers under the Manufacturer Discount Program

Reminder: If any other organization like the ones listed above pays part or all of your out-of-pocket costs for drugs, you're required to tell our plan by calling Humana Group Medicare Customer Care (TTY users call 711).

Tracking your out-of-pocket total

- The *SmartSummary* you get includes the current total of your out-of-pocket costs. When this amount reaches $2,100, *SmartSummary* will tell you that you left the Initial Coverage Stage and have moved to the Catastrophic Coverage Stage.
- **Make sure we have the information we need** . Go to Section 3.1 to learn what you can do to help make sure our records of what you spent are complete and up to date.

SECTION 2 Drug payment stages for your plan

There are 3 **drug payment stages** for your drug coverage under your plan. How much you pay for each prescription depends on what stage you're in when you get a prescription filled or refilled. Details of each stage are explained in this chapter. The stages are:

- **Stage 1: Yearly Deductible Stage**
- **Stage 2: Initial Coverage Stage**
- **Stage 3: Catastrophic Coverage Stage**

SECTION 3 Your *SmartSummary* explains which payment stage you are in

Our plan keeps track of your prescription drug costs and the payments you make when you get prescriptions at the pharmacy. This way, we can tell you when you move from one drug payment stage to the next. We track two types of costs:

- **Out-of-Pocket Costs**: this is how much you paid. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, and any payments made for your drugs by "Extra Help" from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).

- **Total Drug Costs**: this is the total of all payments made for your covered Part D drugs. It includes what our plan paid, what you paid, and what other programs or organizations paid for your covered Part D drugs.

If you filled one or more prescriptions through our plan during the previous month , we'll send you a *SmartSummary*. The *SmartSummary* includes:

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

- **Totals for the plan year.** This shows the total drug costs and total payments for your drugs since the plan year began.

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

- **Available lower cost alternative prescriptions.** This shows information about other available drugs with lower cost-sharing for each prescription claim, if applicable.

Section 3.1 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's how you can help us keep your information correct and up to date:

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

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

  - When you purchase a covered drug at a network pharmacy at a special price or use a discount card that's not part of our plan's benefit.

  - When you pay a copayment for drugs provided under a drug manufacturer patient assistance program.

  - Any time you buy covered drugs at out-of-network pharmacies or pay the full price for a covered drug under special circumstances.

  - If you're billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.

- **Send us information about the payments others make for you**. Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.

- **Check the written report we send you.** When you get the *SmartSummary* look it over to be sure the information is complete and correct. If you think something is missing or you have questions, call Humana Group Medicare Customer Care (TTY users call 711). Be sure to keep these reports.

SECTION 4 There is no deductible for this plan

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

SECTION 5 The Initial Coverage Stage

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

During the Initial Coverage Stage, our plan pays its share of the cost of your covered 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.

Our plan has five cost-sharing tiers

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

- **Cost-Sharing Tier 1 : Preferred Generic** - Generic or brand drugs that are available at the lowest cost-share for this plan.
- **Cost-Sharing Tier 2 : Generic** - Generic or brand drugs that Humana offers at a higher cost to you than Tier 1 Preferred Generic drugs.
- **Cost-Sharing Tier 3 : Preferred Brand** - Generic or brand drugs that Humana offers at a lower cost to you than Tier 4 Non-Preferred Drug.
- **Cost-Sharing Tier 4 : Non-Preferred Drug** - Generic or brand drugs that Humana offers at a higher cost to you than Tier 3 Preferred Brand drugs.
- **Cost-Sharing Tier 5 : Specialty** - Some injectables and other high-cost drugs.

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

Your pharmacy choices

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

- A network retail pharmacy
- A pharmacy that isn't in the plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Go to Chapter 5, Section 2.5 to find out when we'll cover a prescription filled at an out-of-network pharmacy
- Our plan's mail-order pharmacy

For more information about these pharmacy choices and filling your prescriptions, go to Chapter 5 and our plan's *Provider Directory* **www.Humana.com/FindCare.**

Section 5.2 Your costs for a *one-month* supply of a covered drug

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

The amount of the copayment or coinsurance depends on the cost-sharing tier.

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

Your costs for a *one-month* supply of a covered Part D drug:

	Standard retail cost-sharing (in-network) (up to a 30 day supply)	**Mail-order cost-sharing (up to a 30 day supply)**	**Long-term care (LTC) cost-sharing (up to a 31 day supply)**	**Out-of-network cost-sharing (up to a 30 day supply)** (coverage is limited to certain situations; see Chapter 5 for details.)*
Cost-Sharing Tier 1 (Preferred Generic)	$2	$2	$2	$2
Cost-Sharing Tier 2 (Generic)	$10	$10	$10	$10
Cost-Sharing Tier 3 (Preferred Brand)	$40	$40	$40	$40
Cost-Sharing Tier 3 (Insulin)	25% coinsurance with $35 maximum out-of-pocket per prescription	25% coinsurance with $35 maximum out-of-pocket per prescription	25% coinsurance with $35 maximum out-of-pocket per prescription	25% coinsurance with $35 maximum out-of-pocket per prescription
Cost-Sharing Tier 4 (Non-Preferred Drug)	$75	$75	$75	$75
Cost-Sharing Tier 4 (Insulin)	25% coinsurance with $35 maximum out-of-pocket per prescription	25% coinsurance with $35 maximum out-of-pocket per prescription	25% coinsurance with $35 maximum out-of-pocket per prescription	25% coinsurance with $35 maximum out-of-pocket per prescription
Cost-Sharing Tier 5 (Specialty)	$75	$75	$75	$75
Cost-Sharing Tier 5 (Insulin)	25% coinsurance with $35 maximum out-of-pocket per prescription	25% coinsurance with $35 maximum out-of-pocket per prescription	25% coinsurance with $35 maximum out-of-pocket per prescription	25% coinsurance with $35 maximum out-of-pocket per prescription

Not all tiers may include insulin. Please refer to your Prescription Drug Guide to confirm insulin coverage.

Go to Section 7 of this chapter for more information on cost sharing for Part D vaccines.

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

If you get less than a full month's supply of certain drugs, you won't have to pay the full month's supply.

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

- If you're responsible for a copayment for the drug, you only pay for the number of days of the drug that you get instead of a whole month. We 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 get.

Section 5.4 Your costs for a *long-term* (up to a 90-day) supply of a covered Part D drug

For some drugs, you can get a long-term supply (also called an extended supply). A long-term supply is up to a 90-day supply.

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

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

Your costs for a *long-term* supply of a covered Part D drug:

	Standard retail cost-sharing (in-network) (up to a 90 day supply)	**Mail-order cost-sharing (in-network) (up to a 90 day supply)**
Cost-Sharing Tier 1 (Preferred Generic)	$4	$4
Cost-Sharing Tier 2 (Generic)	$20	$20
Cost-Sharing Tier 3 (Preferred Brand)	$80	$80
Cost-Sharing Tier 3 (Insulin)	25% coinsurance with $80 maximum out-of-pocket per prescription	25% coinsurance with $80 maximum out-of-pocket per prescription
Cost-Sharing Tier 4 (Non-Preferred Drug)	$150	$150
Cost-Sharing Tier 4 (Insulin)	25% coinsurance with $105 maximum out-of-pocket per prescription	25% coinsurance with $105 maximum out-of-pocket per prescription
Cost-Sharing Tier 5 (Specialty)	A long-term supply is not available for drugs in Tier 5	A long-term supply is not available for drugs in Tier 5

Not all tiers may include insulin. Please refer to your Prescription Drug Guide to confirm insulin coverage.

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

Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach $2,100

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach $2,100. You then move to the Catastrophic Coverage Stage.

The *SmartSummary* you get will help you keep track of how much you, our plan, and any third parties, have spent on your behalf during the year. Not all members will reach the $2,100 limit in a year.

We'll let you know if you reach this $2,100 amount. Go to Section 1.3 for more information on how Medicare calculates your out-of-pocket costs.

SECTION 6 The Catastrophic Coverage Stage

- In the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs. You enter the Catastrophic Coverage Stage when your out-of-pocket costs reach the $2,100 limit for the calendar year. Once you're in the Catastrophic Coverage Stage, you'll stay in this payment stage until the end of the calendar year.
    - During this payment stage, you pay nothing for your covered Part D drugs.

SECTION 7 What you pay for Part D Vaccines

Important message about what you pay for vaccines - Some vaccines are considered medical benefits and are covered under Part B. Other vaccines are considered Part D drugs. You can find these vaccines listed in our plan's Drug Guide. Our plan covers most adult Part D vaccines at no cost to you. Refer to your plan's Drug Guide or contact Humana Group Medicare Customer Care for coverage and cost-sharing details about specific vaccines.

There are 2 parts to our coverage of Part D vaccines:

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

Your costs for a Part D vaccine depend on 3 things:

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

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

- When you get a vaccine, you may have to pay the entire cost for both the vaccine itself and the cost for the provider to give you the vaccine. You can ask our plan to pay you back for our share of the cost under your Part D benefit. For most adult Part D vaccines, this means you'll be reimbursed the entire cost you paid.
- Other times, when you get the vaccine, you will pay only your share of the cost under your Part D benefit. For most adult Part D vaccines, you will pay nothing.

Below are 3 examples of ways you might get a Part D vaccine.

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

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

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

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

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

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

CHAPTER 7:

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

SECTION 1 Situations when you should ask us to pay our share for covered services or drugs

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

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

Examples of situations in which you may need to ask our plan to pay you back or to pay a bill you got:

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

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

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

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

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

- While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we can't pay a provider who isn't eligible to participate in Medicare. If the provider isn't eligible to participate in Medicare, you'll be responsible for the full cost of the services you get.

2. **When a network provider sends you a bill you think you shouldn't pay**

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

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

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

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

3. **If you're retroactively enrolled in our plan.**

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

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

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

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

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

   - Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out-of-network pharmacies in limited circumstances. Go to Chapter 5, Section 2.5 to learn about of these circumstances. We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount we'd pay at an in-network pharmacy.

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

   If you don't have our plan membership card with you, you can ask the pharmacy to call our plan or look up our plan enrollment information. If the pharmacy can't 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. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

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

   You may pay the full cost of the prescription because you find the drug isn't covered for some reason.

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

   - Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor to pay you back for our share of the cost. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

When you send us a request for payment, we'll review your request and decide whether the service or drug should be covered. This is called making a coverage decision. If we decide it should be covered, we'll pay for our share of the cost for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 9 has information about how to make an appeal.

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

You can ask us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records. **You must submit your Part C (medical and dental) claim to us within 12 months** of the date you got the service, item, or Part B drug. **You must submit your Part D (prescription drug) claim to us within 36 months** of the date you received the drug.

To make sure you're 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'll help us process the information faster. The data we need to make a decision are listed below. Because we might need other information to make a reimbursement determination in some cases, we strongly encourage you to provide any other information you can to support your request.

  - Your name and the member ID from your Humana ID card,
  - Your receipt or other proof of your payment
  - An itemized statement from the provider showing the services provided that includes the following information. If the information isn't included on the provider's itemized statement, you'll need to contact the provider to request it.

    - Date(s) of service for those services provided
    - Provider or supplier's name, address, National Provider Identifier (NPI), and Tax ID Number (TIN)
    - If a different provider ordered the service or referred you to the rendering provider, the name, address, NPI and TIN for the ordering/referring provider
    - Description of each service or supply provided, and the following service codes:
      - Revenue code(s), if applicable
      - Relevant CPT and HCPCS code(s)
    - Charge for each service provided
    - Description of illness or injury and diagnosis code(s)
    - Place of treatment

- Your, or your legal representative's, signature

- Download a copy of the form from our website at **(https://www.Humana.com/member/documents-and-forms)** or call Humana Group Medicare Customer Care and ask for the form. (Phone numbers for Humana Group Medicare Customer Care are located in Chapter 2, Section 1 of this booklet.)

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

Requests for payment for Medical Services:

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

Requests for payment for Part D Drugs:

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

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

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

- If we decide the medical care or drug is covered and you followed all the rules, we'll pay for our share of the cost. Our share of the cost might not be the full amount that you paid (for example, if you got a drug at an out-of network pharmacy or if the cash price you paid for a drug is higher than our negotiated price). If you already paid for the service or drug, we'll mail your reimbursement of our share of the cost to you. If you haven't paid for the service or drug yet, we'll mail the payment directly to the provider.

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

Section 3.1 If we tell you that we pay for all or part of the medical care or drug, you can make an appeal

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

CHAPTER 8:

Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities

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

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

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

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

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

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

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

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

Si tiene alguna dificultad para obtener información de nuestro plan en un formato que sea accesible y apropiado, llame para presentar una queja formal ante el Departamento de Servicios para Afiliados 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 you get timely access to covered services and drugs

You have the right to choose a provider for your care.

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

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

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

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws. A right to be treated with respect and recognition of their **dignity** and their right to privacy.

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

How do we protect the privacy of your health information?

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

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

You have the right to look at your medical records held at our plan, and to get a copy of your records. We're 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'll work with your health care provider to decide whether the changes should be made.

