



Evidence of Coverage:

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

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

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

This document is available for free in Spanish.

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

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

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

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

2025 Evidence of Coverage

Table of Contents

- Chapter 1. Getting started as a member**
- Chapter 2. Important phone numbers and resources**
- Chapter 3. Using the plan's coverage for your Part D prescription drugs**
- Chapter 4. What you pay for your Part D prescription drugs**
- Chapter 5. Asking us to pay our share of the costs for covered drugs**
- Chapter 6. Your rights and responsibilities**
- Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**
- Chapter 8. Ending your membership in the plan**
- Chapter 9. Legal notices**
- Chapter 10. Definitions of important words**
- Exhibit A. State Agency Contact Information**

CHAPTER 1:

Getting started as a member

SECTION 1 Introduction

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

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

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

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

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

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

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

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

Section 1.3 Legal information about the *Evidence of Coverage*

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

The contract is in effect for months in which you are enrolled in Humana Group Medicare PDP Plan coverage between January 1, 2025, and December 31, 2025.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of the Humana Group Medicare PDP Plan after December 31, 2025. We can also choose to stop offering the plan in your service area, after December 31, 2025.

Chapter 1 Getting started as a member

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

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

Section 2.1 Your eligibility requirements

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

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

Chapter 1 Getting started as a member

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

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

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

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

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

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

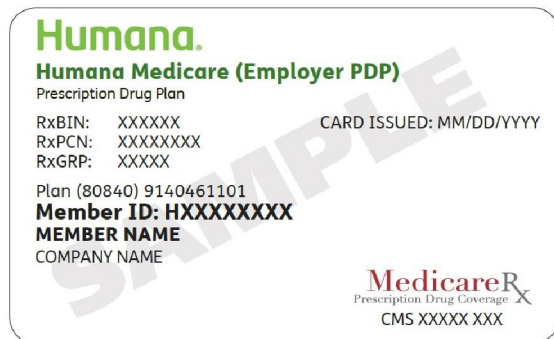
Section 2.3 Lawful presence

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

SECTION 3 Important Membership Materials You Will Receive

Section 3.1 Your plan membership card

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



Please carry your card with you at all times and remember to show your card when you get covered drugs. If your plan membership card is damaged, lost, or stolen, call Humana Group Medicare Customer Care right away and we will send you a new card.

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

Section 3.2 Pharmacy Directory

The *Pharmacy Directory* www.Humana.com/SearchResources lists our network pharmacies. **Network pharmacies** are all of the pharmacies that have agreed to fill covered prescriptions for our plan members. You can use the *Pharmacy Directory* to find the network pharmacy you want to use. See Chapter 3, Section 2.5 for information on when you can use pharmacies that are not in the plan's network.

If you don't have the *Pharmacy Directory*, you can get a copy from Humana Group Medicare Customer Care. Requests for hard copy *Provider Directories* will be mailed to you within three business days. You can also find this information on our website at <https://your.Humana.com/kppa>.

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

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

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

We will provide you a copy of the Drug Guide. The Drug Guide we provide you includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the provided Drug Guide. If one of your drugs is not listed in the Drug Guide, you should visit our website or contact Humana Group Medicare Customer Care to find out if we cover it.

To get the most complete and current information about which drugs are covered, you can visit the plan's website <https://your.Humana.com/kppa> or call Humana Group Medicare Customer Care.

SECTION 4 Your monthly premium for Humana Group Medicare PDP Plan

Your costs may include the following:

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

In some situations, your plan premium could be less

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

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

Medicare Part B and Part D premiums differ for people with different incomes. If you have questions about these premiums, review your copy, of *Medicare & You 2025* handbook, the section called *2025 Medicare Costs*. If you need a copy, you can download it from the Medicare website www.medicare.gov/medicare-and-you. Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.1 Plan premium

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

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

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

Section 4.3 Part D Late Enrollment Penalty

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

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

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

- You receive "Extra Help" from Medicare to pay for your prescription drugs.
 - You have gone less than 63 days in a row without creditable coverage.
 - You have had creditable drug coverage through another source such as a former employer, union, TRICARE, or Veterans Health Administration (VA). Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information because you may need it if you join a Medicare drug plan later.
-
- **Note:** Any notice must state that you had creditable prescription drug coverage that is expected to pay as much as Medicare's standard prescription drug plan pays.
 - **Note:** The following are not creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.

Chapter 1 Getting started as a member

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

- If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, the plan will count the number of full months that you did not have coverage. The penalty is 1% for every month that you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2025, this average premium amount was **\$36.78**. This amount may change for 2026.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here, it would be 14% times **\$36.78**, which equals **\$5.14**. This rounds to **\$5.10**. This amount would be added to the monthly premium for someone with a **Part D late enrollment penalty**.

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

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

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

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

Section 4.4 Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA. The extra charge is figured out using your modified adjusted gross income as reported on your IRS tax return from two years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit

<https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans>.

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

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

Section 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 7 to make a complaint or appeal.

SECTION 5 More information about your monthly premium

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

For questions regarding premium payment, please call 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 have a right to ask us to reconsider this decision by making a complaint. Chapter 7, Section 7 of this booklet tells how to make a complaint. If you had an emergency circumstance that was out of your control and it caused you to not be able to pay your premiums within our grace period, you can ask us to reconsider this decision by calling Humana Group Medicare Customer Care. (Phone numbers for Humana Group Medicare Customer Care are located in Chapter 2, Section 1 of this booklet.) You must make your request no later than 60 calendar days after the date your membership ends.

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

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

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

SECTION 6 Keeping your plan membership record up to date

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

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

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other medical or drug insurance coverage you have (such as from your employer, your spouse or domestic partner's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident

Chapter 1 Getting started as a member

- If you have been admitted to a nursing home
- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study (**Note:** You are not required to tell your plan about the clinical research studies you intend to participate in, but we encourage you to do so)

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

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

SECTION 7 How other insurance works with our plan

Other insurance

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

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

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

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

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

Chapter 1 Getting started as a member

- If you're over 65 and you or your spouse or domestic partner is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

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

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

CHAPTER 2:

Important phone numbers and resources

Chapter 2 Important phone numbers and resources

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

How to contact our plan's Humana Group Medicare Customer Care

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

Method	Humana Group Medicare Customer Care - Contact Information
CALL	<p>Humana Group Medicare Customer Care at (855) 267-1935. Calls to this number are free. We are available Monday through Friday from 8 a.m. to 9 p.m., Eastern time. Our phone system may answer your call after hours, and on Saturdays, Sundays, and some holidays.</p> <p>Humana Group Medicare Customer Care also has free language interpreter services available for non-English speakers.</p>
TTY	<p>711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.</p>
WRITE	<p>Humana P.O. Box 14168 Lexington, KY 40512-4168</p>
WEBSITE	<p>https://your.Humana.com/kppa</p>

How to contact us when you are asking for a coverage decision or appeal

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

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

Chapter 2 Important phone numbers and resources

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

Chapter 2 Important phone numbers and resources**How to contact us when you are making a complaint**

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. For more information on making a complaint, see Chapter 7 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

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

Chapter 2 Important phone numbers and resources**Where to send a request asking us to pay for our share of the cost of a drug you have received**

The coverage determination process includes determining requests to pay for our share of the costs of a drug that you have received. If you have received a bill or paid for drugs (such as a pharmacy bill) that you think we should pay for, you may need to ask us for reimbursement or to pay the pharmacy bill. See Chapter 5 (*Asking us to pay our share of the costs for covered drugs*).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) for more information.

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

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

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

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

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

Method	Medicare (continued) - Contact Information
WEBSITE	<p data-bbox="483 285 748 317"><u>www.medicare.gov</u></p> <p data-bbox="483 317 1419 537">This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in your state.</p> <p data-bbox="483 569 1419 642">The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:</p> <ul data-bbox="483 674 1419 936" style="list-style-type: none"><li data-bbox="483 674 1419 747">● Medicare Eligibility Tool: Provides Medicare eligibility status information.<li data-bbox="483 747 1419 936">● Medicare Plan Finder: Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an <i>estimate</i> of what your out-of-pocket costs might be in different Medicare plans. <p data-bbox="483 968 1419 1041">You can also use the website to tell Medicare about any complaints you have about Humana Group Medicare PDP Plan:</p> <ul data-bbox="483 1073 1419 1304" style="list-style-type: none"><li data-bbox="483 1073 1419 1304">● Tell Medicare about your complaint: You can submit a complaint about Humana Group Medicare PDP Plan directly to Medicare. To submit a complaint to Medicare, go to <u>www.medicare.gov/MedicareComplaintForm/home.aspx</u>. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. <p data-bbox="483 1335 1419 1556">If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website and review the information with you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)</p>

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

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

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

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

METHOD TO ACCESS SHIP and OTHER RESOURCES:

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

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

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

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

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

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

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

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

SECTION 5 Social Security

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

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

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

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

SECTION 6 Medicaid

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

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

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

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

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

The Medicare.gov website (<https://www.medicare.gov/basics/costs/help/drug-costs>) provides information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, described below.

Medicare's "Extra Help" Program

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

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

Chapter 2 Important phone numbers and resources

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

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

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

Proof that you already have "Extra Help" status

- A copy of your Medicaid card showing your name and the date you became eligible for "Extra Help." The date has to be in the month of July or later of last year.
- A letter from the Social Security Administration showing your "Extra Help" status. This letter could be called Important Information, Award Letter, Notice of Change, or Notice of Action.
- A letter from the Social Security Administration showing that you receive Supplemental Security Income. If that's the case, you also qualify for "Extra Help."

Proof that you have active Medicaid status

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

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

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

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

Chapter 2 Important phone numbers and resources

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

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

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

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

Many states and the U.S. Virgin Islands offer help paying for prescriptions, drug plan premiums and/or other drug costs. If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), Medicare's Extra Help pays first.

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

What is the AIDS Drug Assistance Program (ADAP)?

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

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

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

Chapter 2 Important phone numbers and resources

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.

The Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January - December). **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.** "Extra Help" from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in this payment option, regardless of income level, and all Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. Contact us or visit Medicare.gov to find out if this payment option is right for you.

Method	The Medicare Prescription Payment Plan - Contact Information
CALL	<p>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 a.m. to 9 p.m., Eastern time. Our phone system may answer your call after hours, and on Saturdays, Sundays, and some holidays.</p> <p>Humana Group Medicare Customer Care also has free language interpreter services available for non-English speakers.</p>
TTY	<p>711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of operation are the same as above.</p>
WRITE	<p>Humana P.O. Box 14168 Lexington, KY 40512-4168</p>
WEBSITE	<u>www.Humana.com</u>

SECTION 8 How to contact the Railroad Retirement Board

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

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

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

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

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

CHAPTER 3:

Using the plan's coverage for Part D prescription drugs

SECTION 1 Introduction

This chapter **explains rules for using your coverage for Part D drugs.**

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

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

The two examples of drugs described above are covered by Original Medicare. (To find out more about this coverage, see your *Medicare & You 2025 Handbook*.) Your Part D prescription drugs are covered under our plan.

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

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

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription which must be valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription. (See Section 2 in this chapter.) *Or you can fill your prescriptions at a network pharmacy or through the plan's mail-order service.*
- Your drug must be in the plan's *Prescription Drug Guide* (Formulary) (we call it the Drug Guide for short). (See Section 3, 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 Food and Drug Administration or supported by certain references. (See Section 3 in this chapter for more information about a medically accepted indication.)
- Your drug may require approval before we will cover it. (See Section 4 of this chapter for more information about restrictions on your coverage.)

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

Section 2.1 Use a network pharmacy

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

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

Section 2.2 Network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Pharmacy Directory*, visit our website <https://your.Humana.com/kppa>, and/or call Humana Group Medicare Customer Care.

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

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

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another pharmacy in your area, you can get help from Humana Group Medicare Customer Care or use the *Pharmacy Directory*. You can also find information on our website at <https://your.Humana.com/kppa>.

What if you need a specialized pharmacy?

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies, which is typically the pharmacy that the LTC facility uses. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact 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 that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. To locate a specialized pharmacy, look in your *Provider Directory* or call Humana Group Medicare Customer Care.

Section 2.3 Using the plan's mail-order service

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

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

To get order forms and information about filling your prescriptions by mail, please contact 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 receives directly from your doctor's office. The pharmacy will automatically fill and deliver new prescriptions it receives from health care providers, without checking with you first, if either:

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

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

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

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

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

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

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

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

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs. Your *Pharmacy 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 may also receive maintenance drugs through our mail-order program. Please see Section 2.3 for more information.

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

Your prescription may be covered in certain situations

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

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

- **If you need a prescription because of a medical emergency**
 - We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care. In this situation, you will have to pay the full cost (rather than paying just your copayment or coinsurance) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a paper claim form. If the prescription is covered, it will be covered at an out-of-network rate. If you go to an out-of-network pharmacy, you may be responsible for paying the difference between what we would pay for a prescription filled at a network pharmacy and what the out-of-network pharmacy charged for your prescription. (Chapter 5, Section 2.1 explains how to ask the plan to pay you back.)

- **If you need coverage while you are traveling away from the plan's service area**
 - If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. You may be able to order your prescription drugs ahead of time through our prescription mail-order or through a retail network pharmacy that offers an extended supply. If you are traveling outside of your plan's service area but within the United States and territories and become ill, or run out of your prescription drugs, call 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 will cover prescriptions that are filled at an out-of-network pharmacy if you follow all other coverage rules identified within this document. In this situation, you will have to pay the full cost (rather than paying just your copayment or coinsurance) when you fill your prescription.
 - **If the prescription is covered, it will be covered at an out-of-network rate.** You may be responsible for paying the difference between what we would pay for a prescription filled at an in-network pharmacy and what the out-of-network pharmacy charged for your prescription. You can ask us to reimburse you for our share of the cost by submitting a paper claim form. (Chapter 5, Section 2 explains how to ask the plan to pay you back.)
- **Please recognize, however, that multiple non-emergency occurrences of out-of-network pharmacy claims will result in claim denials. In addition, we cannot pay for any stolen medications or prescriptions that are filled by pharmacies outside the United States and territories, even for a medical emergency, for example on a cruise ship.**

Other times you can get your prescription covered if you go to an out-of-network

pharmacy. These situations will be covered at an out-of-network rate. In these situations, you will have to pay the full cost (rather than paying just your copayment or coinsurance) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a paper claim form. If you go to an out-of-network pharmacy or provider, you may be responsible for paying the difference between what we would pay for a prescription filled at an in-network pharmacy and what the out-of-network pharmacy charged for your prescription. (Chapter 5, Section 2.1 explains how to ask the plan to pay you back.) We will cover your prescription at an out-of-network pharmacy if at least one of the following applies:

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

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 5, Section 2 explains how to ask the plan to pay you back.)

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

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

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

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

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

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

- Approved by the Food and Drug Administration 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 that is 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 biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Biological products have alternatives that are 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.

See Chapter 10 for definitions of the 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.

What is *not* in the Drug Guide?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs. (For more about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug in the Drug Guide. In some cases, you may be able to obtain a drug that is not on the Drug Guide. (For more information, please see Chapter 7.)

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

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

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

To find out which cost-sharing tier your drug is in, look it up in the plan's Drug Guide.

The amount you pay for drugs in each cost-sharing tier is shown in Chapter 4 (*What you pay for your Part D prescription drugs*).

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

You have four ways to find out:

1. Check the most recent Drug Guide we provided electronically. (Please note: The Drug Guide we provide includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the provided Drug Guide. If one of your drugs is not listed in the Drug Guide, you should visit our website or contact Humana Group Medicare Customer Care to find out if we cover it.)
2. Visit the plan's website <https://your.Humana.com/kppa>. 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 to ask for a copy of the Drug Guide.
4. Use the plan's "Real-Time Benefit Tool" by visiting <https://your.Humana.com/kppa> and logging into MyHumana or by calling Humana Group Medicare Customer Care. With this tool you can search for drugs on the Drug Guide to see an estimate of what you will pay and if there are alternative drugs on the Drug Guide that could treat the same condition.

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

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

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

Section 4.2 What kinds of restrictions?
--

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

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. Contact Humana Group Medicare Customer Care to learn what you or your provider would need to do to get coverage for the drug. **If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception.** We may or may not agree to waive the restriction for you. (see Chapter 7).

Getting plan approval in advance

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

Trying a different drug first

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

Quantity limits

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

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

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

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

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

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

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

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

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

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

You may be able to get a temporary supply

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

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

- **If you are a new member**, we will cover a temporary supply of your drug during the first 90 days of your membership in the plan.
- **If you were in the plan last year**, we will cover a temporary supply of your drug during the first 90 days of the calendar year.
- This temporary supply will be for a maximum of 30 days. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of 30 days of medication. The prescription must be filled at a network pharmacy. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For those members who have been in the plan for more than 90 days, and reside in a long-term care facility and need a supply right away:**

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

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

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

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

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

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

Policies for Temporary Drug Supplies During the Transition Period

We consider the first 90 days of the 2025 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 2025, 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 are using a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You have two options:

1) You can change to another drug

Talk with your provider about whether there is a different drug covered by the plan that may work just as well for you. You can call 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.

2) You can ask for an exception

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

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

If you and your provider want to ask for an exception, Chapter 7, Section 5.4 tells you what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

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

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

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, talk to your provider. There may be different drug in a lower cost-sharing tier that might work just as well for you. Call 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 - Preferred Brand, Tier 3: Non-Preferred Drugs, you and your provider can ask the plan to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule.

If you and your provider want to ask for an exception, Chapter 7, Section 5.4 tells you what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

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

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

Section 6.1 The Drug Guide can change during the year

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

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

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

See Chapter 10 for definitions of the drug types discussed in this chapter.

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

Information on changes to drug coverage

When changes to the Drug Guide occur, we post information on our website about those changes. We update our online Drug Guide regularly. This section describes the types of changes we may make to the Drug Guide and when you will get direct notice if changes are made for a drug that you are taking.

Changes we may make to the Drug Guide that affect you during the current 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 will make these immediate changes only if we are adding a new generic version of a brand name or adding 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 are taking the drug that we are removing or making changes to. If you are taking the like drug at the time we make the change, we will 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 with advance notice.**
 - 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 version of the drug that we add 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 will make these changes only if we are adding a new generic version of a brand name drug or adding certain new biosimilar versions of an original biological product that was already on the Drug Guide.
 - We will 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 are taking.
- **Removing unsafe drugs and other drugs on the Drug Guide that are withdrawn from the market.**
 - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug Guide If you are taking that drug, we will tell you 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 will 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 any of these changes to any of the drugs you are taking, talk with your prescriber about the options that would work best for you, including changing to a different drug to treat your condition, or requesting a coverage decision to satisfy any new restrictions on the drug you are taking. You or your prescriber can ask us for an exception to continue covering the drug or version of the drug you have been taking. For more information on how to ask for a coverage decision, including an exception, see Chapter 7.

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

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

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

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

If any of these changes happen for a drug you are taking (except for market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), 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 will not tell you about these types of changes directly during the current plan year. You will need to check the Drug Guide for the next plan year (when the guide is available during the open enrollment period) to see if there are any changes to the drugs you are taking that will impact you during the next plan year.

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

Section 7.1 Types of drugs we do not cover

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

If you get drugs that are excluded, you must pay for them yourself. If you appeal and the requested drug is found not to be excluded under Part D, we will pay for or cover it. (For information about appealing a decision, go to Chapter 7).

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

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States or its territories.
- Our plan cannot cover *off-label* use of a drug when the use is not 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 Food and Drug Administration.

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

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra, and Caverject
- Drugs used for treatment of anorexia, weight loss, or weight gain

Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

We offer additional coverage of some prescription drugs not normally covered in a Medicare prescription drug plan. The amount you pay when you fill a prescription for these drugs does not count toward qualifying you for the Catastrophic Coverage Stage. (The Catastrophic Coverage Stage is described in Chapter 4, Section 7 of this booklet.) Your cost for certain vitamins, cough and cold medication will depend on the drug tier which these certain drugs fall into. Please refer to the benefit chart in Chapter 4 for your drug tier cost shares. These prescription drugs are available in at least a 30-day supply and not more than a 90-day supply.

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

SECTION 8 Filling a prescription

Section 8.1 Provide your membership information

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

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

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

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up.** (You can then ask us to reimburse you for our share. See Chapter 5, Section 2.1 for information about how to ask the plan for reimbursement.)

SECTION 9 Part D drug coverage in special situations

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

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

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

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

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

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

Please refer to Section 5.2 about a temporary or emergency supply.

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

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

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

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

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

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

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

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

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

Special note about creditable coverage:

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

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

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

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

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

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

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

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

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

- Possible medication errors
- Drugs that may not be necessary because you are taking another 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 are allergic to
- Possible errors in the amount (dosage) of a drug you are taking
- Unsafe amounts of opioid pain medications

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

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

We have a program that helps make sure members safely use prescription opioids and other frequently abused medications. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several 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 may get these medications or how much you can get, we will send you a letter in advance. The letter will tell you if we will limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific prescriber or pharmacy. You will 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 will send you another letter confirming the limitation. If you think we made a mistake or you disagree with our decision or with the limitation, you and your prescriber have the right to appeal. If you appeal, we will review your case and give you a new decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we will automatically send your case to an independent reviewer outside of our plan. See Chapter 7 for information about how to ask for an appeal.