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

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

Insurance ACE
Notice of Privacy Practices

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

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

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

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

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

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

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

How do we protect your information?
In keeping with federal and state laws and our own policy, we have a responsibility to protect the privacy of your information. We have administrative, technical and physical safeguards in place to protect your information in various ways including:

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

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

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

We have the right to use and disclose your information:

- To a doctor, a hospital, or other health care provider so you can receive medical care.
- For payment activities, include claims payment for covered services provided to you by healthcare providers and for health plan premium payments.
- For health care operation activities including processing your enrollment, responding to your inquiries and requests for services, coordinating your care, resolving disputes, conducting medical management, improving quality, reviewing the competence of health care professionals, and determining premiums.
- For performing underwriting activities. However, we will not use any results of genetic testing or ask questions regarding family history.
- To your plan sponsor to permit them to perform, plan administration functions such as eligibility, enrollment and disenrollment activities. We may share summary level health information about you with your plan sponsor in certain situations such as to allow your plan sponsor to obtain bids from other health plans. We will not share detailed health information to your plan sponsor unless you provide us your permission, or your plan sponsor must certify they agree to maintain the privacy of your information.

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

Additional restriction on use and disclosure for specific types of information:

- Some federal and state laws may restrict the use and disclosure of certain sensitive health information such as: Substance Use Disorder; Biometric Information; Child or Adult Abuse or Neglect, including Sexual Assault; Communicable Diseases; Genetic Information; HIV/AIDS; Mental Health; Reproductive Health; and Sexually Transmitted Diseases.

- Reproductive Health Information: We will not use or disclose information to conduct an investigation into identifying (or the attempt to impose liability against) any person for the act of seeking, obtaining, providing, or facilitating lawful reproductive health care. In response to a government agency's (or other person's) request for information that might be related to reproductive health care, the person making the request must provide a signed attestation that the purpose of the request does not violate the prohibition on disclosing reproductive health care information.

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

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

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

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

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

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

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

- Amendment - You have the right to request correction of any of this personal information through amendment or deletion. Within 60 business days of receipt of your written request, we will notify you of our amendment or deletion of the information in dispute, or of our refusal to make such correction after further investigation.

- If we refuse to amend or delete the information in dispute, you have the right to submit to us a written statement of the reasons for your disagreement with our assessment of the information in dispute and what you consider to be the correct information. We shall make such a statement accessible to any and all parties reviewing the information in dispute. *

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

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

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

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

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

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

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

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

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

How do I exercise my rights or obtain a copy of this notice?
All of your privacy rights can be exercised by obtaining the applicable forms. You may obtain any of the forms by:

- Contacting us at 866-861-2762
- Accessing our Website at **Humana.com** and going to the Privacy Practices link
- Send completed request form to:

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

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

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

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

If you want any of the following kinds of information, call Humana Group Medicare Customer Care.

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

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

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

- We have special programs that focus on keeping you healthy, detecting early identification of health risks, ensuring your care is delivered safely and efficiently across all levels of care, and managing chronic conditions. Our care management program offers supportive services to members with complicated medical conditions, or those who have been hospitalized. The Humana Care Management team will help you navigate through the health care system and assist in coordinating your care. We have programs to help people manage health conditions like diabetes, congestive heart failure, chronic obstructive pulmonary disease (COPD) and other illness. In addition, the Humana Care Management team is available to assist with the coordination of care and benefits. All of these programs are voluntary. If you qualify and are contacted about one of these programs, we encourage you to participate as most members find care management to be very helpful. You may choose to discontinue it anytime by letting your care manager know. If you would like more information about these health programs, call the Nurse Advice Line at 1-800-491-4164, TTY 711

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

Section 1.5 You have the right to know your treatment options and participate in decisions about your care

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

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

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

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

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

You have the right to give instructions about what's to be done if you can't 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 *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.

Legal documents you can use to give directions in advance in these situations are called **advance directives**. Documents like a **living will** and **power of attorney for health care** are examples of advance directives.

How to set up an advance directive to give instructions:

- **Get a form.** You can get an advance directive form from your lawyer, a social worker, or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also call Humana Group Medicare Customer Care to ask for the forms.
- **Fill it out the form and sign it.** No matter where you get this form, that it's a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to the right people.** Give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

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

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

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

If your instructions aren't followed

If you sign an advance directive and you believe that a doctor or hospital didn't follow the instructions in it, you can 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 ask us to reconsider decisions we made

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

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

If you have any problems, concerns, or complaints and need to ask for coverage, or make an appeal, Chapter 9 of this document tells what you can do. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

Section 1.7 If you believe you're being treated unfairly, or your rights aren't being respected?

If you believe you've been treated unfairly or your rights haven't been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, 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.

If you believe you've been treated unfairly or your rights haven't been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you're having from these places:

- You can **call Humana Group Medicare Customer Care.**
- **Call your local SHIP**. You'll find numbers and website URLs in Exhibit A in the back of this document.
- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227), (TTY users call 1-877-486-2048 .)

Section 1.8 How to get more information about your rights

Get more information about your rights from these:

- **Call our Humana Group Medicare Customer Care.**
- **Call your local SHIP**. You'll find numbers and website URLs in Exhibit A in the back of this document.
- Contact **Medicare**.
  - Visit **www.Medicare.gov** read the publication Medicare Rights & Protections. (available at: **www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf** .)
  - Call 1-800-MEDICARE (1-800-633-4227), (TTY users call 1-877-486-2048.)

SECTION 2 Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. .For questions, call Humana Group Medicare Customer Care.

- **Get familiar with your covered services or drugs and the rules you must follow to get these covered services or drugs.** Use this Evidence of Coverage to learn what's covered and the rules you need to follow to get covered services.
  - Chapters 3 and 4 give details about medical services.
  - Chapters 5 and 6 give details about Part D prescription drug coverage.
- **If you have any other health coverage or drug coverage in addition to our plan, you're required to tell us**. Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you're enrolled in our plan.** Show our plan membership card whenever you get medical care or Part D drugs .
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions you and your doctors agree on.
  - Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have questions, be sure to ask and get an answer you can understand .

- **Be considerate.** We expect our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.

- **Pay what you owe.** As a plan member, you're responsible for these payments:

  - You must pay our plan premiums.

  - You must continue to pay your Medicare Part B premiums to stay a member of our plan.

  - For most of your medical services or drugs covered by our plan, you must pay your share of the cost when you get the service or drug.

  - If you're required to pay a late enrollment penalty, you must pay the penalty to keep your drug coverage.

  - If you're required to pay the extra amount for Part D because of your yearly income, you must continue to pay the extra amount directly to the government to stay a member of our plan.

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

- **If you move *outside* our plan service area, you can't stay a member of our plan.**

- If you move, tell Social Security (or the Railroad Retirement Board).

- A right to make recommendations regarding the organization's member rights and responsibilities policy.

CHAPTER 9:

If you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 What to do if you have a problem or concern

This chapter explains 2 types of processes for handling problems and concerns:

- For some problems, you need to use the **process for coverage decisions and appeals**.
- For other problems, you need to use the **process for making complaints** (also called grievances).

Both processes have been approved by Medicare. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

The information in this chapter will help you identify the right process to use and what to do.

Section 1.1 Legal terms

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people. To make things easier, this chapter uses more familiar words in place of some legal terms.

However, it's sometimes important to know the correct legal terms. To help you know which terms to use to get the right help or information, we include these legal terms when we give details for handling specific situations.

SECTION 2 Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Customer Care for help. In some situations, you may also want help or guidance from someone who isn't connected with us. Two organizations that can help are:

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you're 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'll find phone numbers and website URLs in Exhibit A at the end of this document.

Medicare

You can also contact Medicare for help.

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.
- Visit **www.Medicare.gov/**

SECTION 3 Which process to use for your problem

Is your problem or concern about your benefits or coverage? This includes problems about whether medical care (medical items, services and/or Part B drugs) are covered or not, the way they are covered, and problems related to payment for medical care.	
Yes. Go to **Section 4, A guide to coverage decisions and appeals.**	**No.** Go to **Section 10, 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 coverage decisions and appeals

Coverage decisions and appeals deal with problems about your benefits and coverage for medical care (services, items and Part B drugs, including payment). To keep things simple, we generally refer to medical items, services and Medicare Part B drugs as **medical care**. You use the coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions before you get services

If you want to know if we'll cover medical care before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical care. For example, if your plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either you or your network doctor can show that you got a standard denial notice for this medical specialist, or the *Evidence of Coverage* makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we'll cover a particular medical service or refuses to provide medical care you think that you need.

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'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We make a coverage decision whenever we decide what is covered for you and how much we pay. In some cases, we might decide medical care or drug isn't covered or is no longer covered for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after you get a benefit, and you aren't satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, you can ask for an expedited or **fast appeal** of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we properly follow the rules. When we complete the review, we give you our decision. In limited circumstances a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we say no to all or part of your Level 1 appeal for medical care, your appeal will automatically go to a Level 2 appeal conducted by an independent review organization that isn't connected to us.

- You don't need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we don't fully agree with your Level 1 appeal.
- Go to **Section 6.6** more information about Level 2 appeals.
- Part D appeals are discussed further in Section 6.

If you aren't satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (this chapter explains the Level 3, 4, and 5 appeal processes).

Section 4.1 Get help asking for a coverage decision or making an appeal

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- **Call Humana Group Medicare Customer Care.**
- **Get free help** from your State Health Insurance Assistance Program.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Call Humana Group Medicare Customer Care and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at **www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.**)
    - For medical care or Part B drugs, your doctor can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
    - For Part D drugs, your doctor or other prescriber can ask for a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied, your doctor or prescriber can ask a Level 2 appeal.
- **You can ask someone to act on your behalf.** You can name another person to act for you as your *representative* to ask for a coverage decision or make an appeal.

- If you want a friend, relative or other person to be your representative, call Humana Group Medicare Customer Care and ask for the *Appointment of Representative* form (The form is also available on Medicare's website at **www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf** or on our website at **https://www.humana.com/member/documents-and-forms**). This form gives that person permission to act on your behalf. It must be signed by you and by the person who you want to act on your behalf. You must give us a copy of the signed form.

- We can accept an appeal request from a representative without the form, but we can't complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.

- **You also have the right to hire a lawyer.** You can 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 aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.2 Rules and deadlines for different situations

There are 4 different types of situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines. We give the details for each of these situations:

- **Section 5**: Medical care: How to ask for a coverage decision or make an appeal

- **Section 6**: Part D drugs: How to ask for a coverage decision or make an appeal

- **Section 7**: How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon

- **Section 8**: How to ask us to keep covering certain medical services if you think your coverage is ending too soon (*Applies only to these services:* home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which information applies to you, call Humana Group Medicare Customer Care. You can also get help or information from your SHIP.

SECTION 5 Medical care: How to ask for a coverage decision or make an appeal

Section 5.1 What to do if you have problems getting coverage for medical care or want us to pay you back for our share of the cost of your care

Your benefits for medical care are described in Chapter 4 in the Medical Benefits Chart. In some cases, different rules apply to a request for a Part B drug. In those cases, we'll explain how the rules for Part B drugs are different from the rules for medical items and services.

This section tells what you can do if you're in any of the 5 following situations:

1. You aren't getting certain medical care you want, and you believe this is covered by our plan. **Ask for a coverage decision. Section 5.2.**

2. Our plan won't approve the medical care your doctor or other medical provider wants to give you, and you believe this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**

3. You got medical care that you believe should be covered by our plan, but we said we won't pay for this care. **Make an appeal. Section 5.3.**

4. You got and paid for medical care that you believe should be covered by our plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5**

5. You're told that coverage for certain medical care you've been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 5.3.**

NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, go to sections 7 and 8 of this Chapter. Special rules apply to these types of care.

Section 5.2 How to ask for a coverage decision

Legal Terms:
A coverage decision that involves your medical care, it is called an **organization determination.**

A fast coverage decision is called an **expedited determination.**

Step 1: Decide if you need a standard coverage decision or a fast coverage decision.

A standard coverage decision is usually made within 7 calendar days when the medical item or service is subject to our prior authorization rules, 14 calendar days all other medical items and services, or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. To get a fast coverage decision, you must meet 2 requirements:

- You may *only ask* for coverage for medical items and/or services (not requests for payment for items and/or services you already got).
- 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 regain function.*
- **If your doctor tells us that your health requires a fast coverage decision, we'll automatically agree to give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor's support, we'll decide whether your health requires that we give you a fast coverage decision.** If we don't approve a fast coverage decision, we'll send you a letter that:
  - Explains that we'll use the standard deadlines.
  - Explains if your doctor asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
  - Explains that you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for.

Step 2: Ask our plan to make a coverage decision or fast coverage decision.

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this. Chapter 2 has contact information.

Step 3: We consider your request for medical care coverage and give you our answer.

For standard coverage decisions we use the standard deadlines.

This means we'll give you an answer within 7 calendar days after we get your request for a medical item or service that is subject to our prior authorization rules. If your requested medical item or service is not subject to our prior authorization rules, we'll give you an answer within 14 calendar days after we get your request. If your request is for a Part B drug, we'll give you an answer within 72 hours after we get your request.

- **However,** if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a fast complaint. We'll give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. Go to Section 10 for information on complaints .)

For fast coverage decisions we use an expedited timeframe.

A fast coverage decision means we'll answer within 72 hours if your request is for a medical item or service. If your request is for a Part B drug, we'll answer within 24 hours.

- **However,** if you ask for more time, or if we need more information that may benefit you **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.

- If you believe we shouldn't take extra days, you can file a fast complaint. (Go to Section 10 for information on complaints.) We'll call you as soon as we make the decision.

- If our answer is no to part or all of what you asked for, we'll send you a written statement that explains why we said no.

Step 4: If we say no to your request for coverage for medical care, you can appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the medical care coverage you want. If you make an appeal, it means you're going on to Level 1 of the appeals process.