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

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

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

Our program is called a Medication Therapy Management (MTM) program. These programs are voluntary and free. A team of pharmacists and doctors developed the programs for us to help make sure that 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 members use their 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 receive information on the safe disposal of prescription medications that are controlled substances.

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

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

CHAPTER 4:

What you pay for your Part D prescription drugs

Are you currently getting help to pay for your drugs?

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

SECTION 1 Introduction

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

This chapter focuses on what you pay for Part D prescription drugs. To keep things simple, we use *drug* in this chapter to mean a Part D prescription drug. As explained in Chapter 3, not all drugs are Part D drugs -- some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law.

To understand the payment information, 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 3, Sections 1 through 4 explain these rules. When you use the plan's "Real-Time Benefit Tool" to look up drug coverage (see Chapter 3, Section 3.3), the cost shown is provided in "real time," meaning the cost you see in the tool reflects a moment in time to provide an estimate of the out-of-pocket costs you are expected to pay. You can also obtain information provided by the "Real-Time Benefit Tool" by calling Humana Group Medicare Customer Care.

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

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

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

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

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

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

Your out-of-pocket costs include the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 3):

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

It matters who pays:

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are *also included* in your out-of-pocket costs if they are made on your behalf by **certain other individuals or organizations**. This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, by a State Pharmaceutical Assistance Program that is qualified by Medicare, employer, or union health plans, TRICARE, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of \$2,000 in out-of-pocket costs within the calendar year, you will move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

These payments are not included in your out-of-pocket costs

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

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

Chapter 4 What you pay for your Part D prescription drugs

- Payments you make toward drugs covered under our additional coverage but not normally covered in a Medicare Prescription Drug Plan
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan
- Payments for your drugs that are made by group health plans including employer health plans
- Payments for your drugs that are made by 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 such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan by calling Humana Group Medicare Customer Care.

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

- **We will help you.** The Part D Explanation of Benefits (EOB) report you receive includes the current amount of your out-of-pocket costs. When this amount reaches \$2,000, this report will tell you that you have left the Initial Coverage Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

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

Section 2.1 What are the drug payment stages for Humana Group Medicare PDP Plan members?

There are three drug payment stages for your prescription drug coverage under your Humana Group Medicare PDP Plan. How much you pay depends on what stage you are in when you get a prescription filled or refilled. Keep in mind you are always responsible for the plan's monthly premium regardless of the drug payment stage.

Details of each stage are in Sections 4 through 6 of this chapter. The stages are:

Stage 1: Yearly Deductible Stage

Stage 2: Initial Coverage Stage

Stage 3: Catastrophic Coverage Stage

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

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

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

- We keep track of how much you have paid. This is called your **Out-of-Pocket Costs**. 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, TRICARE, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- We keep track of your **Total Drug Costs**. This is the total of all payments made for your covered Part D drugs. It includes what the plan paid, what you paid, and what other programs or organizations paid for your covered Part D drugs.

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

- **Information for that month.** This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the plan year.** This is called year-to-date information. It shows the total drug costs and total payments for your drugs since the plan year began.
- **Drug price information.** This information will display the total drug price, and information about increases in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This will include information about other available drugs with lower cost-sharing for each prescription claim, if applicable.

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

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

- **Show your membership card every time you get a prescription filled.** This helps us make sure we know about the prescriptions you are filling and what you are paying.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. Here are examples of when you should give us copies of your drug receipts:
 - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.
 - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
 - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
 - If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 5, Section 2.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive a *SmartSummary* look it over to be sure the information is complete and correct. If you think something is missing or you have any questions, please call Humana Group Medicare Customer Care. Be sure to keep these reports.

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

There is no deductible for Humana Group Medicare PDP Plan. You begin in the Initial Coverage Stage when you fill your first prescription of the year. See Section 5 for information about your coverage in the Initial Coverage Stage.

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

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

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

The plan has four cost-sharing tiers

Every drug on the plan's Drug Guide (See Section 1.1 of this chapter for how to access the *Drug Guide*.) is in one of four cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

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

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

Your pharmacy choices

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

- A network retail pharmacy
- A pharmacy that is not in the plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 3, Section 2.5 to find out when we will cover a prescription filled at an out-of-network pharmacy
- The plan's mail-order pharmacy

For more information about these pharmacy choices and filling your prescriptions, see Chapter 3 the plan's *Pharmacy Directory* [Humana.com/SearchResources](https://www.humana.com/SearchResources).

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

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

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

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

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

	Standard retail cost-sharing (in-network) (up to a 30 day supply)	Mail-order cost-sharing (up to a 30 day supply)	Long-term care (LTC) cost-sharing (up to a 31 day supply)	Out-of-network cost-sharing (up to a 30 day supply) (coverage is limited to certain situations; see Chapter 3 for details.)*
Cost-Sharing Tier 1 (Generic or Preferred Generic)	\$10	\$10	\$10	\$10
Cost-Sharing Tier 2 (Preferred Brand)	\$30	\$30	\$30	\$30
Cost-Sharing Tier 3 (Non-Preferred Drug)	\$55	\$55	\$55	\$55
Cost-Sharing Tier 4 (Specialty)	\$55	\$55	\$55	\$55

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

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

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

- If you are responsible for coinsurance, you pay a *percentage* of the total cost of the drug. Since the coinsurance is based on the total cost of the drug, your cost will be lower since the total cost for the drug will be lower
- If you are responsible for a copayment for the drug, you will only pay for the number of days of the drug that you receive instead of a whole month. We will calculate the amount you pay per day for your drug (the daily cost-sharing rate) and multiply it by the number of days of the drug you receive.

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

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

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

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

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

Chapter 4 What you pay for your Part D prescription drugs

	Standard retail cost-sharing (in-network) (up to a 90 day supply)	Mail-order cost-sharing (in-network) (up to a 90 day supply)
Cost-Sharing Tier 1 (Generic or Preferred Generic)	\$20	\$20
Cost-Sharing Tier 2 (Preferred Brand)	\$60	\$60
Cost-Sharing Tier 3 (Non-Preferred Drug)	\$110	\$110
Cost-Sharing Tier 4 (Specialty)	A long-term supply is not available for drugs in Tier 4	A long-term supply is not available for drugs in Tier 4

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

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

Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach \$2,000

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach \$2,000. You then move on to the Catastrophic Coverage Stage.

The *SmartSummary* that you receive will help you keep track of how much you, the plan, and any third parties, have spent on your behalf during the year. Not all members will reach the \$2,000 limit in a year.

We will let you know if you reach this \$2,000 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage.

See Section 1.3 on how Medicare calculates your out-of-pocket costs.

SECTION 6 During the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs

- You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the \$2,000 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.
 - During this payment stage, you pay nothing for your covered Part D drugs.

SECTION 7 Part D Vaccines. What you pay for depends on how and where you get them

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 the plan's Drug Guide. Our plan covers most adult Part D vaccines at no cost to you. Refer to your plan's Drug Guide or contact Humana Group Medicare Customer Care for coverage and cost-sharing details about specific vaccines.

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

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

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

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

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

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

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

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

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

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

- When you get the vaccines, you may have to pay for the entire cost of the vaccine itself and the cost for the provider to give it to you.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 5.
- For most adult Part D vaccines, you will be reimbursed the full amount you paid less any coinsurance or copayment for the vaccine (including administration), and less any difference between the amount the doctor charges and what we normally pay. (If you get "Extra Help", we will reimburse you for this difference.)

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

- For most adult Part D vaccines, you will pay nothing for the vaccine itself.
- For other Part D vaccines, you will pay the pharmacy your coinsurance or copayment for the vaccine itself.
- When your doctor gives you the vaccine, you may have to pay the entire cost for this service.
- You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 5.
- For most adult Part D vaccines, you will be reimbursed the full amount you paid. For other Part D vaccines, you will be reimbursed the amount you paid less any coinsurance for the vaccine administration.
- , and less any difference between the amount the doctor charges and what we normally pay. (If you get "Extra Help", we will reimburse you for this difference.)

CHAPTER 5:

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

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

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

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

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

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

- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out-of-network pharmacies in limited circumstances. See Chapter 3, Section 2.5 for a discussion 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 that we would pay at an in-network pharmacy.

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

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

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

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

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

- For example, the drug may not be in the plan's Drug Guide; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it. (See Chapter 4, Section 1.1 of this booklet for how to access the Drug Guide.)

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

4. If you are retroactively enrolled in our plan

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

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

- Please call 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.)

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 7 of this document has information about how to make an appeal.

SECTION 2 How to ask us to pay you back

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

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

- You don't have to use the form, but it will help us process the information faster.
- Send us your request for payment along with the following information:
 - Proof of payment
 - Itemized bill listing the item received
 - Physician order (if applicable)
 - Medical records

- Any other supporting documentation
- Either download a copy of the form from our website (<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:

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

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

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

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

- If we decide that the drug is covered and you followed all the rules, we will pay for our share of the cost. Our share of the cost might not be the full amount you paid (for example, if you obtained a drug at an out-of-network pharmacy or if the cash price you paid for a drug is higher than our negotiated price). We will mail your reimbursement of our share of the cost to you. We will send payment within 30 days after your request was received.
- If we decide that the drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter explaining the reasons why we are not sending the payment and your right to appeal that decision.

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

If you think we have made a mistake in turning down your request for payment or the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 7 of this document.

CHAPTER 6:

Your rights and responsibilities

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

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

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

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call 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 the plan's network for a specialty are not available, it is the plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you will only pay in-network cost sharing. If you find yourself in a situation where there are no specialists in the plan's network that cover a service you need, call the plan for information on where to go to obtain this service at in-network cost sharing.

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

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

Chapter 6 Your rights and responsibilities

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

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

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

You have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays. If you think that you are not getting your Part D drugs within a reasonable amount of time.

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 do not require us to get your written permission first. These exceptions are allowed or required by law.
 - We are required to release health information to government agencies that are checking on quality of care.
 - Because you are a member of our plan through Medicare, we are required to give Medicare your health information, including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

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

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

Chapter 6 Your rights and responsibilities

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

If you have questions or concerns about the privacy of your personal health information, please call 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 may change our privacy practices and the terms of this notice at any time, as allowed by law, including information we created or received before we made the changes. When we make a significant change in our privacy practices, we will change this notice and send the notice to our health plan subscribers.

What is Nonpublic personal or health information?

Nonpublic personal or health information includes both medical information and personal 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 or and health information. This includes information created or received by a health care provider or health plan. The information relates to your physical or mental health or condition, providing health care to you, or the payment for such health care.

How do we 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?

We have a responsibility to protect the privacy of your information in all formats including electronic and oral 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 employees about our privacy programs and procedures

How do we use and disclose your information?

We use and disclose your information:

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

We have the right to use and disclose your information:

- To a doctor, a hospital, or other health care provider so you can receive medical care.
- For payment activities, 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, coordinating your care, improving quality, and determining premiums.
- For performing underwriting activities. However, we will not use any results of genetic testing or ask questions regarding family history.
- To your plan sponsor to permit them to perform, plan administration functions such as eligibility, enrollment and disenrollment activities. We may share summary level health information about you with your plan sponsor in certain situations. For example, to allow your plan sponsor to obtain bids from other health plans. Your detailed health information will not be shared with your plan sponsor. We will ask your permission, or your plan sponsor 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 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. This applies if the information is directly relevant to their involvement with your health care or payment for that care. For example, if a family member or a caregiver calls us with prior knowledge of a claim, we may confirm if the claim has been received and paid.
- To provide payment information to the subscriber for Internal Revenue Service substantiation.

- To public health agencies, if we believe that there is a serious health or safety threat.
- To appropriate authorities when there are issues about abuse, neglect, or domestic violence
- In response to a court or administrative order, subpoena, discovery request, or other lawful process.
- For law enforcement purposes, to military authorities and as otherwise required by law.
- To help with disaster relief efforts.
- For compliance programs and health oversight activities.
- To fulfill our obligations under any workers' compensation law or contract.
- To avert a serious and imminent threat to your health or safety or the health or safety of others.
- For research purposes in limited circumstances and provided that they have taken appropriate measures to protect your privacy.
- For procurement, banking, or transplantation of organs, eyes, or tissue.
- To a coroner, medical examiner, or funeral director.

Will we use your information for purposes not described in this notice?

We will not use or disclose your information for any reason that is not described in this notice, without your written permission. You may cancel your permission at any time by notifying us in writing. The following uses and disclosures will require your written permission:

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

What do we do with your information when you are no longer a member?

Your information may continue to be used for purposes described in this notice. This includes when you do not obtain coverage through us. After the required legal retention period, we destroy the information following strict procedures to maintain the confidentiality.

What are my rights concerning my information?

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

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

Chapter 6 Your rights and responsibilities

- Adverse Underwriting Decision - If we decline your application for insurance, you have the right to be provided a reason for the denial.
- Alternate Communications - To avoid a life-threatening situation, you have the right to receive your information in a different manner or at a different place. We will accommodate your request if it is reasonable.
- Amendment - You have the right to request 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. This does not apply to treatment, payment, health plan operations, and certain other activities. We maintain this information and make it available to you for six years. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee.
- Notice - You have the right to request and receive a written copy of this notice any time.
- Restriction - You have the right to ask to limit how your information is used or disclosed. We are not required to agree to the limit, but if we do, we will abide by our agreement. You also have the right to agree to or terminate a previously submitted limitation.

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

If I believe my privacy has been violated, what should I do?

If you believe that your privacy has been violated, you may file a complaint with us by calling us at 1-866-861-2762 any time.

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

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

Chapter 6 Your rights and responsibilities

Our Responsibilities

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

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

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

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

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

- Contacting us at 1-866-861-2762
- Accessing our Website at <https://your.Humana.com/kppa> and going to the Privacy Practices link
- Send completed request form to:

Humana Inc.

Privacy Office 003/10911

101 E. Main Street

Louisville, KY 40202

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

As a member of our plan, you have the right to get several kinds of information from us.

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

- **Information about our plan.** This includes, for example, information about the plan's financial condition.
- **Information about our network providers and pharmacies.** You have the right to get information from us about the pharmacies in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapter 3 and 4 provide information about Part D prescription drug coverage.
- **Information about why something is not covered and what you can do about it.** Chapter 7 provides information on asking for a written explanation on why a medical service or Part D drug is not covered or if your coverage is restricted. Chapter 7 also provides information on asking us to change a decision, also called an appeal.

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

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

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

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

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

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

Chapter 6 Your rights and responsibilities

- **Get the form.** You can get an advance directive form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

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

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

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

What if your instructions are not followed?

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

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

If you have any problems, concerns, or complaints and need to request coverage, or make an appeal, Chapter 7 of this document tells what you can do. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

Section 1.7 What can you do if you believe you are being treated unfairly or your rights are not being respected?
--

If it is about discrimination, call the Office for Civil Rights

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, sexual orientation or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, *and it's not* about discrimination, you can get help dealing with the problem you are having:

- You can **call Humana Group Medicare Customer Care**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY users should call 1-877-486-2048).

Section 1.8 How to get more information about your rights
--

There are several places where you can get more information about your rights:

- You can **call Humana Group Medicare Customer Care**
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- You can contact **Medicare**.
 - You can visit the Medicare website to read or download the publication Medicare Rights & Protections. (The publication is available at:
www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
 - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 2 You have some responsibilities as a member of the plan

Things you need to do as a member of the plan are listed below. If you have any questions, please call Humana Group Medicare Customer Care. We're here to help.

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

Chapter 6 Your rights and responsibilities

- **If you have any other prescription drug coverage in addition to our plan, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and pharmacist that you are enrolled in our plan.** Show your plan membership card whenever you get your Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
 - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
 - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
 - If you have any questions, be sure to ask and get an answer you can understand.
- **Pay what you owe.** *As a plan member, you are responsible for these payments:*
 - If you have a monthly plan premium, you must pay your plan premiums to continue being a member of our plan.
 - For most of your drugs covered by the plan, you must pay your share of the cost when you get the drug.
 - If you are required to pay a late enrollment penalty, you must pay the penalty to remain a member of the plan.
 - If you are required to pay the extra amount for Part D because of your yearly income, you must continue to pay the extra amount directly to the government to remain a member of the plan.
- **If you move *within* our plan service area, we still need to know** so we can keep your membership record up-to-date and know how to contact you.
- **If you move *outside* of our plan service area, you** cannot remain a member of our plan.
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).
- A right to make recommendations regarding the organization's member rights and responsibilities policy.

CHAPTER 7:

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

BACKGROUND

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

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

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

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

The guide in Section 3 will help you identify the right process to use and what you should do.

Section 1.2 What about the legal terms?

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand. To make things easier, this chapter:

- Uses simpler words in place of certain legal terms. For example, this chapter generally says, making a complaint rather than filing a grievance, coverage decision rather than coverage determination or at-risk determination, and independent review organization instead of Independent Review Entity.
- It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 You can get help from government organizations that are not connected with us

We are always available to help you. Even if you have a complaint about our treatment of you, we are obligated to honor your right to complain. Therefore, you should always reach out to customer service for help. But in some situations, you may also want help or guidance from someone who is not connected with us. Below are two entities that can assist you.

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

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers in Exhibit A at the end of this document.

Medicare

You can contact Medicare to get help. To contact Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can visit the Medicare website www.medicare.gov.

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

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

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

Is your problem or concern about your benefits or coverage?

This includes problems about whether medical care (medical items, services and/or Part B prescription drugs) are covered or not, the way they are covered, and problems related to payment for prescription drugs.

Yes.

Go on to the next section of this chapter, **Section 4, A guide to the basics of coverage decisions and appeals.**

No.

Skip ahead to **Section 7** at the end of this chapter: **How to make a complaint about quality of care, waiting times, customer service or other concerns.**

COVERAGE DECISIONS AND APPEALS

SECTION 4 A guide to the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals: the big picture

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

Asking for coverage decisions prior to receiving benefits

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

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide a drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

Making an appeal

If we make a coverage decision, whether before or after a benefit is received, and you are not satisfied, you can appeal the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, which we discuss later, you can request an expedited or fast appeal of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we were properly following the rules. When we have completed the review, we give you our decision.

In limited circumstances a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

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

If we do not dismiss your case but say no to all or part of your Level 1 appeal, you can go on to a Level 2 appeal. The Level 2 appeal is conducted by an independent review organization that is not connected to us. Part D appeals are discussed further in Section 5 of this chapter. If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (Section 6 in this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

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

- **You can call Humana Group Medicare Customer Care.**
- **You can get free help** from your State Health Insurance Assistance Program.
- **Your doctor or other prescriber can make a request for you.** For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied, your doctor or prescriber can request a Level 2 appeal.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your representative to ask for a coverage decision or make an appeal.
 - If you want a friend, relative, or another 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://docushare-web.apps.cf.humana.com/Marketing/docushare-app?file=639132>.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
 - While we can accept an appeal request without the form, we cannot complete our review until we receive it. If we do not receive the form before (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

SECTION 5 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

Section 5.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (See Chapter 3 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs please see Chapters 3 and 4.

- **This section is about your Part D drugs only.** To keep things simple, we generally say drug in the rest of this section, instead of repeating covered outpatient prescription drug or Part D drug every time. We also use the term Drug Guide instead of List of Covered Drugs or Formulary.
- If you do not know if a drug is covered or if you meet the rules, you can ask us. Some drugs require that you get approval from us before we will cover it.
- If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

Legal Terms

An initial coverage decision about your Part D drugs is called a coverage determination .
--

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs. This section tells what you can do if you are in any of the following situations:

- Asking to cover a Part D drug that is not on the plan's *List of Covered Drugs*. **Ask for an exception. Section 5.2**
- Asking to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get, prior authorization, or the requirement to try another drug first) **Ask for an exception. Section 5.2**
- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier. **Ask for an exception. Section 5.2**

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

- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 5.4**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 5.4**

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal.

Section 5.2 What is an exception?

Legal Terms

Asking for coverage of a drug that is not on the Drug Guide is sometimes called asking for a **formulary exception**.

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

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

If a drug is not covered in the way you would like it to be covered, you can ask us to make an exception. An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not in our plan's *Prescription Drug Guide*.** If we agree to cover a drug not on our Drug Guide, you will need to pay the cost-sharing amount that applies to drugs in Cost-Sharing Tier 3 - Non-Preferred Drug. You cannot ask for an exception to the cost-sharing amount we require you to pay for the drug.
2. **Removing a restriction for a covered drug.** Chapter 3 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.

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

3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug in our Drug Guide is in one of four cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.
- 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 the cost-sharing amount. This would be the lowest tier cost that contains biological product alternatives for treating your condition.
 - If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.
 - If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
 - You cannot ask us to change the cost-sharing tier for any drug in the Specialty tier.
 - If we approve your tiering exception request and there is more than one lower cost-sharing tier with alternative drugs you can't take, you will usually pay the lowest amount.

Section 5.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug Guide includes more than one drug for treating a particular condition. These different possibilities are called *alternative* drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception. If you ask us for a tiering exception, we will generally *not* approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.

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

- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal.