Section 5.3 How to make a Level 1 appeal

Legal Terms:
An appeal to our plan about a medical care coverage decision is called a plan **reconsideration.**

A fast appeal is also called an **expedited reconsideration.**

Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal is usually made within 30 calendar days or 7 calendar days for Part B drugs. A fast appeal is generally made within 72 hours.

- If you're appealing a decision we made about coverage for care, you and/or your doctor need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we'll give you a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 5.2 of this chapter.

Step 2: Ask our plan for an appeal or a fast appeal

- **If you are asking for a standard appeal, submit your standard appeal in writing.** You may also ask for an appeal by calling us. Chapter 2 has contact information.
- **If you are asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.** We are allowed to charge a fee for copying and sending this information to you.

Step 3: We consider your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take a careful look at all of the information. We check to see if we follow all the rules when we said no to your request.
- We'll gather more information if needed and may contact you or your doctor.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal.** We'll give you our answer sooner if your health requires us to.
  - If you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time if your request is for a Part B drug.
  - If we don't give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage we have agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for,** we'll automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we receive your appeal. We'll give you our decision sooner if your health condition requires us to.
  - If you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - If you believe we shouldn't take extra days, you can file a fast complaint. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (Go to Section 10 of this chapter for information on complaints.)
  - If we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Part B drug.

- **If our plan says no to part or all of your appeal,** we'll automatically send your appeal to the independent review organization for a Level 2 appeal.

Section 5.4 The Level 2 Appeal process

Legal Term
The formal name for the independent review organization is the **Independent Review Entity.** It's sometimes called the **IRE.**

The independent review organization is an independent organization hired by Medicare. It isn't connected with us and isn't a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: The independent review organization reviews your appeal.

- We'll send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file** . We're allowed to charge you a fee for copying and sending this information to you.

- You have a right to give the independent review organization additional information to support your appeal.

- Reviewers at the independent review organization will take a careful look at all of the information about your appeal.

If you had a fast appeal at Level 1, you'll also have a fast appeal at Level 2.

- For the fast appeal the independent review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it gets your appeal.

- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

If you had a standard appeal at Level 1, you'll also have a standard appeal at Level 2

- For the standard appeal if your request is for a medical item or service the independent review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it receives your appeal. If your request is for a Part B drug, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it gets your appeal.

- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

Step 2: The independent review organization gives you its answer.

The independent review organization will tell you its decision in writing and explain the reasons for it.

- **If the independent review organization says yes to part or all of a request for a medical item or service,** we must authorize the medical care coverage within **72 hours** or provide the service within 14 calendar days after we get the decision from the independent review organization for **standard requests**. For **expedited requests**, we have **72 hours** from the date we get the decision from the independent review organization.

- **If the independent review organization says yes to part or all of a request for a Part B drug**, we must authorize or provide the Part B drug within **72 hours** after we get the decision from the independent review organization for **standard requests.** For **expedited requests** we have **24 hours** from the date we get the decision from the independent review organization.

- **If this organization says no to part or all of your appeal** , it means it agrees with us that your request (or part of your request) for coverage for medical care shouldn't be approved. (This is called **upholding the decision**. It is also called **turning down your appeal** .) In this case, the independent review organization will send you a letter that:

  - Explains the decision.

  - Lets you know about your right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.

  - Tells you how to file a Level 3 appeal.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 explains the Levels 3, 4, and 5 of the appeals processes.

Section 5.5 If you're asking us to pay for our share of a bill you got for medical care

Chapter 7 describes when you may need to ask for reimbursement or to pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork asking for reimbursement, you're asking for a coverage decision. To make this decision, we'll check to see if the medical care you paid for is covered. We'll also check to see if you followed the rules for using your coverage for medical care.

- **If we say yes to your request:** If the medical care is covered and you followed the rules, we'll send you the payment for our share of the cost typically within 30 calendar days, but no later than 60 calendar days after we get your request. If you haven't paid for the medical care, we'll send the payment directly to the provider.
- **If we say no to your request:** If the medical care is *not* covered, or you did *not* follow all the rules, we won't send payment. Instead, we'll send you a letter that says we won't pay for the medical care and the reasons why.

If you don't agree with our decision to turn you down, you can make an appeal. If you make an appeal, it means you're asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals in Section 5.3 . For appeals concerning reimbursement, note:

- We must give you our answer within 60 calendar days after we get your appeal. If you're asking us to pay you back for medical care you already got and paid for, you aren't allowed to ask for a fast appeal.

- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you asked for to you or the provider within 60 calendar days.

SECTION 6 Part D drugs: How to ask for a coverage decision or make an appeal

Section 6.1 What to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (Go to Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs go to see Chapters 5 and 6. **This section is about your Part D drugs only.** To keep things simple, we generally say *drug* in the rest of this section, instead of repeating *covered outpatient prescription drug* or *Part D drug* every time. We also use the term Drug Guide instead of *List of Covered Drugs* or *formulary.*

- If you don't know if a drug is covered or if you meet the rules, you can ask us. Some drugs require you to get approval from us before we'll cover it.

- If your pharmacy tells you that your prescription can't be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

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

A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your drugs. This section tells what you can do if you are in any of the following situations:

- Asking to cover a Part D drug that's not on our plan's Drug Guide. **Ask for an exception. Section 6.2**

- Asking to waive a restriction on our plan's coverage for a drug (such as limits on the amount of the drug you can get , prior authorization criteria, or the requirement to try another drug first). **Ask for an exception. Section 6.2**
- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier. **Ask for an exception. Section 6.2**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 6.4**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 6.4**

If you disagree with a coverage decision we made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to ask for an appeal.

Section 6.2 Asking for an exception

Legal Terms:
Asking for coverage of a drug that's not on the Drug Guide is a **formulary exception.**

Asking for removal of a restriction on coverage for a drug is a **formulary exception.**

Asking to pay a lower price for a covered non-preferred drug is a **tiering exception.**

If a drug isn't covered in the way you'd like it to be covered, you can ask us to make an **exception**. An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that's not on our Drug Guide.** If we agree to cover a drug not on the Drug Guide, you'll need to pay the cost-sharing amount that applies to drugs in Cost-Sharing Tier 3 - Non-Preferred Drug. You can't ask for an exception to the cost-sharing amount we require you to pay for the drug.

2. **Removing a restriction for a covered drug** . Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our Drug Guide. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the cost-sharing amount we require you to pay for the drug.

3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug Guide is in one of 5 cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

   - If our Drug Guide contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s).

   - If the drug you're taking is a biological product you can ask us to cover your drug at a lower cost-sharing amount. This would be the lowest tier that contains brand name alternatives for treating your condition.

   - If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.

   - If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.

   - If your drug is in the Non-Preferred Drug tier you can ask us to cover it at the cost sharing amount that applies to drugs in the Preferred Brand tier. Also, if your generic drug is in the Preferred Brand tier you can ask us to cover it at the cost-sharing amount that applies to the Preferred Generic and Generic tier. This would lower your share of the cost for the drug.

   - You can't ask us to change the cost-sharing tier for any drug in the Specialty tier.

   - If we approve your tiering exception request and there is more than one lower cost-sharing tier with alternative drugs you can't take, you'll usually pay the lowest amount.

Section 6.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons you're asking for an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Our Drug Guide typically 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're asking for and wouldn't cause more side effects or other health problems, we generally won't approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request you can ask for a review by making an appeal.

Section 6.4 How to ask for a coverage decision, including an exception

Legal Term:
A fast coverage decision is called an **expedited coverage determination.**

Step 1: Decide if you need a standard coverage decision or a fast coverage decision.

Standard coverage decisions are made within **72 hours** after we get your doctor's statement.
Fast coverage decisions are made within **24 hours** after we get your doctor's statement.

If your health requires it, ask us to give you a fast coverage decision. **To get a fast coverage decision, you must meet 2 requirements:**

- You must be asking for a drug you didn't get yet. (You can't ask for fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- **If your doctor or other prescriber tells us that your health requires a fast coverage decision, we'll automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we'll decide whether your health requires that we give you a fast coverage decision.** If we don't approve a fast coverage decision, we'll send you a letter that:

- Explains that we'll use the standard deadlines.
- Explains if your doctor or other prescriber asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
- Tells you how you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for. We'll answer your complaint within 24 hours of receipt.

Step 2: Ask for a standard coverage decision or a fast coverage decision.

Start by calling, writing, or faxing our plan to ask us to authorize or provide coverage for the medical care you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the *CMS Model Redetermination Request Form* or on our plan's form, which is OR are available on our website. Chapter 2 has contact information. To help us process your request, include your name, contact information, and information that shows which drug is being requested.

You, your doctor (or other prescriber), or your representative can do this. You can also have a lawyer act on your behalf. Section 4 tells how you can give written permission to someone else to act as your representative.

- **If you're asking for an exception, provide the supporting statement** which is the medical reasons for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

Step 3: We consider your request and give you our answer.

Deadlines for a fast coverage decision

- We must generally give you our answer **within 24 hours** after we get your request.
  - For exceptions, we'll give you our answer within 24 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
  - If we don't meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

If our answer is yes to part or all of what you asked for, we must provide the coverage we agreed to within 24 hours after we get your request or doctor's statement supporting your request.

- **If our answer is no to part or all of what you asked for** , we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Deadlines for a standard coverage decision about a drug you didn't get yet

- We must generally give you our answer **within 72 hours** after we get your request.
  - For exceptions, we'll give you our answer within 72 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
  - If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it'll be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for,** we must provide the coverage we have agreed to provide within 72 hours after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for** , we'll send you a written statement that explains why we said no. We'll 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 get your request.
  - If we don't meet this deadline, we're required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for** , we're 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 asked for** , we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

<u>Step 4:</u> If we say no to your coverage request, you can make an appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the drug coverage you want. If you make an appeal, it means you're going on to Level 1 of the appeals process.

Section 6.5 How to make a Level 1 appeal

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

A fast appeal is called an **expedited redetermination.**

Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal is usually made within 7 calendar days. A fast appeal is generally made within 72 hours. If your health requires it, ask for a fast appeal

- If you're appealing a decision we made about a drug you didn't get yet, you and your doctor or other prescriber will need to decide if you need a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 6.4 of this chapter.

Step 2: You, your representative, doctor or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a **fast appeal.**

- **For standard appeals, submit a written request.** Chapter 2 has contact information.
- **For fast appeals either submit your appeal in writing or call us at 1-800-867-6601.** Chapter 2 has contact information.
- **We must accept any written request,** including a request submitted on the *CMS Model Redetermination Request Form*, which is available on our website **https://www.humana.com/member/member-rights/medical-pharmacy-preauthorizations**. Include your name, contact information, and information about your claim to help us process your request.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.

- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal. We're allowed to charge a fee for copying and sending this information to you.

Step 3: We consider your appeal and give you our answer

When we review your appeal, we take another careful look at all the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a fast appeal

- *For fast appeals*, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.
  - If we don't give you an answer within 72 hours, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for** , we'll send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal for a drug you didn't get yet

- For standard appeals, we must give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if you didn't get the drug yet and your health condition requires us to do so.
  - If we don't give you a decision within 7 calendar days, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we get your appeal.

- **If our answer is no to part or all of what you asked for** , we'll send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal about payment for a drug you already bought

- We must give you our answer **within 14 calendar days** after we get your request.
  - If we don't meet this deadline, we're required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for,** we're also required to make payment to you within 30 calendar days after we get your request.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make another appeal.

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

Section 6.6 How to make a Level 2 appeal

Legal Term:
The formal name for the independent review organization is the **Independent Review Entity.** It is sometimes called the **IRE.**

The **independent review organization is an independent organization hired by Medicare.** It isn't connected with us and isn't a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

- If we say no to your Level 1 appeal, the written notice we send you'll 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 the independent organization.

- **You must make your appeal request within 65 calendar days** from the date on the written notice.

- If we did not complete our review within the applicable timeframe or make an unfavorable decision regarding an **at-risk** determination under our drug management program, we'll automatically forward your request to the IRE.

- We'll send the information about your appeal to the independent review organization. This information is called your **case file. You have the right to ask us for a copy of your case file**. We're allowed to charge you a fee for copying and sending this information to you.

- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal .

Reviewers at the independent review organization will take a careful look at all of the information about your appeal.

Deadlines for fast appeal

- If your health requires it, ask the independent review organization for a fast appeal.

- If the organization agrees to give you a fast appeal, the review organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.

Deadlines for standard appeal

For standard appeals, the independent 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 didn't get yet. If you're asking us to 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 gets your request.

Step 3: The independent review organization gives you its answer.

For fast appeals

- **If the independent review organization says yes to part or all of what you asking for,** we must provide the drug coverage that was approved by the independent review organization **within 24 hours** after we receive the decision from the independent review organization.

For standard appeals

- **If the independent review organization says yes to part or all of your request for coverage,** we must provide the drug coverage that was approved by the review organization **within 72 hours** after we receive the decision from the independent review organization.

- **If the independent review organization says yes to part or all of your request to pay you back** for a drug you already bought, we're required to **send payment to you within 30 calendar days** after we get the decision from the independent review organization.

What if the independent review organization says no to your appeal?

If this organization says no to **part or all of** your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called **upholding the decision.** It is also called **turning down your appeal.**). In this case, the independent review organization will send you a letter that:

- Explains the decision.

- Lets you know about your right to a Level 3 appeal if the dollar value of the drug coverage you're asking for meets a certain minimum. If the dollar value of the drug coverage you're asking for is too low, you can't make another appeal and the decision at Level 2 is final.

- Tells you the dollar value that must be in dispute to continue with the appeals process.

Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal).

- If you want to go on to Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 Appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon

When you're admitted to a hospital, you have the right to get all covered hospital services necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day you leave the hospital. They'll help arrange for care you may need after you leave.