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

Legal Terms

A fast coverage decision is called an expedited coverage determination.

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

Standard coverage decisions are made within **72 hours** after we receive your doctor's statement. **Fast coverage decisions** are made within **24 hours** after we receive your doctor's statement.

If your health requires it, ask us to give you a fast coverage decision. To get a fast coverage decision, you must meet two requirements:

- You must be asking for a *drug you have not yet received*. (You cannot ask for a fast coverage decision if you are asking us to pay you back for a drug you have already bought.)
- Using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor or other prescriber tells us that your health requires a fast coverage decision, we will automatically agree to give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own (without your doctor's or other prescriber's support), we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
 - Explains that we will use the standard deadlines.
 - Explains if your doctor or other prescriber asks for the fast coverage decision, we will automatically give a fast coverage decision.
 - Tells you how to file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. We will answer your complaint within 24 hours of receipt.

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

Step 2: Request a standard coverage decision or a fast coverage decision.

Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the prescription you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request form or on our plan's form, which are available on our website. Chapter 2 has contact information. To assist us in processing your request, please be sure to include your name, contact information, and information identifying which 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 of this chapter tells how you can give written permission to someone else to act as your representative.

- **If you are requesting an exception, provide the supporting statement,** Which is the medical reasons for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

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

Deadlines for a fast coverage decision

- We must generally give you our answer within **24 hours** after we receive your request.
 - For exceptions, we will give you our answer within 24 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a standard coverage decision about a drug you have not yet received

We must generally give you our answer **within 72 hours** after we receive your request.

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

- For exceptions, we will give you our answer within 72 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
- If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

If our answer is yes to part or all of what you requested, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.

If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a standard coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Step 4: If we say no to your coverage request, you can make an appeal.

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

Section 5.5 Step-by-step: How to make a Level 1 appeal

Legal Terms

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

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

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

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 are appealing a decision, we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 5.4 of this chapter.

Step 2: 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. Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request.
- **You must make your appeal request within 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 requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal. We are allowed to charge a fee for copying and sending this information to you.

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

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

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request.
- We may contact you or your doctor or other prescriber to get more information.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires it.
 - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal for a drug you have not yet received

- For standard appeals, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.
 - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.6 explains the Level 2 appeals process.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how you can appeal our decision.

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

Deadlines for a standard appeal about getting payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 30 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

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

Legal Terms

The formal name for the Independent Review Organization is the Independent Review Entity . It is sometimes called the IRE .

The independent review organization is an independent organization hired by Medicare. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

- If we say no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the review organization. If, however, we did not complete our review within the applicable timeframe, or make an unfavorable decision regarding **at-risk** determination under our drug management program, we will automatically forward your claim to the IRE.
- We will send the information we have about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file.** We are allowed to charge you a fee for copying and sending this information to you.

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

- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

Deadlines for fast appeal

- If your health requires it, ask the independent review organization for a fast appeal.
- If the organization agrees to give you a fast appeal, the organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.

Deadlines for standard appeal

- For standard appeals, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal if it is for a drug, you have not received. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your level 2 appeal **within 14 calendar days** after it receives your request.

Step 3: The independent review organization gives you their answer.

For fast appeals:

- **If the independent review organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

For standard appeals:

- **If the independent review organization says yes to part or all of your request for coverage,** we must provide the drug coverage that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
- **If the independent review organization says yes to part or all of your request to pay you back for a drug you already bought, we are required to** send payment to you within 30 calendar days **after we receive the decision from the review organization.**

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

What if the review organization says no to your appeal?

If this organization says no to part or all of your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called **upholding the decision**. It is also called **turning down your appeal**.) In this case, the independent review organization will send you a letter:

- Explaining its decision.
- Notifying you of the right to a Level 3 appeal if the dollar value of the drug coverage you are requesting meets a certain minimum. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final.
- Telling you the dollar value that must be in dispute to continue with the appeals process.

Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If you want to go on to Level 3 appeal, the details on how to do this are in the written notice you got after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 6 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 6 Taking your appeal to Level 3 and beyond

Section 6.1 Appeal Levels 3, 4 and 5 for Part D Drug Requests

This section may be appropriate for you if you have made a Level 1 appeal and a Level 2 appeal, and both of your appeals have been turned down.

If the value of the drug you have appealed meets certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

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

Level 3 Appeal An Administrative Law Judge or attorney adjudicator who works for the Federal government will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may or may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 Appeal The Medicare Appeals Council (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may or may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal A judge at the **Federal District Court** will review your appeal.

- A judge will review all of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

MAKING COMPLAINTS

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

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

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

Quality of your medical care

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

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 are being encouraged to leave the plan?

Waiting times

- Have you been kept waiting too long by pharmacists? Or by our Humana Group Medicare Customer Care or other staff at the plan?
 - Examples include waiting too long on the phone, in the waiting room, or getting a prescription.

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

Cleanliness

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

Information you get from us

- Did we fail to give you a required notice?
- Is our written information hard to understand?

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

Timeliness

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

- You asked us for a fast coverage decision or a fast appeal, and we have said no, you can make a complaint.
- You believe we are not meeting the deadlines for coverage decisions or appeals you have made, you can make a complaint.
- You believe we are not meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint.
- You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 7.2 How to make a complaint
--

Legal Terms

- | |
|---|
| <ul style="list-style-type: none">● A complaint is also called a grievance.● Making a complaint is also called filing a grievance.● Using the process for complaints is also called using the process for filing a grievance.● A fast complaint is also called an expedited grievance. |
|---|

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

Section 7.3 Step-by-step: Making a complaint

Step 1: Contact us promptly – either by phone or in writing.

Usually, calling Humana Group Medicare Customer Care is the first step. If there is anything else you need to do, Humana Group Medicare Customer Care will let you know.

- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.

Grievance Filing Instructions

File a verbal grievance by calling Humana Group Medicare Customer Care at 1-800-281-6918. TTY 711.

Send a written grievance to:
Humana Grievances and Appeals Dept.
P.O. Box 14165
Lexington, KY 40512-4165

When filing a grievance, please provide:

- Name
- Address
- Telephone number
- Member identification number
- A summary of the complaint and any previous contact with us related to the complaint
- The action you are requesting from us
- A signature from you or your authorized representative and the date. If you want a friend, relative, your doctor or other provider, or other person to be your representative, call 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.

The **deadline** for making a complaint is **60 calendar days** from the time you had the problem you want to complain about.

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

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.

If you are making a complaint because we denied your request for a fast coverage decision or a fast appeal, we will automatically give you a fast complaint. If you have a fast complaint, it means we will give you **an answer within 24 hours.**

- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will include our reasons in our response to you.

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

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

- **You can make your complaint to the Quality Improvement Organization.** The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

You can make your complaint to both the Quality Improvement Organization and us at the same time.

Section 7.5 You can also tell Medicare about your complaint

You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx.

You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 8:

Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

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

- You might leave our plan because you have decided that you want to leave. Sections 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, our plan must continue to provide your medical care and prescription drugs and you will continue to pay your cost share until your membership ends.

SECTION 2 When can you end your membership in our plan?

Please be advised, you may not be able to resume group coverage from your employer or group if you voluntarily choose to disenroll from this plan. Contact 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 PDP Plan may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply to you. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website www.medicare.gov:

- Usually, when you have moved
- If you have Medicaid.
- If we violate our contract with you.
- If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital.
- Where applicable, if you enroll in the Program of All-inclusive Care for Elderly (PACE).

The enrollment periods may vary depending on your situation.

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

Chapter 8 Ending your membership in the plan

To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:

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

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 or more days in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

Your membership will usually end on the first day of the month after your request to change your plan is received.

If you receive "Extra Help" from Medicare to pay for your prescription drugs: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

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

If you have any questions about ending your membership you can:

- **Call Humana Group Medicare Customer Care.**
- Find the information in the *Medicare & You 2025* handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY 1-877-486-2048)

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

Until your membership ends, and your new Medicare coverage begins, you must continue to get your prescription drugs through our plan.

- **Continue to use our network pharmacies or mail order to get your prescriptions filled**

SECTION 5 Humana Group Medicare PDP Plan must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?
--

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

- If you no longer have Medicare Part A or Part B (or both).
- If you move out of our service area.
- If you are away from our service area for more than 12 months.
 - If you move or take a long trip, call Humana Group Medicare Customer Care to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you are not a United States citizen or lawfully present in the United States.
- If you lie or withhold information about other insurance you have that provides prescription drug coverage.
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)

Chapter 8 Ending your membership in the plan

- If you let someone else use your membership card to get prescription drugs. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
 - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan and you will lose prescription drug coverage.

Where can you get more information?

If you have questions or would like more information on when we can end your membership call Humana Group Medicare Customer Care.

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

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

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week (TTY 1-877-486-2048).

Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

CHAPTER 9:

Legal notices

SECTION 1 Notice about governing law

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

SECTION 2 Notice about non-discrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare prescription drug plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at <https://www.hhs.gov/ocr/index>.

If you have a disability and need help with access to care, please call us at 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 prescription drugs for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Humana Medicare Employer PDP, as a Medicare prescription drug plan sponsor, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

SECTION 4 Additional Notice about Subrogation (Recovery from a Third Party)

Our right to recover payment

If we pay a claim for you, we have subrogation rights. This is a very common insurance provision that means we have the right to recover the amount we paid for your claim from any third party that is responsible for the medical expenses or benefits related to your injury, illness, or condition. You assign to us your right to take legal action against any responsible third party, and you agree to:

1. Provide any relevant information that we request; and
2. Participate in any phase of legal action, such as discovery, depositions, and trial testimony, if needed.

If you don't cooperate with us or our representatives, or you do anything that interferes with our rights, we may take legal action against you. You also agree not to assign your right to take legal action to someone else without our written consent.

Our right of reimbursement

We also have the right to be reimbursed if a responsible third party pays you directly. If you receive any amount as a judgment, settlement, or other payment from any third party, you must immediately reimburse us, up to the amount we paid for your claim.

Our rights take priority

Our rights of recovery and reimbursement have priority over other claims, and will not be affected by any equitable doctrine. This means that we're entitled to recover the amount we paid, even if you haven't been compensated by the responsible third party for all costs related to your injury or illness. If you disagree with our efforts to recover payment, you have the right to appeal, as explained in Chapter 7.

We are not obligated to pursue reimbursement or take legal action against a third party, either for our own benefit or on your behalf. Our rights under Medicare law and this *Evidence of Coverage* will not be affected if we don't participate in any legal action you take related to your injury, illness, or condition.

SECTION 5 Notice of coordination of benefits

Why do we need to know if you have other coverage?

We coordinate benefits in accordance with the Medicare Secondary Payer rules, which allow us to bill, or authorize a provider of services to bill, other insurance carriers, plans, policies, employers, or other entities when the other payer is responsible for payment of services provided to you. We are also authorized to charge or bill you for amounts the other payer has already paid to you for such services. We shall have all the rights accorded to the Medicare Program under the Medicare Secondary Payer rules.

Who pays first when you have other coverage?

When you have additional coverage, how we coordinate your coverage depends on your situation. With coordination of benefits, you will often get your care as usual through our plan providers, and the other plan or plans you have will simply help pay for the care you receive. If you have group health coverage, you may be able to maximize the benefits available to you if you use providers who participate in your group plan **and** our plan. In other situations, such as for benefits that are not covered by our plan, you may get your care outside of our plan.

Employer and employee organization group health plans

Sometimes, a group health plan must provide health benefits to you before we will provide health benefits to you. This happens if:

- You have coverage under a group health plan (including both employer and employee organization plans), either directly or through your spouse, and
- The employer has twenty (20) or more employees (as determined by Medicare rules), and
- You are not covered by Medicare due to disability or End Stage Renal Disease (ESRD).

If the employer has fewer than twenty (20) employees, generally we will provide your primary health benefits. If you have retiree coverage under a group health plan, either directly or through your spouse, generally we will provide primary health benefits. Special rules apply if you have or develop ESRD.

Employer and employee organization group health plans for people who are disabled

If you have coverage under a group health plan, and you have Medicare because you are disabled, generally we will provide your primary health benefits. This happens if:

- You are under age 65, and
- You do not have ESRD, and
- You do not have coverage directly or through your spouse under a large group health plan.

A large group health plan is a health plan offered by an employer with 100 or more employees, or by an employer who is part of a multiple-employer plan where any employer participating in the plan has 100 or more employees. If you have coverage under a large group health plan, either directly or through your spouse, your large group health plan must provide health benefits to you before we will provide health benefits to you. This happens if:

- You do not have ESRD, and
- Are under age 65 and have Medicare based on a disability.

In such cases, we will provide only those benefits not covered by your large employer group plan. Special rules apply if you have or develop ESRD.

Chapter 9 Legal notices

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.

Chapter 9 Legal notices

Non-duplication of benefits

We will not duplicate any benefits or payments you receive under any automobile, accident, liability, or other coverage. You agree to notify us when such coverage is available to you, and it is your responsibility to take any actions necessary to receive benefits or payments under such automobile, accident, liability, or other coverage. We may seek reimbursement of the reasonable value of any benefits we have provided in the event that we have duplicated benefits to which you are entitled under such coverage. You are obligated to cooperate with us in obtaining payment from any automobile, accident, or liability coverage or other carrier.

If we do provide benefits to you before any other type of health coverage you may have, we may seek recovery of those benefits in accordance with the Medicare Secondary Payer rules. Please also refer to the **Additional Notice about Subrogation (Recovery from a Third Party)** section for more information on our recovery rights.

More information

This is just a brief summary. Whether we pay first or second – or at all – depends on what types of additional insurance you have and the Medicare rules that apply to your situation. For more information, consult the brochure published by the government called "Medicare & Other Health Benefits: Your Guide to Who Pays First." It is CMS Pub. No. 02179. Be sure to consult the most current version. Other details are explained in the Medicare Secondary Payer rules, such as the way the number of persons employed by an employer for purposes of the coordination of benefits rules is to be determined. The rules are published in the Code of Federal Regulations.

Appeal rights

If you disagree with any decision or action by our plan in connection with the coordination of benefits and payment rules outlined above, you must follow the procedures explained in Chapter 7 What to do if you have a problem or complaint (coverage decisions, appeals, complaints) in this *Evidence of Coverage*.

CHAPTER 10:

Definitions of important words

Chapter 10. Definitions of important words

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

Appeal - An appeal is something you do if you disagree with our decision to deny a request for coverage of prescription drugs or payment for drugs you already received.

Biological Product - A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. See also "**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 \$2,000 for Part D covered drugs during the covered year. During this payment stage, the plan pays the full cost for your covered Part D drugs 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-SNPs are SNPs that restrict enrollment to MA eligible individuals who have one or more severe or disabling chronic conditions, as defined under 42 CFR 422.2, including restricting enrollment based on the multiple commonly co-morbid and clinically-linked condition groupings specified in 42 CFR 422.4(a)(1)(iv).

Coinsurance - An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services or prescription drugs.

Complaint- The formal name for making a complaint is **filing a grievance**. The complaint process is used *only* for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.

Chapter 10 Definitions of important words

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

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

Cost-Sharing Tier - Every drug on the list of covered drugs is in one of four cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination - A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called coverage decisions in this document.

Covered Drugs - The term we use to mean all of the prescription drugs covered by our plan.

Creditable Prescription Drug Coverage - Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

Customer Care – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

Daily cost-sharing rate – A daily cost-sharing rate may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is \$30, and a one month's supply in your plan is 30 days, then your daily cost-sharing rate is \$1 per day.

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

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.

Chapter 10 Definitions of important words

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

Evidence of Coverage (EOC) and Disclosure Information - This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception - A type of coverage decision that, if approved, allows you to get a drug that is not on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also request an exception if our plan requires you to try another drug before receiving the drug you are requesting, 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 are requesting (a formulary exception).

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

Generic Drug - A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a generic drug works the same as a brand name drug and usually costs less.

Grievance - A type of complaint you make about our plan, providers, us or pharmacies, including a complaint concerning the quality of your care. This does not involve coverage or payment disputes.

Humana Group Medicare Customer Care - A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

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.

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 related to 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) - See "Extra Help".

Manufacturer Discount Program - A program under which drug manufacturers pay a portion of the 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.

Medicaid (or Medical Assistance) - A joint Federal and State program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Accepted Indication - A use of a drug that is either approved by the Food and Drug Administration or supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information system.

Medically Necessary - Drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare - The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

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-Covered Services - Services covered by Medicare Part A and Part B. The term Medicare-Covered Services does not include the extra benefits, such as vision, dental or hearing, that a Medicare Advantage plan may offer.

Chapter 10 Definitions of important words

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare 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.

Original Biological Product - A biological product that has been approved by the Food and Drug Administration (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 like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part (Medical Insurance) and is available everywhere in the United States.

Our plan – The plan you are enrolled in.

Out-of-Network Pharmacy - A pharmacy that does not have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Pocket Costs – See the definition for cost-sharing above. A member's cost-sharing requirement to pay for a portion of drugs received is also referred to as the member's out-of-pocket cost requirement.

Chapter 10 Definitions of important words

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 receive both their Medicare and Medicaid benefits through the plan.

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

Part D - The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs - Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded as covered Part D drugs by Congress. Certain categories of Part D drugs must be covered by every plan.

Part D Late Enrollment Penalty - An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you are first eligible to join a Part D plan.

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

Premium - The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Prescription Drug Guide (Formulary) - A list of covered drugs provided by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand name and generic drugs.

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

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.

Chapter 10 Definitions of important words

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.

Service Area - A geographic area where you must live to join a particular prescription drug plan. The plan may disenroll you if you permanently move out of the plan's service area.

Special Enrollment Period - A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting "Extra Help" with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

Step Therapy - A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) - A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Exhibit A: State Agency Contact Information

ALABAMA	
QIO	KEPRO 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609 1-888-317-0751 1-855-843-4776 (TTY) 1-833-868-4058 (fax)
SHIP	Alabama Department of Senior Services 201 Monroe St., Suite 350, Montgomery, AL 36104 1-800-243-5463 (1-800-AGELINE)(toll free) 1-334-242-5594 (fax) http://www.alabamaageline.gov/
SMO	Alabama Medicaid Agency 501 Dexter Avenue, P.O. Box 5624, Montgomery, AL 36103-5624 1-800-362-1504 (toll free) 1-334-242-5000 (local) http://www.medicaid.alabama.gov/
SPAP	Not Applicable
ADAP	Alabama AIDS Drug Assistance Programs, HIV/AIDS Division Alabama Department of Public Health The RSA Tower, 201 Monroe Street, Suite 1400, Montgomery, AL 36104 1-866-574-9964 1-334-206-6221 (fax) http://www.alabamapublichealth.gov/hiv/adap.html
ALASKA	
QIO	KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-305-6759 1-855-843-4776 (TTY) 1-833-868-4064 (fax)
SHIP	Alaska State Health Insurance Assistance Programs (SHIP) 550 W. 7th Ave., Suite 1230, Anchorage, AK 99501 1-800-478-6065 (toll free) 1-907-269-7800 (local) 1-800-770-8973 (TTY)(toll free) www.medicare.alaska.gov
SMO	Alaska Department of Health and Social Services 350 Main Street Room 304, P.O. Box 110640, Juneau, AK 99811 1-800-780-9972 (toll free) 1-907-465-3030 (local) 1-907-465-3068 (fax) www.dhss.alaska.gov/dpa
SPAP	Not Applicable
ADAP	Alaskan AIDS Assistance Association 1057 W. Fireweed Lane, Ste 102, Anchorage, AK 99503 1-800-478-2437 1-907-263-2051 (fax) www.alaskanids.org/index.php/client-services/adap
ARIZONA	
QIO	Livanta BFCC-QIO Program 10820 Guilford Rd, Ste 202, Annapolis Junction, MD 20701 1-877-588-1123 1-855-887-6668 (TTY) 1-833-868-4063 (fax)

Exhibit A: State Agency Contact Information

SHIP	Arizona State Health Insurance Assistance Program (SHIP) 1789 West Jefferson St., (Site Code 950A), Phoenix, AZ 85007 1-800-432-4040 (toll free) (Spanish available upon request) 1-602-542-4446 (local) 711 (TTY) https://des.az.gov/services/older-adults/medicare-assistance
SMO	Arizona Health Care Cost Containment System (AHCCCS) 801 E. Jefferson St., Phoenix, AZ 85034 1-800-523-0231 (toll free) 1-602-417-4000 (local) 1-602-252-6536 (fax) 1-602-417-4000 (Spanish) http://www.azahcccs.gov/
SPAP	Not Applicable
ADAP	Office of Disease Integration and Services, Arizona Department of Health Services 150 North 18th Avenue Suite 110, Phoenix, AZ 85007 1-800-334-1540 1-602-364-3610 1-602-364-3263 (fax) https://www.azdhs.gov/preparedness/epidemiology-disease-control/disease-integration-services/index.php#aids-drug-assistance-program-home
ARKANSAS	
QIO	KEPRO 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609 1-888-315-0636 1-855-843-4776 (TTY) 1-833-868-4060 (fax)
SHIP	Senior Health Insurance Information Program (SHIIP) 1 Commerce Way, Little Rock, AR 72202 1-800-282-9134 (toll free) 1-501-371-2782 (local) 1-501-371-2781 (fax) 1-501-683-4468 (TTY) www.insurance.arkansas.gov/pages/consumer-services/senior-health/
SMO	Arkansas Medicaid Donaghey Plaza South, P.O. Box 1437 Slot S401, Little Rock, AR 72203-1437 1-800-482-5431 (toll free) 1-501-682-8233 (local) 1-800-482-8988 (Spanish) 1-501-682-8820 (TTY) www.medicaid.mmis.arkansas.gov/
SPAP	Not Applicable
ADAP	Arkansas AIDS Drug Assistance Program, Arkansas Department of Health 4815 West Markham Street; Slot 33, Little Rock, AR 72205 1-501-661-2408 1-501-661-2082 (fax) www.healthy.arkansas.gov/programs-services/topics/ryan-white-program