- The day you leave the hospital is called your **discharge date**.
- When your discharge date has been decided, your doctor or the hospital staff will tell you.
- If you think you're being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered.

Section 7.1 During your inpatient hospital stay, you'll get a written notice from Medicare that tells you about your rights

Within 2 calendar days of being admitted to the hospital , you'll be given a written notice called *An Important Message from Medicare about Your Rights.* Everyone with Medicare gets a copy of this notice. If you don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Humana Group Medicare Customer Care or 1-800-MEDICARE (1-800-633-4227), (TTY users call 1-877-486-2048).

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you:
   - Your right to get Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
   - Your right to be involved in any decisions about your hospital stay.
   - Where to report any concerns you have about quality of your hospital care.
   - Your right to **request an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so we'll cover your hospital care for a longer time.

2. **You'll be asked to sign the written notice to show that you got it and understand your rights.**
   - You or someone who is acting on your behalf will be asked to sign the notice.
   - Signing the notice shows *only* that you got the information about your rights. The notice doesn't give your discharge date. Signing the notice **doesn't mean** you're agreeing on a discharge date.
3. **Keep your copy** of the notice so you have the information about making an appeal (or reporting a concern about quality of care) if you need it.
   - If you sign the notice more than 2 calendar days before discharge date, you'll get another copy before you're scheduled to be discharged.
   - To look at a copy of this notice in advance, call Humana Group Medicare Customer Care or 1-800 MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can also get the notice online at **https://www.cms.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im**

Section 7.2 How to make a Level 1 appeal to change your hospital discharge date

To ask us to cover your inpatient hospital services for a longer time, use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it** . If you have questions or need help call Humana Group Medicare Customer Care (TTY users call 711) or, call your State Health Insurance Assistance Program (SHIP) for personalized help. The services of (SHIP) counselors are free. You'll find phone numbers and website URLs in Exhibit A in the back of this document.

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you. The **Quality Improvement Organization** is a group of doctors and other health care professionals paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts aren't part of our plan.

Step 1: Contact the Quality Improvement Organization for your state and ask for a an immediate review of your hospital discharge. You must act quickly.

How can you contact this organization?

- The written notice you got (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Exhibit A in the back of this document.

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge.**
  - **If you meet this deadline,** you can to stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision on your appeal from the Quality Improvement Organization.
  - **If you don't meet this deadline,** contact us. If you decide to stay in the hospital after your planned discharge date, *you may have to pay the costs* for hospital care you get after your planned discharge date.
- Once you ask for an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we're contacted, we'll give you a **Detailed Notice of Discharge.** This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.
- You can get a sample of the **Detailed Notice of Discharge** by calling Humana Group Medicare Customer Care (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. Or you can get a sample notice online at **www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.**

You must use the network providers to get your medical care and services, by calling Humana Group Medicare Customer Care or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at **www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.**

Step 2: The Quality Improvement Organization conducts an independent review of your case.

- Health professionals at the Quality Improvement Organization (the *reviewers*) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want.

- The reviewers will also look at your medical information, talk with your doctor, and review information that we and the hospital gave them.

- By noon of the day after the reviewers told us of your appeal, you'll get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the independent review organization says *yes*, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**

- You'll have to keep paying your share of the costs (such as deductibles or copayments if these apply). In addition, there may be limitations on your covered hospital services.

What happens if the answer is no?

- If the independent review organization says *no*, they're saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.

- If the independent review organization says *no* to your appeal and you decide to stay in the hospital, **you may have to pay the full cost** of hospital care you get after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization said *no* to your appeal, *and* you stay in the hospital after your planned discharge date, you can make another appeal. Making another appeal means you're going on to **Level 2** of the appeals process.

Section 7.3 How to make a Level 2 Appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at its decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you stay in the hospital after the date your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information about your appeal.

Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you it's decision.

If the independent review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you have got since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.**

- You must continue to pay your share of the costs and coverage limitations may apply.

If the independent review organization says no:

- It means they agree with the decision they made on your Level 1 appeal.

- The notice you get will tell you in writing what you can do if you want to continue with the review process.

Step 4: If the answer is no, you need to decide whether you want to take your appeal further by going on to Level 3.

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision .

- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

When you're getting covered **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)** , you have the right to keep getting your services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it's time to stop covering any of the 3 types of care for you, we're required to tell you in advance. When your coverage for that care ends, *we'll stop paying our share of the cost for your care.*

If you think we're ending the coverage of your care too soon, **you can appeal our decision** . This section tells you how to ask for an appeal.

Section 8.1 We'll tell you in advance when your coverage will be ending

Legal Term:
Notice of Medicare Non-Coverage. It tells you how you can request a **fast-track appeal.** Asking for a fast-track appeal is a formal, legal way to ask for a change to our coverage decision about when to stop your care.

1. **You get a notice in writing** at least 2 calendar days before our plan is going to stop covering your care. The notice tells you:

   - The date when we'll stop covering the care for you.
   - How to ask for a fast track appeal to ask us covering your care for a longer period of time.

2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you got.** Signing the notice shows *only* that you have got the information about when your coverage will stop. **Signing it doesn't mean you agree** with our plan that it's time to stop getting the care.

Section 8.2 How to make a Level 1 Appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it** . If you have questions or need help call Humana Group Medicare Customer Care. Or call your State Health Insurance Assistance Program (SHIP) for personalized help. The services of SHIP counselors are free. You'll find phone numbers and website URLs in Exhibit A in the back of this document.help. The services of SHIP counselors are free. You'll find phone numbers and website URLs in Exhibit A in the back of this document.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate .

The **Quality Improvement Organization** is a group of doctors and other health care experts paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts aren't part of our plan.

<u>Step 1:</u> Make your Level 1 appeal: contact the Quality Improvement Organization ask for a fast-track appeal . You must act quickly.

How can you contact this organization?

- The written notice you got *(Notice of Medicare Non-Coverage)* tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Exhibit A in the back of this document .

Act quickly

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the Notice of Medicare Non-Coverage.
- If you miss the deadline, and you wish to file an appeal, you still have appeal rights. Contact the Quality Improvement Organization. The services of SHIP counselors are free. You'll find phone numbers and website URLs in Exhibit A in the back of this document.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

Legal Term: **Detailed Explanation of Non-Coverage.** Notice that gives details on reasons for ending coverage.

What happens during this review?

- Health professionals at the Quality Improvement Organization (the reviewers) will ask you, or your representative, why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you wish.
- The independent review organization will also look at your medical information, talk with your doctor, and review information our plan gives to them.
- By the end of the day the reviewers tell us of your appeal, and you'll get the **Detailed Explanation of Non-Coverage** from us that explains in detail our reasons for ending our coverage for your services.

Step 3: Within one full day after they have all the information they need; the reviewers will tell you its decision.

What happens if the reviewers say yes?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it is medically necessary** .
- You'll have to keep paying your share of the costs (such as deductibles or copayments, if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say *no* to your appeal, then **your coverage will end on the date we told you.**

- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, **you'll have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If reviewers say *no* to your Level 1 appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make a Level 2 appeal.

Section 8.3 How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day when the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all the information about your appeal.

Step 3: Within 14 calendar days of receipt of your appeal request, reviewers will decide on your appeal and tell you its decision.

What happens if the independent review organization says yes?

- **We must reimburse you** for our share of the costs of care you got since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it's medically necessary.

- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the independent review organization says no?

- It means they agree with the decision we made to your Level 1 appeal.

- The notice you get will tell you in writing what you can do if you want to continue with the review process. It will give you the details about how to go to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you'll need to decide whether you want to take your appeal further.

- There are 3 additional levels of appeal after Level 2, for a total of 5 levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.

- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 Taking your appeal to Level 3 and beyond

Section 9.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

This section may be right for you if you made a Level 1 appeal and a Level 2 appeal, and both of your appeals were turned down.

If the dollar value of the item or medical service you appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you can't appeal any further. The written response you get to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 level. Here's who handles the review of your appeal at each of these levels.

Level 3 Appeal
An **Administrative Law Judge** or an attorney adjudicator who works for the federal government will review your appeal and give you an answer.

- If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may* or *may not* be over. Unlike a decision at Level 2 appeal, we have the right to appeal a Level 3 decision that is favorable to you. If we decide to appeal it will go to a Level 4 appeal.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after we get the Administrative Law Judge's or attorney adjudicator's decision.
  - If we decide to appeal, we'll send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over**.
  - If you decide to accept the decision that turns down your appeal, the appeals process is over.
  - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do a level 4 appeal.

Level 4 Appeal
The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the federal government.

The Medicare Appeals Council (Council) will review your appeal and give you an answer. The Council is part of the federal government

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may* or *may not* be over**. Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We'll decide whether to appeal this decision to Level 5.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after getting the Council's decision.
  - If we decide to appeal the decision, we'll let you know in writing.

- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 Appeal
The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the federal government .

- A judge will review all the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Section 9.2 Appeal Levels 3, 4 and 5 for Part D Drug Requests

This section may be right for you if you made a Level 1 appeal and a Level 2 appeal, and both of your appeals were turned down.

If the value of the drug you appealed meets a certain dollar amount, you may be able to go to additional levels of appeal. If the dollar amount is less, you can't appeal any further. The written response you get 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 3 levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

Level 3 Appeal
An Administrative Law Judge or an attorney adjudicator who work for the federal government will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over** . We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we get the decision.
- **If the answer is no, the appeals process *may* or *may not* be over.**
  - If you decide to accept the decision that turns down your appeal, the appeals process is over.
  - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 Appeal
The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the federal government.

- **If the answer is yes, the appeals process is over** . We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we get the decision.

- **If the answer is no, the appeals process *may* or *may not* be over.**

  - If you decide to accept the decision that turns down your appeal, the appeals process is over.

  - If you don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice will tell you whether the rules allow you to go on to a Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal
A judge at the **Federal District Court** will review your appeal.

- A judge will review all the information and decide yes or no to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

MAKING COMPLAINTS

SECTION 10 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 10.1 What kinds of problems are handled by the complaint process?

The complaint process is *only* used for certain types of problems . This includes problems about quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Quality of your medical care

- Are you unhappy with the quality of the care you got (including care in the hospital)?

Respecting your privacy

- Did someone not respect your right to privacy or share confidential information?

Disrespect, poor customer service, or other negative behaviors

- Has someone been rude or disrespectful to you?
- Are you unhappy with our Humana Group Medicare Customer Care ?
- Do you feel you're being encouraged to leave the plan?

Waiting times

- Are you having trouble getting an appointment, or waiting too long to get it?
- Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Humana Group Medicare Customer Care or other staff at our plan?
    - Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.

Cleanliness

- Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?

Information you get from us

- Did we fail to give you a required notice ?
- Is our written information hard to understand?

Timeliness

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

If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples:

- You asked us for a fast coverage decision or a fast appeal, and we said no, you can make a complaint.
- You believe we aren't meeting the deadlines for coverage decisions or appeals, you can make a complaint.
- You believe we aren't meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint.
- You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 10.2 How to make a complaint

Legal Terms:

- A **complaint** is also called a **grievance**
.
- **Making a complaint** is **filing a grievance**
- **Using the process for complaints** is called **using the process for filing a grievance.**
- A **fast complaint** is called an **expedited grievance.**

Step 1: Contact us promptly – either by phone or in writing.

- **Calling Humana Group Medicare Customer Care is usually the first step.** If there is anything else you need to do, Humana Group Medicare Customer Care will let you know.

- **If you don't 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'll respond to your complaint in writing.

- **Grievance Filing Instructions**

  File a verbal grievance by calling Humana Group Medicare Customer Care. (TTY users should call 711.) We are available Monday through Friday from 8 a.m. to 9 p.m. Eastern time.

  Send a written grievance to:
  Humana Grievances and Appeals Dept.
  P.O. Box 14165
  Lexington, KY 40512-4165

  When filing a grievance, please provide:
  - ☐ Name
  - ☐ Address
  - ☐ Telephone number
  - ☐ Member identification number
  - ☐ A summary of the complaint and any previous contact with us related to the complaint
  - ☐ The action you're 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 Humana Group Medicare Customer Care and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at **www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf**). The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.

- 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 of a 72-hour appeal.

  It's best to call Humana Group Medicare 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 Humana Group Medicare Customer Care right away.** You can make the complaint at any time after you had the problem you want to complain about.

- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

Step 2: We look into your complaint and give you our answer.

- **If possible, we'll answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.

- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we'll tell you in writing.

- **If you're making a complaint because we denied your request for a fast coverage decision or a fast appeal, we'll automatically give you a fast complaint.** If you have a fast complaint, it means we'll give you **an answer within 24 hours.**

- **If we don't agree** with some or all of your complaint or don't take responsibility for the problem you're complaining about, we'll include our reasons in our response to you.

Section 10.3 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you have 2 extra options:

- **You can make your complaint to the Quality Improvement Organization** . The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. You'll find phone numbers and website URLs in Exhibit A in the back of this document.

- **You can make your complaint to both the Quality Improvement Organization and us at the same time.**

Section 10.4 You can also tell Medicare about your complaint

You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to **https://www.medicare.gov/my/medicare-complaint .**

You can also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users call 1-877-486-2048.

CHAPTER 10:

Ending membership in our plan

SECTION 1 Ending your membership in our plan

Ending your membership in our Humana Group Medicare Advantage PPO Plan may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you decided that you want to leave. Sections 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where we're required to end your membership. Section 5 tells you about situations when we must end your membership.