Exhibit A: State Agency Contact Information

CALIFORNIA	
QIO	Livanta BFCC-QIO Program 10820 Guilford Rd, Ste 202, Annapolis Junction, MD 20701 1-877-588-1123 1-855-887-6668 (TTY) 1-833-868-4063 (fax)
SHIP	California Health Insurance Counseling & Advocacy Program (HICAP) 1300 National Drive, Suite 200, Sacramento, CA 95834-1992 1-800-434-0222 (toll free) 1-916-928-2267 (fax) 1-800-735-2929 (TTY) www.aging.ca.gov/HICAP/
SMO	Medi-Cal (Medicaid) P.O. Box 997413 MS 4400, Sacramento, CA 95899-7413 1-800-541-5555 (toll free) 1-916-636-1980 (local) www.medi-cal.ca.gov/
SPAP	Not Applicable
ADAP	AIDS Drug Assistance Program California Department of Public Health, Office of AIDS MS 7700, P.O. Box 997426, Sacramento, CA 95899 1-844-421-7050 https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OAadap.aspx
COLORADO	
QIO	KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-317-0891 1-855-843-4776 (TTY) 1-833-868-4062 (fax)
SHIP	Senior Health Insurance Assistance Program (SHIP) 1560 Broadway, Suite 850, Denver, CO 80202 1-800-886-7675 (toll free) 1-866-665-9668 (Spanish) 1-303-894-7880 (TTY) www.colorado.gov/dora/division-insurance
SMO	Health First Colorado 1570 Grant Street, Denver, CO 80203-1818 1-800-221-3943 (toll free) 1-303-866-2993 (local) 1-303-866-4411 (fax) www.colorado.gov/hcpf
SPAP	Colorado Bridging the Gap, Colorado Department of Public Health and Environment 4300 Cherry Creek Drive South, Denver, CO 80246 1-303-692-2783 (local) 1-303-692-2716 (local) https://www.colorado.gov/pacific/cdphe/prevention-care
ADAP	Colorado AIDS Drug Assistance Program CDPHE Care and Treatment Program ADAP 4300 Cherry Creek Drive South, Denver, CO 80246-1530 1-303-692-2716 1-303-691-7736 (fax) https://www.colorado.gov/pacific/cdphe/prevention-care

2025 Evidence of Coverage for Humana Group Medicare Advantage PDP Plan
Exhibit A: State Agency Contact Information

CONNECTICUT	
QIO	<p>KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-319-8452 1-855-843-4776 (TTY) 1-833-868-4055 (fax)</p>
SHIP	<p>CHOICES 55 Farmington Avenue, 12th Floor, Hartford, CT 06105-3730 1-800-994-9422 (toll free for in-state) 1-866-218-6631 (out of state callers) 1-860-424-4850 (fax) 1-860-247-0775 (toll free TTY) www.ct.gov/agingservices</p>
SMO	<p>HUSKY Health Connecticut 55 Farmington Avenue, Hartford, CT 06105-3730 1-855-626-6632 (toll free) 1-860-424-4908 (local) 1-800-842-4524 (TTY) www.ct.gov/dss/site/default.asp</p>
SPAP	<p>Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled Program (PACE) P.O. Box 5011, Hartford, CT 06102 1-800-423-5026 (toll free) 1-860-269-2029 (local) www.payingforseniorcare.com/prescription-drugs/assistance-for-the-elderly.html</p>
ADAP	<p>Connecticut AIDS Drug Assistance Program (CADAP) Department of Social Services Medical Operations Unit #4 25 Sigourney Street, Hartford, CT 06106-5033 1-800-233-2503 (toll free) www.portal.ct.gov/DSS/Health-And-Home-Care/CADAP/Connecticut-AID S-Drug-Assistance-Program-CADAP</p>
DELAWARE	
QIO	<p>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)</p>
SHIP	<p>Delaware Medicare Assistance Bureau (DMAB) 1351 West North Street Suite 101, Dover, DE 19904 1-800-336-9500 (toll free) 1-302-674-7364 (local) https://insurance.delaware.gov/divisions/dmab/</p>
SMO	<p>Delaware Health and Social Services Division of Medicaid and Medical Assistance 1901 N. DuPont Highway, New Castle, DE 19720 1-800-372-2022 (toll free) 1-302-255-9500 (local) 1-302-255-4429 (fax) http://www.dhss.delaware.gov/dhss/dmma/</p>

Exhibit A: State Agency Contact Information

SPAP	Delaware Chronic Renal Disease Program 11-13 North Church Ave, Milford, DE 19963 0950 1-800-464-4357 (toll free) 1-302-424-7180 https://www.dhss.delaware.gov/dhss/dmma/crdprog.html
ADAP	Delaware HIV Consortium Thomas Collins Building, 540 S. DuPont Highway, Dover, DE 19901 1-302-744-1050 1-302-739-2548 (fax) http://www.ramsellcorp.com/medical_professionals/de.aspx
DISTRICT OF COLUMBIA	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-396-4646 1-888-985-2660 (TTY) 1-833-868-4057 (fax)
SHIP	Health Insurance Counseling Project (HICP) 500 K Street, NE, Washington, DC 20002 1-202-724-5626 (local) 711 (TTY) 1-202-724-2008 (fax) https://dcoa.dc.gov/service/health-insurance-counseling
SMO	Department of Health- District of Columbia 899 North Capitol Street NE, Washington, DC 20002 1-855-532-5465 (toll free) 1-202-442-5955 (local) 1-202-442-4795 (fax) 711 (TTY) http://www.doh.dc.gov/
SPAP	Not Applicable
ADAP	DC AIDS Drug Assistance Program District of Columbia Department of Health 899 North Capitol Street N.E. 4th floor, Washington, DC 20002 1-202-671-4900 1-202-673-4365 (fax) 1-202-671-4815 (DC ADAP Hotline) https://www.dchealth.dc.gov/DC-ADAP
FLORIDA	
QIO	KEPRO 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609 1-888-317-0751 1-855-843-4776 (TTY) 1-833-868-4058 (fax)
SHIP	Serving Health Insurance Needs of Elders (SHINE) 4040 Esplanade Way, Suite 270, Tallahassee, FL 32399-7000 1-800-963-5337 (toll free/llamada gratuito) 1-850-414-2150 (fax) 1-800-955-8770 (TTY) www.floridaSHINE.org

2025 Evidence of Coverage for Humana Group Medicare Advantage PDP Plan
Exhibit A: State Agency Contact Information

SMO	Florida Medicaid 1317 Winewood Blvd. Building 1, Room 202, Tallahassee, FL 32399-0700 1-866-762-2237 (toll free/llamada gratuito) 1-850-487-1111 (local) 1-850-922-2993 (fax) www.ahca.myflorida.com/
SPAP	Not Applicable/No corresponde
ADAP	Florida ADAP Program, HIV/AIDS Section 4052 Bald Cypress Way, Tallahassee, FL 32399 1-850-245-4422 1-800-545-7432 (1-800-545-SIDA) (español) 1-800-2437-101 (1-800-AIDS-101) (Creole/Kreyòl Ayisiyen) 1-888-503-7118 (TTY) www.floridahealth.gov/diseases-and-conditions/aids/adap/index.html
GEORGIA	
QIO	KEPRO 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609 1-888-317-0751 1-855-843-4776 (TTY) 1-833-868-4058 (fax)
SHIP	GeorgiaCares 2 Peachtree Street NW, 33rd Floor, Atlanta, GA 30303 1-866-552-4464 (Option 4) 1-404-657-1929 (TTY) http://www.mygeorgiacares.org/
SMO	Georgia Department of Community Health (DCH) (Medicaid) 2 Peachtree Street NW, Atlanta, GA 30303 1-800-436-7442 (toll free) 1-404-656-4507 (local) http://www.dch.georgia.gov/
SPAP	Not Applicable
ADAP	Georgia AIDS Drug Assistance Program Georgia Department of Public Health 2 Peachtree St. NW, Atlanta, GA 30303-3186 1-404-656-9805 https://dph.georgia.gov/aids-drug-assistance-program-adap-0
HAWAII	
QIO	Livanta BFCC-QIO Program 10820 Guilford Rd, Ste 202, Annapolis Junction, MD 20701 1-877-588-1123 1-855-887-6668 (TTY) 1-833-868-4063 (fax)
SHIP	Sage PLUS Program Executive Office on Aging No. 1 Capitol District 250 South Hotel St., Suite 406, Honolulu, HI 96813-2831 1-888-875-9229 (toll free) 1-808-586-7299 (local) 1-808-586-0185 (fax) 1-866-810-4379 (toll free TTY) http://www.hawaiiiship.org/

Exhibit A: State Agency Contact Information

SMO	Med QUEST 801 Dillingham Boulevard, 3rd Floor, Honolulu, HI 96817-4582 1-800-316-8005 (toll free) 1-808-524-3370 (local) 1-800-603-1201 (TTY) 1-800-316-8005 (Spanish) http://www.med-quest.us/
SPAP	Not Applicable
ADAP	HDAP, Harm Reduction Services Branch 728 Sunset Avenue, Honolulu, HI 96816 1-808-733-9360 http://health.hawaii.gov/harmreduction/hiv-aids/hiv-programs/hiv-medical-management-services/
IDAHO	
QIO	KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-305-6759 1-855-843-4776 (TTY) 1-833-868-4064 (fax)
SHIP	Senior Health Insurance Benefit Advisors (SHIBA) 700 West State Street 3rd Floor, P.O. Box 83720, Boise, ID 83720-0043 1-800-247-4422 (toll free) 1-208-334-4389 (fax) www.doi.idaho.gov/SHIBA
SMO	Idaho Health Plan Coverage P.O. Box 83720, Boise, ID 83720 1-877-456-1233 (toll free) 1-208-334-6700 (local) 1-866-434-8278 (fax) www.healthandwelfare.idaho.gov/
SPAP	Idaho AIDS Drug Assistance Program (IDAGAP), Department of Health and Welfare P. O. Box 83720, Boise, ID 83720 1-800-926-2588 (toll free) 1-208-334-5943 (local) www.healthandwelfare.idaho.gov/Health/FamilyPlanningSTDHIV/HIVCareandTreatment/tabid/391/Default.aspx
ADAP	Idaho ADAP, Idaho Ryan White Part B Program 450 West State Street, P.O. Box 83720, Boise, ID 83720-0036 1-208-334-5612 1-208-332-7346 (fax) https://healthandwelfare.idaho.gov/Health/HIV,STD,HepatitisPrograms/HIVCare/tabid/391/Default.aspx
ILLINOIS	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-524-9900 1-888-985-8775 (TTY) 1-833-868-4059 (fax)