If you're leaving our plan, our plan must continue to provide your medical care and prescription drugs and you will continue to pay your cost share until your membership ends.

SECTION 2 When can you end your membership in our plan?

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

Section 2.1 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of Humana Group Medicare Advantage PPO Plan may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply. These are just examples. For the full list you can contact our plan, call Medicare, or visit **(www.Medicare.gov).**

- Usually, when you move.
- If you have Medicaid.
- If we violate our contract with you.
- If you're eligible for "Extra Help" with paying for your Medicare drug coverage.
- If you're 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).

Enrollment periods may vary depending on your situation.

To find out if you're eligible for a Special Enrollment Period, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. If you're eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:

- Another Medicare health plan with or without drug coverage.
- Original Medicare *with* a separate Medicare drug plan.
- - *or* - Original Medicare *without* a separate Medicare prescription drug plan.

  Note: If you disenroll from Medicare drug coverage and go without creditable prescription drug coverage for 63 or more days in a row, you may have to pay a late enrollment penalty if you join a Medicare drug plan later.

Your membership will usually end on the first day of the month after we get your request to change our plan.

If you get "Extra Help" from Medicare to pay your drugs coverage costs: If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you opt out of automatic enrollment.

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

If you have questions about ending your membership you can:

- **Call Humana Group Medicare Customer Care** for additional information. (TTY users should call 711).
- Find the information in the ***Medicare & You 2026*** handbook.
- Call **Medicare** at 1-800-MEDICARE (1-800-633-4227) TTY users call 1-877-486-2048.

SECTION 3 How to end your membership in our plan?

The table below explains how you should end your membership in our plan.

To switch from our plan to:	Here's what to do:
• Another Medicare health plan.	• Enroll in the new Medicare health plan. • You'll automatically be disenrolled from Humana Group Medicare Advantage PPO Plan when your new plan's coverage starts.
• Original Medicare *with* a separate Medicare drug plan.	• Enroll in the new Medicare drug plan. • You'll automatically be disenrolled from Humana Group Medicare Advantage PPO Plan when your new plan's coverage starts.
• Original Medicare *without* a separate Medicare drug plan.	• **Send us a written request to disenroll.** Call Humana Group Medicare Customer Care for additional information. (TTY users should call 711). If you need more information on how to do this. • You can also call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users call 1-877-486-2048. • You'll be disenrolled from Humana Group Medicare Advantage PPO Plan when your coverage in Original Medicare starts.

SECTION 4 Until your membership ends, you must keep getting your medical items, services and drugs through our plan

Until your membership ends, and your new Medicare coverage starts, you must continue to get your medical services, items and prescription drugs through our plan.

- **Continue to use our network providers to get medical care.**
- **Continue to use our network pharmacies or mail order to get your prescriptions filled until your membership in our plan ends.**
- **If you're hospitalized on the day your membership ends, your hospital stay will usually be covered by our plan until you're discharged** (even if you are discharged after your new health coverage starts).

SECTION 5 Humana Group Medicare Advantage PPO Plan must end our plan membership in certain situations

Humana Group Medicare Advantage PPO Plan must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.
- If you move out of our service area.
- If you are away from our service area for more than 6 months.
  - If you move or take a long trip, call Humana Group Medicare Customer Care for additional information. (TTY users should call 711). To find out if the place you're moving or traveling to is in our plan's area.

- If you become incarcerated (go to prison).
- If you're no longer a United States citizen or lawfully present in the United States.
- If you lie or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you're enrolling in our plan and that information affects your eligibility for our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We can't 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 have questions or would like more information on when we can end your membership call Humana Group Medicare Customer Care for additional information. (TTY users should call 711).

Section 5.1 We can't ask you to leave our plan for any health-related reason

Humana Group Medicare Advantage PPO Plan is not allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel that you're 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 call 1-877-486-2048).

Section 5.2 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

CHAPTER 11:

Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services (CMS). In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws aren't included or explained in this document.

SECTION 2 Notice about non-discrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, 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 Advantage P lans, 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, call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at **www.HHS.gov/ocr/index**.

If you have a disability and need help with access to care, please call Humana Group Medicare Customer Care. If you have a complaint, such as a problem with wheelchair access, Humana Group Medicare Customer Care can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare isn't the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, our plan, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

SECTION 4 Additional Notice about Subrogation (Recovery from a Third Party)

Our right to recover payment

If we pay a claim for you, we have subrogation rights. This is a very common insurance provision that means we have the right to recover the amount we paid for your claim from any third party that is responsible for the medical expenses or benefits related to your injury, illness, or condition. You assign to us your right to take legal action against any responsible third party, and you agree to:

1. Provide any relevant information that we request; and
2. Participate in any phase of legal action, such as discovery, depositions, and trial testimony, if needed.

If you don't cooperate with us or our representatives, or you do anything that interferes with our rights, we may take legal action against you. You also agree not to assign your right to take legal action to someone else without our written consent.

Our right of reimbursement

We also have the right to be reimbursed if a responsible third party pays you directly. If you receive any amount as a judgment, settlement, or other payment from any third party, you must immediately reimburse us, up to the amount we paid for your claim.

Our rights take priority

Our rights of recovery and reimbursement have priority over other claims, and will not be affected by any equitable doctrine. This means that we're entitled to recover the amount we paid, even if you haven't been compensated by the responsible third party for all costs related to your injury or illness. If you disagree with our efforts to recover payment, you have the right to appeal, as explained in Chapter 9.

We are not obligated to pursue reimbursement or take legal action against a third party, either for our own benefit or on your behalf. Our rights under Medicare law and this *Evidence of Coverage* will not be affected if we don't participate in any legal action you take related to your injury, illness, or condition.

SECTION 5 Notice of coordination of benefits

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

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

Who pays first when you have other coverage?

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

Employer and employee organization group health plans

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

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

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

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

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

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

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

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

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

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

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

Workers' Compensation and similar programs

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

Accidents and injuries

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

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

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

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

Non-duplication of benefits

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

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

More information

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

Appeal rights

If you disagree with any decision or action by our plan in connection with the coordination of benefits and payment rules outlined above, you must follow the procedures explained in Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals, complaints) in this *Evidence of Coverage*.

CHAPTER 12:

Definitions

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

Allowed Amount - Individual charge determined by a carrier for a covered medical service or supply.

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already got. You may also make an appeal if you disagree with our decision to stop services that you're getting.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than our plan's allowed cost-sharing amount. As a member of our plan, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We don't allow providers to balance bill or otherwise charge you more than the amount of cost-sharing our plan says you must pay.

Benefit Period – The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. For our plan, you will have a benefit period for your skilled nursing facility benefits. For some plans, this may also include the inpatient hospital benefit if the plan has a deductible associated with that benefit. A benefit period begins on the first day you go into an inpatient hospital or a skilled nursing facility. The benefit period will accumulate one day for each day you are inpatient at a hospital or SNF. The benefit period ends when you haven't got any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

Biological Product - A prescription drug that's made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. Go to **"Original Biological Product"** and **"Biosimilar"**.

Biosimilar - A biological product that is very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription (See **"Interchangeable Biosimilar"**).

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent $2,100 for Part D covered drugs during the covered year. During this payment stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.

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

Chronic-Care Special Needs Plan (C-SNP) - C-SNPs are SNPs that restrict enrollment to MA eligible people who have specific severe and chronic diseases.

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services or prescription drugs.

Combined Maximum Out-of-Pocket Amount – If your plan has this feature, this is the most you will pay in a plan year for all Part A and Part B services from both network (preferred) providers and out-of-network (non-preferred) providers. See Chapter 4, Section 1.3 for information about your combined maximum out-of- pocket amount.

Complaint - The formal name for making a complaint is **filing a grievance.** The complaint process is used *only* for certain types of problems. This includes problems about quality of care, waiting times, and the customer service you get. It also includes complaints if our plan doesn't follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

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

Contracted Rate - The rate the network provider or pharmacy has agreed to accept for covered services or prescription drugs.

Copayment (or copay) – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is usually a set amount (for example $10) , rather than a percentage.

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

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of five 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 our plan and the amount, if any, you're required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called coverage decisions in this document.

Covered Drugs – The term we use to mean all the prescription drugs covered by our plan.

Covered Services – The term we use to mean all of the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you don't need skilled medical care or skilled nursing care. Custodial care, provided by people who don't have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Customer Care – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

Daily cost-sharing rate – A daily cost-sharing rate may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you're 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 our plan is 30 days, then your daily cost-sharing rate is $1 per day.

Deductible – The amount you must pay for health care or prescriptions before our plan pays.

Diagnostic Mammogram - A radiological procedure furnished to a man or woman with signs or symptoms of breast disease.

Disenroll or **Disenrollment** – The process of ending your membership in our plan.

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

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

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

Emergency Care – Covered services that are: (1) rendered by a provider qualified to furnish emergency services; and (2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage decision that, if approved, allows you to get a drug that isn't on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also ask for an exception if our plan requires you to try another drug before getting the drug you're asking for, if our plan requires a prior authorization for a drug and you want us to waive the criteria restriction, or if our plan limits the quantity or dosage of the drug you're asking for (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.

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

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

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

Generic Drug – A prescription drug that is approved by the FDA as having the same active ingredient(s) as the brand name drug. Generally, a generic drug works the same as a brand name drug and usually costs less.

Grievance - A type of complaint you make about our plan, providers, us or pharmacies, including a complaint concerning the quality of your care. This doesn't involve coverage or payment disputes.

Health Maintenance Organization (HMO) - A type of health insurance plan where members must receive care from the plan's network of doctors, hospitals, and other health care providers.

Home Health Aide – A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Home Health Care - Skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in Chapter 4, Medical Benefits Chart under the heading "Home health care." If you need home health care services, our plan will cover these services for you provided the Medicare coverage requirements are met. Home health care can include services from a home health aide if the services are part of the home health plan of care for your illness or injury. They aren't covered unless you are also getting a covered skilled service. Home health services don't include the services of housekeepers, food service arrangements, or full-time nursing care at home.

Hospice - A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. Our plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums, you are still a member of our plan. You can still get all medically necessary services as well as the supplemental benefits we offer.

Hospice Care - Specialized care for people who are terminally ill, focused on comfort not cure. This also includes counseling for patients' families. Depending on the situation, this type of care may be in the home, a hospice facility, a hospital, or a nursing home, and is given by a team of licensed health professionals.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an outpatient.

Humana Group Medicare Customer Care - A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

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

Income Related Monthly Adjustment Amount (IRMAA) - If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Initial Coverage Stage – This is the stage before your out-of-pocket costs for the year have reached the out-of-pocket threshold amount .

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

In-Network Maximum Out-of-Pocket Amount – If applicable for your plan, this is the most you will pay for covered Part A and Part B services received from network (preferred) providers. After you have reached this limit, you will not have to pay anything when you get covered services from network providers for the rest of the contract year. However, until you reach your combined out-of-pocket amount, you must continue to pay your share of the costs when you seek care from an out-of-network (non-preferred) provider. See Chapter 4, Section 1.3 for information about your in-network maximum out-of-pocket.

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

Interchangeable Biosimilar - A biosimilar that may be used as a substitute for an original biosimilar product at the pharmacy without needing a new prescription because it meets additional requirements about the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

List of Covered Drugs (formulary or *Drug Guide*) – A list of prescription drugs covered by the plan.

Low Income Subsidy (LIS) – Go to Extra Help.

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

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

Manufacturer Discount Program - A program under which drug manufacturers pay a portion of our plan's full cost for covered Part D brand name drugs and biologics. Discounts are based on agreements between the Federal government and drug manufacturers.

Maximum Fair Price - The price Medicare negotiated for a selected drug.

Maximum Out-of-Pocket Amount - The most that you pay out-of-pocket during the calendar year for covered Part A and Part B services. Amounts you pay for our plan premiums, Medicare Part A and Part B premiums and prescription drugs don't count toward the maximum out-of-pocket amount. See Chapter 4 for information about your maximum out-of-pocket amount.

Medicaid (or Medical Assistance) – A joint federal and State program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Accepted Indication – A use of a drug that is either approved by the FDA or supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information system.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be i) an HMO, ii) a PPO, iii) a Private Fee-for-Service (PFFS) plan, or iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage.**

Medicare Allowable Charge - The most amount of money that can be charged for a particular medical service covered by Medicare. These are set amounts decided by Medicare.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all the services that are covered by Medicare Part A and B. The term Medicare-Covered Services doesn't include the extra benefits, such as vision, dental or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in our plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medication Therapy Management (MTM) program - A Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications.

Medicare Limiting Charge - In the Original Medicare plan, the highest amount of money you can be charged for a covered service by doctors and other health care suppliers who do not accept assignment. The limiting charge is 15 percent over Medicare's approved amount. The limiting charge only applies to certain services and does not apply to supplies or equipment.

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Medigap (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill gaps in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

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

Network Pharmacy – A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider – Provider is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. **Network providers** have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called **plan providers.**

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

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

Observation Services - are hospital outpatient services given to help the doctor decide if a patient needs to be admitted as an inpatient or can be discharged. Observation services may be given in the emergency department or another area of the hospital. Even if you stay overnight in a regular hospital bed, you might be an outpatient.

Organization Determination - A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called coverage decisions in this document.

Original Biological Product - A biological product that has been approved by the FDA and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.

Original Medicare (Traditional Medicare or Fee-for- Service Medicare) – Original Medicare is offered by the government, and not a private health plan such as Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has 2 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. Most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that doesn't have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan.

Out-of-Pocket Costs – Go to the definition for cost-sharing above. A member's cost-sharing requirement to pay for a portion of services or drugs gotten is also referred to as the member's out-of-pocket cost requirement.

Out-of-Pocket Threshold - The maximum amount you pay out of pocket for Part D drugs.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care services and supports (LTSS) for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans get both their Medicare and Medicaid benefits through our plan.

Part C – see Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded as covered Part D drugs by Congress. Certain categories of Part D drugs must be covered by every plan.

Part D Late Enrollment Penalty - An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare drug coverage) for a continuous period of 63 days or more after you're first eligible to join a Part D plan .

Plan Provider – see "Network Provider".

Point-of-Service (POS) Plan - A Medicare managed care plan option that lets you use doctors and hospitals outside the plan for an additional cost.

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

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

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they're gotten from network or out-of-network providers. Member cost-sharing may be higher when plan benefits are gotten from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Prescription Drug Guide (Formulary) – A list of covered drugs provided by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand-name and generic drugs.

Preventive services - Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

Primary Care Physician (PCP) – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization – Approval in advance to get services or certain drugs based on specific criteria. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary and our criteria is posted on our website.

Prosthetics and Orthotics - Medical devices including, but are not limited to: arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Real Time Benefit Tool - A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

Referral - A written order from your primary care doctor for you to visit a specialist or get certain medical services. Without a referral, our plan may not pay for services from a specialist.

Rehabilitation Services – These services include inpatient rehabilitation care, physical therapy, speech and language therapy (outpatient), and occupational therapy.

Screening Mammogram - A radiological procedure for early detection of breast cancer, and; includes a physician's interpretation of the results.

Selected Drug - A drug covered under Part D for which Medicare negotiated a Maximum Fair Price.

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. Our plan may disenroll you if you permanently move out of our plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period - A set time when members can change their health or drug plan or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you're getting Extra Help with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

Special Needs Plan - A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who live in a nursing home, or who have certain chronic medical conditions.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we'll 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 aren't the same as Social Security benefits.

Urgent Care Center - A licensed health facility where doctors and nurses provide services to identify and treat a sudden injury or illness, with no overnight stay.

Urgently Needed Services - A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our service area, or it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits, such as annual checkups aren't considered urgently needed even if you're outside the service area or the plan network is temporarily unavailable.

ALABAMA	
QIO	Acentra Health 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609 1-888-315-0636 711 (TTY) 1-844-878-7921 (fax) **https://www.keproqio.com/**
SHIP	Alabama Department of Senior Services 201 Monroe St., Suite 350, Montgomery, AL 36104 1-877-425-2243 1-334-242-5743 1-334-242-5594 (fax) **https://alabamaageline.gov/about/**
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/**
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 **http://www.alabamapublichealth.gov/hiv/adap.html**
ALASKA	
QIO	Acentra Health 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-315-0636 711 (TTY) 1-844-878-7921 (fax) **https://www.keproqio.com/**
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) **https://dhss.alaska.gov/pages/default.aspx**
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) 1-855-694-2929 (fax) **https://livantaqio.com/**
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/aging-and-adult/state-health-insurance-assistance-program-ship SMO AHCCCS (a.k.a. Access) (formerly-Health Care Cost Containment of Arizona)**
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	Acentra Health 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609 1-888-315-0636 711 (TTY) 1-844-878-7921 (fax) **https://www.keproqio.com/**
SHIP	Senior Health Insurance Information Program (SHIIP) 1 Commerce Way, Little Rock, AR 72202 1-800-224-6330 (toll free) 1-501-371-2782 (local) 1-501-371-2618 (fax) 1-501-683-4468 (TTY) **https://www.shiipar.com/**
SMO	Department of Human Services of Arkansas Donaghey Plaza South, P.O. Box 1437 Slot S401, Little Rock, AR 72203-1437 1-800-482-5431 (toll free) 1-501-682-8292 (local) 501-682-1197 (fax) 1-800-482-8988 (Spanish) 1-501-682-8933 (TTY) Monday-Friday 8-4:30 p.m **https://humanservices.arkansas.gov/divisions-shared-services/medical-services**
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 1-800-462-0599 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) 1-855-694-2929 (fax) **https://livantaqio.com/**
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) **https://www.aging.ca.gov/Programs_and_Services/Medicare_Counseling/**
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) 711 (TTY) **http://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 1-916-558-1784 **https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OAadap.aspx**

COLORADO	
QIO	Acentra Health 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-315-0636 711 (TTY) 1-844-878-7921 (fax) **https://www.keproqio.com/**
SHIP	Senior Health Insurance Assistance Program (SHIP) Colorado Division of Insurance 1560 Broadway, Suite 850, Denver, CO 80202 1-800-930-3745 (toll free) 1-303-894-7499 (local) 1-888-696-7213 (fax) **https://doi.colorado.gov/insurance-products/health-insurance/senior-health-care-medicare**
SMO	Health First Colorado (Medicaid) 1575 Sherman St. Denver, CO 80203-1818 Monday to Friday, 8:00 a.m. to 4:30 p.m 1-800-221-3943 (toll free) 1-303-866- 5700 (local) 1-303-866-4411 (fax) 711 (TTY) **https://www.healthfirstcolorado.com/**
SPAP	Colorado Bridging the Gap, Colorado Department of Public Health and Environment 4300 Cherry Creek Drive South, Denver, CO 80246 1-303-692-2687 (local) 1-303-692-2716 (local) **https://cdphe.colorado.gov/state-drug-assistance-program**
ADAP	Colorado State Drug Assistance Program CDPHE Care and Treatment Program ADAP 4300 Cherry Creek Drive South, Denver, CO 80246-1530 303-692-2000 **https://cdphe.colorado.gov/state-drug-assistance-program**

CONNECTICUT	
QIO	Acentra Health 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-315-0636 711 (TTY) 1-844-878-7921 (fax) **https://www.keproqio.com/**
SHIP	CHOICES 55 Farmington Avenue, 12th Floor, Hartford, CT 06105-3730 1-800-994-9422 (toll free) 1-860-424-5055 1-860-424-4850 (fax) 1-860-247-0775 (TTY) **www.ct.gov/agingservices**
SMO	HUSKY Health Connecticut (Medicaid) 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	Not Applicable
ADAP	Connecticut AIDS Drug Assistance Program (CADAP) No physical address for ADAP program, administered by MagellanRx Connecticut Department of Public Health 410 Capitol Ave. Hartford, CT 06134 1-800-424-3310 (toll free) 1-800-424-7462 (fax) **https://ctdph.magellanrx.com/**
DELAWARE	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-396-4646 1-888-985-2660 (TTY) 1-855-694-2929 (fax) **https://livantaqio.com/**
SHIP	Delaware Medicare Assistance Bureau (DMAB) 1351 West North Street Suite 101, Dover, DE 19904 1-800-336-9500 (toll free) 1-302-674-7300 (local) **https://insurance.delaware.gov/divisions/dmab/**
SMO	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 Prescription Assistance Program 11-13 North Church Ave, Milford, DE 19963 0950 1-800 -996-9969 (toll free) 1-302-424-7180 **https://www.dhss.delaware.gov/dhss/dmma/dpap.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) 1-855-694-2929 (fax) **https://livantaqio.com/**
SHIP	Health Insurance Counseling Project (HICP) 500 K Street, NE, Washington, DC 20002 1-202-724-5626 (local) 711 (TTY) 1-202-724-2008 **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, HIV/AIDS, Hepatitis, STD, and TB Administration, AIDS Drugs Assistance Program 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	Acentra Health 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609 1-888-315-0636 711 (TTY) 1-844-878-7921 (fax) **https://www.keproqio.com/**
SHIP	Serving Health Insurance Needs of Elders (SHINE) Department of Elder Affairs 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 2727 Mahan Drive, Tallahassee, FL 32308-5407 888-419-3456 (toll free) 850-412-4000 (local) 850-922-2993 (fax) 800-955-8771 (TTY) **www.ahca.myflorida.com/**
SPAP	Not Applicable/No corresponde
ADAP	Florida AIDS Drug Assistance Program, HIV/AIDS Section 4052 Bald Cypress Way, Tallahassee, FL 32399 1-850-245-4422 1-800-545-7432 (1-800-545-SIDA) (Spanish) 1-800-2437-101 (1-800-AIDS-101) (Creole) 1-888-503-7118 (TTY) **www.floridahealth.gov/diseases-and-conditions/aids/adap/index.html**
GEORGIA	
QIO	Acentra Health 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609 1-888-315-0636 711 (TTY) 1-844-878-7921 (fax) **https://www.keproqio.com/**
SHIP	GeorgiaCares 2 Peachtree Street NW, 33rd Floor, Atlanta, GA 30303 1-866-552-4464 (Option 4) 1-404-657-1929 (TTY) 1-404-657-5285 (fax) **https://aging.georgia.gov/georgia-ship**
SMO	Georgia Department of Community Health (DCH) (Medicaid) 2 Martin Luther King Jr Drive SE East Tower, Atlanta, GA 30334 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 200 Piedmont Avenue, SE, Atlanta, GA 30334 1-404-656-9805 **https://dph.georgia.gov/hiv-care/aids-drug-assistance-program-adap**

HAWAII	
QIO	Livanta BFCC-QIO Program 10820 Guilford Rd, Ste 202, Annapolis Junction, MD 20701 1-877-588-1123 1-855-887-6668 (TTY) 1-855-694-2929 (fax) **https://livantaqio.com/**
SHIP	Hawaii SHIP Hawaii State Department of Health 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) **http://www.hawaiiship.org/**
SMO	Department of Human Services of Hawaii 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	HIV Medical Management Services, 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	Acentra Health 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-315-0636 711 (TTY) 1-844-878-7921 (fax) **https://www.keproqio.com/**
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 Department of Health and Welfare 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	Not Applicable
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) 1-855-694-2929 (fax) **https://livantaqio.com/**
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) **https://ilaging.illinois.gov/ship.html**
SMO	Illinois Department of Healthcare and Family Services 100 South Grand Avenue East, Springfield, IL 62762 1-800-843-6154 (toll free) 1-217-782-4977(local) 1-866-324-5553 (TTY) **https://www.dhs.state.il.us**
SPAP	Not Applicable
ADAP	Illinois AIDS Drug Assistance Program, Illinois ADAP Office 525 West Jefferson Street First Floor, Springfield, IL 62761 1-800-825-3518 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) 1-855-694-2929 (fax) **https://livantaqio.com/**
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) **https://www.in.gov/ship/**
SMO	Family and Social Services Administration of Indiana 402 West Washington Street, P.O. Box 7083, Indianapolis, IN 46204-7083 800-457-4584 (toll free) 1-317-233-4454 (local) **https://www.in.gov/medicaid/**
SPAP	Hoosier RX 402 W. Washington St., Room 374, Indianapolis, IN 46204 1-866-267-4679 (toll free) 1-317-234-1381 (local) **https://www.in.gov/medicaid/members/member-programs/hoosierrx/**
ADAP	Indiana AIDS Drug Assistance Program Indiana State Department of Health 2 N Meridian St., Suite 6C, Indianapolis, IN 46204 1-800-382-9480 **http://www.in.gov/health/**
IOWA	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-755-5580 1-888-985-9295 (TTY) 1-855-694-2929 (fax) **https://livantaqio.com/**
SHIP	Senior Health Insurance Information Program (SHIIP) Iowa Insurance Division 601 Locust St., 4th Floor, Des Moines, IA 50309-3738 1-800-351-4664 (toll free) 1-800-735-2942 (toll free TTY) 1-515-654-6500 (Fax) **https://shiip.iowa.gov/**
SMO	Iowa HHS (Medicaid) 321 East 12th Street, Des Moines, IA 50315 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	Care & Support Services - The Ryan White Part B Program, Iowa Department of Public Health 321 E. 12th Street, Des Moines, IA 50319-0075 1-515-380-6942 (Holly Hanson, Coordinator) **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) 1-855-694-2929 (fax) **https://livantaqio.com/**
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 1-785-296-8844 1-785-559-4225 (fax) **https://www.kdhe.ks.gov/355/The-Ryan-White-Part-B-Program**

KENTUCKY	
QIO	Acentra Health 5201 W. Kennedy Blvd, Suite 900, Tampa, FL 33609 1-888-315-0636 711 (TTY) 1-844-878-7921 (fax) **https://www.keproqio.com/**
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	Cabinet for Health Services of Kentucky 275 East Main Street, Frankfort, 6EC KY 40621 1-800-635-2570 (toll free) 502-564-3852 (local) 711(TTY) **https://chfs.ky.gov/agencies/dms/Pages/default.aspx**
SPAP	Not Applicable
ADAP	Kentucky HIV/AIDS Care Coordinator Program (KHCCP) Kentucky Cabinet for Public Health and Family Services 275 East Main Street HS2E-C, Frankfort, KY 40621 502-564-6539 1-877-353-9380 (fax) 1-800-420-7431 1-502-564-9865 (fax) **https://www.chfs.ky.gov/agencies/dph/dehp/hab/Pages/services.aspx**

LOUISIANA	
QIO	Acentra Health 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609 1-888-315-0636 711 (TTY) 1-844-878-7921 (fax) **https://www.keproqio.com/**
SHIP	Senior Health Insurance Information Program (SHIIP) 1702 N. Third Street, P.O. Box 94214, Baton Rouge, LA 70802 1-800-259-5300 (toll free) 1-225-342-5301 (local) 1-800-259-5300 (Spanish) 1-504-568-3157 (Spanish fax) **http://www.ldi.la.gov/SHIIP/**
SMO	Healthy Louisiana (Medicaid) Louisiana Department of Health 628 N. 4th Street, Baton Rouge, LA 70802 1-888-342-6207 (toll free) 225-342-9500 (local) 888-342-6207 (Spanish) **https://ldh.la.gov/subhome/1**
SPAP	Not Applicable
ADAP	Louisiana Health Access 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) 1-504-568-7474 (Spanish) 1-504-568-3157 (Spanish fax) **http://www.lahap.org**
MAINE	
QIO	Acentra Health 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-315-0636 711 (TTY) 1-844-878-7921 (fax) **https://www.keproqio.com/**
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) 1-207-287-3005 (Fax) 1-207-287-3707 (local) **www.maine.gov/dhhs/oads/community-support/ship.html**
SMO	Maine Department of Health and Human Services 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 ADAP 40 State House Station, Augusta, ME 04330 1-207-287-3747 1-207-287-3498 (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) 1-855-236-2423 (fax) **https://livantaqio.com/**
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) **www.aging.maryland.gov/Pages/default.aspx**
SMO	Maryland Department of Health and Mental Hygiene 201 W. Preston St., Baltimore, MD 21201-2399 800-638-3403 (toll free) 1-410-767-6500 (local) 1-855-642-8573 (TTY) **https://health.maryland.gov/mmcp/Pages/home.aspx**
SPAP	Maryland Senior Prescription Drug Assistance Program Maryland SPDAP c/o Pool Administrators PO Box 749 Greenbelt 20768-0749 1-800-551-5995 (toll free) 1-410-767-5000 (local) **www.marylandspdap.com**
ADAP	Maryland AIDS Drug Assistance Program 201 W. Preston Street, Baltimore, MD 21202 1-410-767-6500 1-410-333-2608 (fax) 1-877-463-3464 **https://health.maryland.gov/phpa/OIDPCS/Pages/MADAP.aspx**
MASSACHUSETTS	
QIO	Acentra Health 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-315-0636 711 (TTY) 1-844-878-7921 (fax) **https://www.keproqio.com/**
SHIP	Serving Health Information Needs of Elders (SHINE) Executive Office of Elder Affairs 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/health-insurance-counseling**

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) 1-508-793-1166 (fax) **https://www.prescriptionadvantagema.org/**
ADAP	Massachusetts HIV Drug Assistance Program (HDAP) CRI 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) 1-855-236-2423 (fax) **https://livantaqio.com/**
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 333 S. Grand Ave, P.O. Box 30195, Lansing, MI 48909 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 Drug Assistance Program HIV Care Section Division of Health, Wellness and Disease Control, 109 Michigan Avenue 9th Floor, Lansing, MI 48913 1-888-826-6565 1-517-335-7723 (fax) 1-517-335-8376 **https://www.michigan.gov/mdhhs/keep-mi-healthy/chronicdiseases/hivsti/michigan-drug-assistance-program**

MINNESOTA	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-524-9900 1-888-985-8775 (TTY) 1-855-236-2423 (fax) **https://livantaqio.com/**
SHIP	Minnesota State Health Insurance Assistance Program/Senior LinkAge Line Elmer L. Anderson Human Services 85 East 7th Place, PO Box 64882, St. Paul, MN 55164 1-800-333-2433 (toll free) 1-651-431-2500 (local) 1-651-431-7453 (fax) **https://mn.gov/senior-linkage-line/**
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	HIV: medication program (ADAP) HIV/AIDS Programs, Minnesota Department of Human Services P.O. Box 64972, St. Paul, MN 55164 1-651-431-2414 1-651-431-7414 (fax) **https://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/programs-services/medications.jsp**

MISSISSIPPI	
QIO	Acentra Health 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609 1-888-315-0636 711 (TTY) 1-844-878-7921 (fax) **https://www.keproqio.com/**
SHIP	MS Dept of Human Services - Division of Aging & Adult Services 200 South Lamar St., Jackson, MS 39201 1-844-822-4622 (toll free) 1-601-359-4500 (local) **www.mdhs.ms.gov/**
SMO	Mississippi Division of Medicaid 550 High Street, Suite 1000, Jackson, MS 39201 1-800-421-2408 (toll free) 1-601-359-6050 (local) 1-601-359-6294 (fax) 1-228-206-6062 (Video Phone) **www.medicaid.ms.gov/**
SPAP	Not Applicable
ADAP	HIV Care and Treatment 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) 1-601-362-4879 **https://msdh.ms.gov/msdhsite/_static/14,13047,150.html**
MISSOURI	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-755-5580 1-888-985-9295 (TTY) 1-855-694-2929 (fax) **https://livantaqio.com/**
SHIP	Missouri SHIP 1105 Lakeview Avenue, Columbia, MO 65201 1-800-390-3330 (toll free) 1-573-817-8320 (local) **http://www.missouriclaim.org**
SMO	Missouri Department of Social Services 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/mhd/**
SPAP	Missouri RX Plan P.O. Box 6500, Jefferson City, MO 65102 1-800-375-1406 (toll free) 1-573-751-6963 **https://mydss.mo.gov/mhd/morx-general-faqs**

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) 1-888-252-8045 **http://www.health.mo.gov/living/healthcondiseases/communicable/hivaids/casemgmt.php**
MONTANA	
QIO	Acentra Health 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-315-0636 711 (TTY) 1-844-878-7921 (fax) **https://www.keproqio.com/**
SHIP	Montana State Health Insurance Assistance Program (SHIP) 1100 N Last Chance Gulch, 4th Floor, Helena, MT 59601 1-800-551-3191 (toll free) **http://www.dphhs.mt.gov/sltc/aging/SHIP.aspx**
SMO	Montana Department of Public Health and Human Services Division of Child and Adult Health Resources 111 North Sanders Street, Helena, MT 59601-4520 1-800-362-8312 (toll free) 1-406-444-1970 (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) 1-(406) 444-3846 (fax) **https://dphhs.mt.gov/SLTC/aging/BigSky**
ADAP	Ryan White HIV/AIDS Program (RWHAP) Cosswell Bldg. C – 211, 1400 Broadway, Helena, MT 59620-2951 1-406-444-3565 1-406-444-6842 (fax) **https://dphhs.mt.gov/publichealth/hivstd/treatment/mtryanwhiteprog**
NEBRASKA	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-755-5580 1-888-985-9295 (TTY) 1-855-694-2929 (fax) **https://livantaqio.com/**

SHIP	Nebraska Senior Health Insurance Information Program (SHIIP) Nebraska Department of Insurance, P.O. Box 95026, Lincoln, NE 68509 1-800-234-7119 (toll free) 1-402-471-2201(local) 1-402-471-4610 (fax) 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 System 301 Centennial Mall South 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 P.O. Box 95026, Lincoln, NE 68509 1-402-471-2101 1-402-553-5527 (fax) **https://dhhs.ne.gov/Pages/HIV-Care.aspx**
NEVADA	
QIO	Livanta BFCC-QIO Program 10820 Guilford Rd, Ste 202, Annapolis Junction, MD 20701 1-877-588-1123 (toll free) 1-855-694-2929 (fax) 1-855-887-6668 (TTY) **https://livantaqio.com/**
SHIP	State Health Insurance Assistance Program (SHIP) 3416 Goni Road, Suite D-132, Carson City NV, 89706 1-800-307-4444 (toll free) 1-775-687-4210 (local) **https://adsd.nv.gov/Programs/Seniors/Medicare_Assistance_Program_(MAP)/MAP_Prog/**
SMO	Nevada Department of Health and Human Services Division of Welfare and Supportive Services, 1860 E. Sahara Ave., Suite 102, Las Vegas, NV 89104 877-638-3472 (toll free) 775-684-3600(local) **https://www.medicaid.nv.gov**
SPAP	Not Applicable
ADAP	Nevada AIDS Drug Assistance Program Office of HIV/AIDS 2290 S. Jones Blvd Suite 110, Las Vegas, NV 89146 1-702-486-0768 **https://endhivnevada.org/adap-nmap/**

NEW HAMPSHIRE	
QIO	Acentra Health 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-315-0636 711 (TTY) 1-844-878-7921 (fax) **https://www.keproqio.com/**
SHIP	NH SHIP - ServiceLink Aging and Disability Resource Center 129 Pleasant Street, Concord, NH 03301-3857 1-866-634-9412 (toll free) 1-844-275-3447 **https://www.dhhs.nh.gov/**
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 1-603-271-9000 **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) 1-855-236-2423 (fax) 1-866-868-2289 (TTY) **https://livantaqio.com/**
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) **https://nj.gov/humanservices/doas/services/q-z/ship/**
SMO	Department of Human Services of New Jersey 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	AIDS Drug Distribution Program New Jersey ADDP Office, P.O. Box 722, Trenton, NJ 08625-0722 1-877-613-4533 1-609-588-7037 (fax) **https://www.nj.gov/health/hivstdtb/hiv-aids/medica**
NEW MEXICO	
QIO	Acentra Health 5201 W. Kennedy Blvd., Suite 900, Tampa FL 33609 1-888-315-0636 711 (TTY) 1-844-878-7921 (fax) **https://www.keproqio.com/**
SHIP	Benefits Counseling Program 2550 Cerrillos Road, Santa Fe, NM 87505 1-800-432-2080 (toll free) 1-505-476-4937 (TTY) **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) **https://livantaqio.com/**
SHIP	Health Insurance Information Counseling and Assistance Program (HIICAP) 2 Empire State Plaza, Albany, NY 12223-1251 1-800-432-2080 (toll free) **https://aging.ny.gov/health-insurance-information-counseling-and-assistance-program-hiicap-programs**
SMO	Office of Medicaid Inspector General (formerly New York State Department of Health), Office of Medicaid Management 800 North Pearl Street, Albany, NY 12204 1-800-541-2831 (toll free) 1-518-473-3782 (local) **https://www.health.ny.gov/health_care/medicaid/members/**
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 **www.health.ny.gov/diseases/aids/general/resources/adap**

NORTH CAROLINA	
QIO	Acentra Health 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609 1-888-315-0636 711 (TTY) 1-844-878-7921 (fax) **https://www.keproqio.com/**
SHIP	Seniors' Health Insurance Information Program (SHIIP) 3200 Beechleaf Court, Raleigh, NC 27604 1-855-408-1212 (toll free) **http://www.ncdoi.com/SHIIP/Default.aspx**
SMO	North Carolina Department of Health and Human Services 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) 1-919-733-3419 (local) 1-919-733-0490 (fax) **https://epi.dph.ncdhhs.gov/cd/hiv/hmap.html**
ADAP	HIV Medication Assistance Program (HMAP) NC Department of Health and Human Services Division of Public Health Epidemiology Section Communicable Disease Branch 1907 Mail Service Center, Raleigh, NC 27699-1902 1-919-733-9161 1-877-466-2232 (toll free) **https://epi.dph.ncdhhs.gov/cd/hiv/hmap.html**
NORTH DAKOTA	
QIO	Acentra Health 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-315-0636 711 (TTY) 1-844-878-7921 (fax) **https://www.keproqio.com/**
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) 1-800-366-6888 (TTY) **https://www.insurance.nd.gov/consumers/medicare-assistance**
SMO	North Dakota Medicaid 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) **https://www.hhs.nd.gov/healthcare/medicaid**
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 1-701-328-6272 1-800-472-2180 (toll free) 1-701-328-6280 (fax) **https://www.ndhealth.gov/hiv/RyanWhite/**
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, Suite 300, Columbus, OH 43215 1-800-686-1578 (toll free) 1-614-644-3745 (TTY) **www.insurance.ohio.gov**
SMO	Ohio Medicaid 50 West Town Street, Suite 400, Columbus, OH 43215-4197 1-800-324-8680 (toll free) 1-614-280-0977 (fax) 711 (TTY) 1-800-324-8680 (llamada gratuita) **www.medicaid.ohio.gov/**
SPAP	Not Applicable
ADAP	Ohio HIV Drug Assistance Program (OHDAP) Ohio AIDS Drug Assistance Program (OHDAP), HIV Client Services, Ohio Department of Health, 246 N. High Street, Columbus, OH 43215 1-800-777-4775 1-614-995-0775 **https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/Ryan-White-Part-B-HIV-Client-Services/AIDS-Drug-Assistance-Program/**
OKLAHOMA	
QIO	Acentra Health 5201 W. Kennedy Blvd, Suite 900, Tampa, FL 33609 1-888-315-0636 711 (TTY) 1-844-878-7921 (fax) **https://www.keproqio.com/**
SHIP	Oklahoma Medicare Assistance Program (MAP) 400 NE 50th Street, Oklahoma City, OK 73105 1-800-522-0071 (toll free) (in state only) 1-405-521-6628 (local) (out of state only) 1-405-521-6635 (Fax) **https://www.oid.ok.gov/consumers/information-for-seniors/**
SMO	SoonerCare (Medicaid) 4345 N. Lincoln Blvd., Oklahoma City, OK 73105-5101 1-800-987-7767 (toll free) 1-405-522-7300 (local) 711 (TTY) **https://www.oklahoma.gov/ohca.html**
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 **https://oklahoma.gov/health.html**
OREGON	
QIO	Acentra Health 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-315-0636 711 (TTY) 1-844-878-7921 (fax) **https://www.keproqio.com/**
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://shiba.oregon.gov/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	CAREAssist is 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) **https://www.oregon.gov/oha/ph/DiseasesConditions/HIVSTDViralHepatitis/HIVCareTreatment/CAREAssist/Pages/index.aspx**
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) **https://www.aging.pa.gov/Pages/default.aspx**
SMO	Pennsylvania Department of Human Services (Medicaid) 555 Walnut Street, Forum Place 6th floor, Harrisburg, PA 17101 1-800-692-7462 (toll free) 1-800-451-5886 (TTY) 1-800-692-7462 (llamada gratuita) **https://www.pa.gov/agencies/dhs.html**

SPAP	Pharmaceutical Assistance Contract for the Elderly (PACE) PACE/Pacenet Program, P.O. Box 8806, Harrisburg, PA 17105-8806 1-800-225-7223 (toll free) 1-717-651-3600 (local) 1-888-656-0372 (fax) **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) 1-844-377-7367 **https://www.health.pa.gov/topics/programs/HIV/Pages/Special-Pharmaceutical-Benefits.aspx**
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) 1-787-721-6121 (local) 1-787-919-7291 local (TTY) **http://www.agencias.pr.gov/agencias/oppea/educacion/Pages/ship.aspx**
SMO	Medicaid Office of Puerto Rico and Virgin Islands (Medicaid) P.O. Box 70184, San Juan, PR 00936-8184 1-787-641-4224 (local and toll free) 1-787-625-6955 (TTY) 1-787-763-5250 (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 Ext. 5106-5137 **https://www.salud.pr.gov/CMS/137**
RHODE ISLAND	
QIO	Acentra Health 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-315-0636 711 (TTY) 1-844-878-7921 (fax) **https://www.keproqio.com/**
SHIP	Senior Health Insurance Program (SHIP) Office of Healthy Aging 57 Howard Ave, Building 57, Cranston, RI 02920 1-888-884-8721 (local) 1-401-462-0740 (TTY) 1-401-462-3000 **https://oha.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) 1-401-462-3677 (fax) **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 1-401-462-0530 (local) 1-401-462-0740 (local) 1-401-462-0740 (TTY) **https://oha.ri.gov/what-we-do/access/health-insurance-coaching/drug-cost-assistance**
ADAP	Ryan White HIV/AIDS Program Executive Office of Health & Human Services, Virks Building 3 West Road, Suite 227, Cranston, RI 02920 1-401-462-3295 1-401-462-3677 (fax) **https://eohhs.ri.gov/Consumer/Adults/RyanWhiteHIVAIDS.aspx**
SOUTH CAROLINA	
QIO	Acentra Health 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609 1-888-315-0636 711 (TTY) 1-844-878-7921 (fax) **https://www.keproqio.com/**
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) **www.aging.sc.gov/Pages/default.aspx**
SMO	South Carolina Department of Health and Human Services Healthy Connections (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) **Monday - Friday, 8 a.m. to 6 p.m.** **www.scdhhs.gov**
SPAP	Not Applicable
ADAP	South Carolina AIDS Drug Assistance Program (ADAP) DHEC Constituent Services 2600 Bull Street, Columbia, SC 29211 1-800-856-9954 (toll free) **https://scdhec.gov/aids-drug-assistance-program**
SOUTH DAKOTA	

QIO	Acentra Health 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-315-0636 711 (TTY) 1-844-878-7921 (fax) **https://www.keproqio.com/**
SHIP	Senior Health Information and Insurance Education (SHIINE) 2500 W. 46th Street Suite 101., Sioux Falls, SD 57105 1-800-536-8197 (toll free) 1-800-536-8197 (llamada gratuita) **www.shiine.net**
SMO	South Dakota Medical Assistance Program (Medicaid) 700 Governors Drive, Pierre, SD 57501-2291 1-800-597-1603 (toll free) 1-605-773-3165 (local) 1-605-773-3165 (Spanish) 800-597-1603 (llamada gratuita) **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 1-800-592-1861 1-605-773-3361 1-605-773-3737 **https://doh.sd.gov/**
TENNESSEE	
QIO	Acentra Health 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609 1-888-315-0636 711 (TTY) 1-844-878-7921 (fax) **https://www.keproqio.com/**
SHIP	Tennessee Commission on Aging & Disability -TN SHIP 502 Deaderick St, 9th Floor, Nashville, TN 37243-0860 1-877-801-0044 (toll free) 1-615-532-3893 (TTY) 1-877-801-0044 (llamada gratuita) 1-800-848-0299 (llamada gratuita TDD) **https://www.tn.gov/aging/our-programs/state-health-insurance-assistance-program--ship-.html**
SMO	Division of TennCare 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	Ryan White Part B Program 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) **https://www.tn.gov/health/health-program-areas/std/std/ryan-white-part-b-program.html**

TEXAS	
QIO	Acentra Health 5201 W. Kennedy Dr., Suite 900, Tampa, FL 33609 1-888-315-0636 711 (TTY) 1-844-878-7921 (fax) **https://www.keproqio.com/**
SHIP	Texas Department of Aging and Disability Services (HICAP) 4900 N. Lamar Blvd, Austin, TX 78751 1-800-252-9240 (toll free) 1-512-438-3538 (fax) **https://hhs.texas.gov/services/health/medicare**
SMO	Health and Human Services Commission of Texas 4601 West Guadalupe Street., Austin, TX 78751 1-800-252-8263 (toll free) 1-512-424-6500 (local) 1-512-424-6597 (TTY) **https://www.hhs.texas.gov/services/health/medicaid-chip**
SPAP	Texas Kidney Health Care Program (KHC) Department of State Health Services MC 1938 P.O. Box 149030, Austin, TX 78714-9947 1-800-222-3986 (toll free) 1-512-776-7150 (local) 1-800-222-3986 (llamada gratuita) **https://www.hhs.texas.gov/services/health/kidney-health-care**
ADAP	Texas HIV Medication Program (THMP) Texas HIV Medication Program, ATTN: MSJA, MC 1873 P.O Box 149347, Austin, TX 78714 1-800-255-1090 1-512-533-3178 (fax) (eligibility) 1-737-255-4300 **https://www.dshs.texas.gov/hivstd/meds/**
UTAH	
QIO	Acentra Health 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-315-0636 711 (TTY) 1-844-878-7921 (fax) **https://www.keproqio.com/**
SHIP	Senior Health Insurance Information Program (SHIP) 288 North 1460 West, Salt Lake City, UT 84116 1-800-541-7735 (toll free) 1-801-538-3910 (local) 1-801-538-4395 (fax) 1-800-541-7735 (llamada gratuita) **https://daas.utah.gov/seniors/**
SMO	Utah Department of Health and Human Services (Medicaid) P.O. Box 143108, Salt Lake City , UT 84114 1-800-662-9651 (toll free) 1-801-538-6155 (local) 1-866-608-9422 (Spanish) 1-800-346-4128 (TTY) **https://medicaid.utah.gov/**
SPAP	Not Applicable

ADAP	Ryan White HIV/AIDS Program Utah Department of Health Bureau of Epidemiology 288 North 1460 West Box 142104, Salt Lake City, UT 84116-2104 1-801-538-6191 1-801-538-9913 (fax) **http://epi.utah.gov**
VERMONT	
QIO	Acentra Health 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-315-0636 711 (TTY) 1-844-878-7921 (fax) **https://www.keproqio.com/**
SHIP	State Health Insurance Assistance Program (SHIP) 27 Main Street, Suite 14, Montpelier, UT 05602 1-800-642-5119 (toll free) 1-802-225-6210 (local) 1-800-642-5119 (llamada gratuita) **www.vermont4a.org/**
SMO	Agency of Human Services of Vermont Center Building 280 State Drive, Waterbury, VT 05671 1-800-250-8427 (toll free) 1-802-241-0440 (local) 1-800-250-8427 (llamada gratuita) 1-802-879-5962 (fax) **www.humanservices.vermont.gov/**
SPAP	VPharm Green Mountain Care Application and Document Processing Center 280 State Drive, NOB 1 South, Waterbury, VT 05671-1500 1-800-250-8427 (toll free) 1-800-250-8427 (llamada gratuita) **https://dvha.vermont.gov/members/prescription-assistance**
ADAP	Health Resources and Services Administration (HRSA) Vermont Department of Health, Vermont Medication Assistance Program 108 Cherry Street- PO BOX 70, Burlington, VT 05402 1-800-464-4343 1-802-863-7200 **https://www.healthvermont.gov/immunizations-infectious-disease/hiv/care**
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) 1-804-552-3402 (llamada gratuita TTY) **www.vda.virginia.gov**

SMO	Department of Medical Assistance Services (Medicaid) 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) **https://www.dmas.virginia.gov/for-members/**
SPAP	Virginia State Pharmaceutical Assistance Program HCS Unit, 1st Floor James Madison Building 109 Governor Street, Richmond, VA 23219 1-855-362-0658 (toll free) 1-804-864-8050 (fax) 1-855-362-0658 (llamada gratuita) **https://www.vdh.virginia.gov/disease-prevention/vamap/**
ADAP	VIRGINIA MEDICATION ASSISTANCE PROGRAM (VA MAP) 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 1-800-533-4148 **https://www.vdh.virginia.gov/disease-prevention/vamap/**
WASHINGTON	
QIO	Acentra Health 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-315-0636 711 (TTY) 1-844-878-7921 (fax) **https://www.keproqio.com/**
SHIP	Statewide Health Insurance Benefits Advisors (SHIBA) Office of the Insurance Commisioner P.O. Box 40255, Olympia, WA 98504-0255 1-800-562-6900 (toll free) 1-360-586-0241 (TTY) 1-800-562-6900 (llamada gratuita) **www.insurance.wa.gov/shiba**
SMO	Apple Health (Medicaid) Cherry Street Plaza 626 8th Avenue SE, P.O. Box 45531, Olympia, WA 98501 1-800-562-3022 (toll free) 711 (TTY) **http://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) 855-889-4325 (TTY) **http://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	Wisconsin SHIP (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 (DHS)(Medicaid) 1 West Wilson Street, Madison, WI 53703 3445 1-800-362-3002 (toll free) 1-608-266-1865 (local) 1-800-947-3529 (TTY) **http://www.dhs.wisconsin.gov**
SPAP	Wisconsin SeniorCare P.O. Box 6710, Madison, WI 53716-0710 1-800-657-2038 (toll free) **https://www.dhs.wisconsin.gov/seniorcare/index.htm**
ADAP	Wisconsin AIDS Drug Assistance and Insurance 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 1-608-261-6952 **https://www.dhs.wisconsin.gov/hiv/adap.htm**

WYOMING	
QIO	Acentra Health 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-315-0636 (toll free) 711 (TTY) 1-844-878-7921 (fax) **https://www.keproqio.com/**
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) 1-307-856-4466 (fax) **www.wyomingseniors.com**
SMO	Wyoming Department of Health, Division of Healthcare Financing (Medicaid) 122 West 25th St, 4th Floor West, Cheyenne, WY 82001 1-866-571-0944 (toll free) 1-307-777-7656 (local) 1-307-777-6964 (fax) **www.health.wyo.gov/**
SPAP	Not Applicable
ADAP	Wyoming AIDS Drug Assistance Program (ADAP) Wyoming Department of Health 401 Hathaway Building, Cheyenne, WY 82002 1-307-777-5856 (Debi Anderson, CDU Unit Manager) 1-307-777-7382 (fax) **https://health.wyo.gov/publichealth/communicable-disease-unit/hivaids/**

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  - Qualified interpreters
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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:

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עברית [Hebrew]: שירותים אלה זמינים בחינם: שירותי תרגום, אביזרי עזר וטקסטים בפורמטים חלופיים. נא התקשר למספר **877-320-1235 (TTY: 711)**

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GHHNOA2025HUM_0425

ភាសាខ្មែរ [Khmer]៖ សេវាកម្មផ្នែកភាសា ជំនួយ និង សេវាកម្មជាទម្រង់ផ្សេងជំនួសអាចរកបាន។ ទូរស័ព្ទទៅលេខ **877-320-1235 (TTY: 711)**។

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Diné [Navajo]: Saad t'áá jiik'eh, t'áadoole'é binahjį' bee adahodooníłígíí diné bich'į' anídahazt'i'í, dóó łahgo át'éego bee hada'dilyaaígíí bee bika'aanída'awo'í dahólǫ́. Kohjį' hodíilnih **877-320-1235 (TTY: 711)**.

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አማርኛ [Amharic]፡- ቋንቋ፣ አጋዥ ማዳመጫ እና አማራጭ ቅርፀት ያላቸው አገልግሎቶችም ይገኛሉ። በ **877-320-1235 (TTY: 711)** ላይ ይደውሉ።

Bǎsɔ́ ̀[Bassa]: Wuɖu-xwíníín-mú-zà-zà kǔà, Hwòɖǒ-fɔ́ńɔ-́nyɔ,́ kè nyɔ-bɔ̌ǔn-po-kà ɓě ɓɛ́ nyuɛɛ se wíɖí pɛ́ɛ̀-pɛ́ɛ̀ ɖò kɔ̀ ̃**877-320-1235 (TTY: 711)** ɖá.

Bekee [Igbo]: Asụsụ n'efu, enyemaka nkwarụ, na ọrụ usoro ndị ọzọ dị. Kpọọ **877-320-1235 (TTY: 711)**.

Òyìnbó [Yoruba]: Àwọn iṣẹ́ àtìlẹhìn ìrànlọ́wọ́ èdè, àti ọ̀nà kíkà míràn wà lárọ́wọ́tó. Pe **877-320-1235 (TTY: 711)**.

नेपाली [Nepali]: भाषासम्बन्धी नि:शुल्क, सहायक साधन र वैकल्पिक फार्मेट (ढाँचा/व्यवस्था) सेवाहरू उपलब्ध छन् । **877-320-1235 (TTY: 711)** मा कल गर्नुहोस् ।