Exhibit A: State Agency Contact Information

SHIP	Senior Health Insurance Program (SHIP) One Natural Resources Way, Suite 100, Springfield, IL 62702-1271 1-800-252-8966 (toll free) 1-888-206-1327 (TTY) www.illinois.gov/aging/SHIP
SMO	Medical Assistance Program 100 South Grand Avenue East, Springfield, IL 62762 1-800-226-0768 (toll free) 1-217-782-4977(local) 1-800- 526-5812 (toll free TTY) 1-800-547-0466 (TTY) www.illinois.gov/hfs/Pages/default.aspx
SPAP	Not Applicable
ADAP	Illinois AIDS Drug Assistance Program, Illinois ADAP Office 525 West Jefferson Street First Floor, Springfield, IL 62761 1-217-524-5983 1-800-825-3518 (fax) 217-785-8013 (fax) www.dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids/ryan-white-care-and-hopwa-services
INDIANA	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-524-9900 1-888-985-8775 (TTY) 1-833-868-4059 (fax)
SHIP	State Health Insurance Assistance Program (SHIP) 311 West Washington Street, Suite 300, Indianapolis, IN 46204-2787 1-800-452-4800 (toll free) 1-765-608-2318 (local) 1-866-846-0139 (toll free TTY) http://www.in.gov/ship
SMO	Indiana Medicaid 402 West Washington Street, P.O. Box 7083, Indianapolis, IN 46204-7083 1-800-403-0864 (toll free) 1-317-233-4454 (local) 1-317-232-7867 (fax) http://www.in.gov/fssa/
SPAP	Hoosier RX 402 W. Washington St., Room W374 MS07, Indianapolis, IN 46204 1-866-267-4679 (toll free) 1-317-234-1381 (local) https://www.in.gov/fssa/ompp/3526.htm
ADAP	Indiana AIDS Drug Assistance Program Indiana State Department of Health 2 N Meridian St., Suite 6C, Indianapolis, IN 46204 1-866-588-4948 http://www.in.gov/isdh/17740.htm
IOWA	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-755-5580 1-888-985-9295 (TTY) 1-833-868-4061 (fax)

Exhibit A: State Agency Contact Information

SHIP	Senior Health Insurance Information Program (SHIIP) 1963 Bell Avenue Suite 100, Des Moines, IA 50315 1-800-351-4664 (toll free) 1-800-735-2942 (toll free TTY) https://shiip.iowa.gov/
SMO	IA Health Link 1305 E Walnut St, Des Moines, IA 50319 1-800-338-8366 (toll free) 1-515-256-4606 (local) 1-515-725-1351 (fax) 1-800-735-2942 (TTY) http://www.dhs.iowa.gov/iahealthlink
SPAP	Not Applicable
ADAP	Iowa AIDS Drug Assistance Program, Iowa Department of Public Health 321 E. 12th Street, Des Moines, IA 50319-0075 1-515-725-2011 http://www.idph.iowa.gov/hivstdhep/hiv/support
KANSAS	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-755-5580 1-888-985-9295 (TTY) 1-833-868-4061 (fax)
SHIP	Senior Health Insurance Counseling for Kansas (SHICK) New England Building 503 S. Kansas Avenue, Topeka, KS 66603 1-800-860-5260 (toll free) 1-785-296-0256 (fax) http://www.kdads.ks.gov/commissions/commission-on-aging/medicare-programs
SMO	DCR (Formerly Department of Social and Rehabilitation Services of Kansas) Curtis State Office Building, 1000 SW Jackson, Topeka, KS 66612 1-800-766-9012 (toll free) 1-785-296-1500 (local) http://www.kdheks.gov/
SPAP	Not Applicable
ADAP	Kansas AIDS Drug Assistance Program (ADAP) Curtis State Office Building, 1000 SW Jackson Suite 210, Topeka, KS 66612 1-785-296-6174 1-785-559-4225 (fax) http://www.kdheks.gov/sti_hiv/ryan_white_care.htm
KENTUCKY	
QIO	KEPRO 5201 W. Kennedy Blvd, Suite 900, Tampa, FL 33609 1-888-317-0751 1-855-843-4776 (TTY) 1-833-868-4058 (fax)
SHIP	State Health Insurance Assistance Program (SHIP) 275 East Main Street, 3E-E, Frankfort, KY 40621 1-877-293-7447 (toll free) 1-502-564-6930 (local) https://www.chfs.ky.gov/agencies/dail/Pages/ship.aspx

2025 Evidence of Coverage for Humana Group Medicare Advantage PDP Plan
Exhibit A: State Agency Contact Information

SMO	Department for Medicaid Services (DMS) 275 East Main Street, Frankfort, KY 40621 1-800-635-2570 (toll free) 1-502-564-4321 (local) http://www.chfs.ky.gov
SPAP	Not Applicable
ADAP	Kentucky AIDS Drug Assistance Program (KADAP) Kentucky Cabinet for Public Health and Family Services 275 East Main Street HS2E-C, Frankfort, KY 40621 1-800-420-7431 1-502-564-9865 (fax) https://www.chfs.ky.gov/agencies/dph/dehp/hab/Pages/services.aspx
LOUISIANA	
QIO	KEPRO 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609 1-888-315-0636 1-855-843-4776 (TTY) 1-833-868-4060 (fax)
SHIP	Senior Health Insurance Information Program (SHIIP) 1702 N. Third Street, Baton Rouge, LA 70802 1-800-259-5300 (toll free) 1-225-342-5301 (local) http://www.ldi.la.gov/SHIIP/
SMO	Healthy Louisiana (Medicaid) Healthy Louisiana P.O. Box 629, Baton Rouge, LA 70821-0629 1-888-342-6207 (toll free) 1-855-229-6848 (local) 1-877-252-2447 (Spanish) 1-855-526-3346 (TTY) https://ldh.la.gov/
SPAP	Not Applicable
ADAP	Louisiana AIDS Drug Assistance Program (L-DAP) Department of Health & Hospitals Louisiana Health Access Program (LA HAP) 1450 Poydras St Suite 2136, New Orleans, LA 70112 1-504-568-7474 1-504-568-3157 (fax) http://www.lahap.org
MAINE	
QIO	KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-319-8452 1-855-843-4776 (TTY) 1-833-868-4055 (fax)
SHIP	Maine State Health Insurance Assistance Program (SHIP) 109 Capitol Street, 11 State House Station, Augusta, ME 04333 1-800-262-2232 (toll free) Maine relay 711 (TTY) www.maine.gov/dhhs/oads/community-support/ship.html
SMO	Maine Department of Health and Human Services (Medicaid) 109 Capitol St, Augusta, ME 04333-0011 1-800-977-6740 (toll free) 1-207-287-3707 (local) 1-207-287-3005 (fax) 711 (TTY) www.maine.gov/dhhs/

Exhibit A: State Agency Contact Information

SPAP	Maine Low Cost Drugs for the Elderly or Disabled Program Office of MaineCare Services 242 State Street, Augusta, ME 04333 1-866-796-2463 https://www.maine.gov/dhhs/oads/home-support/elderly-physically-disabled/index.html
ADAP	Maine Ryan White Program 40 State House Station, Augusta, ME 04330 1-207-287-3747 1-207-287-3727 (fax) www.maine.gov/dhhs/mecdc/infectious-disease/hiv-std/contacts/adap.shtml
MARYLAND	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-396-4646 1-888-985-2660 (TTY) 1-833-868-4057 (fax)
SHIP	Maryland Department of Aging -Senior Health Insurance Assistance Program (SHIP) 301 West Preston Street, Suite 1007, Baltimore, MD 21201 1-800-243-3425 (toll free) 1-410-767-1100 (local) 1-844-627-5465 (out of state) 711 (TTY) https://aging.maryland.gov/Pages/state-health-insurance-program.aspx
SMO	Maryland Department of Health and Mental Hygiene 201 W. Preston St., Baltimore, MD 21201-2399 1-877-463-3464 (toll free) 1-410-767-6500 (local) 1-855-642-8573 (TTY) https://health.maryland.gov/pages/home.aspx
SPAP	Maryland Senior Prescription Drug Assistance Program Maryland SPDAP c/o Pool Administrators 628 Hebron Avenue, Suite 100, Glastonbury, CT 06033 1-800-551-5995 (toll free) 1-410-767-5000 (local) www.marylandspdap.com
ADAP	Prevention and Health Promotion Administration 500 N Calvert St 5th Floor, Baltimore, MD 21202 1-410-767-6535 1-410-333-2608 (fax) https://phpa.health.maryland.gov/OIDPCS/CHCS/Pages/madap.aspx
MASSACHUSETTS	
QIO	KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-319-8452 1-855-843-4776 (TTY) 1-833-868-4055 (fax)
SHIP	Serving Health Information Needs of Elders (SHINE) One Ashburton Place, 5 floor, Boston, MA 02108 1-800-243-4636 (toll free) 1-617-727-7750 (local) 1-617-727-9368 (fax) 1-877-610-0241 (toll free TTY) https://www.mass.gov/orgs/executive-office-of-elder-affairs

Exhibit A: State Agency Contact Information

SMO	MassHealth 100 Hancock Street, 6th Floor, Quincy, MA 02171 1-800-841-2900 (toll free) 1-800-497-4648 (TTY) http://www.mass.gov/masshealth
SPAP	Massachusetts Prescription Advantage P.O. Box 15153, Worcester, MA 01615 1-800-243-4636 ext. 2 (toll free) http://www.mass.gov/elders/healthcare/prescription-advantage/
ADAP	Community Research Initiative of New England 529 Main Street Suite 301, Boston, MA 02129 1-617-502-1700 1-617-502-1703 (fax) http://crine.org/hdap
MICHIGAN	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-524-9900 1-888-985-8775 (TTY) 1-833-868-4059 (fax)
SHIP	MMAP, Inc. 6105 West St. Joseph Hwy, Suite 204, Lansing, MI 48917 1-800-803-7174 (toll free) www.mmapinc.org
SMO	Michigan Department of Health and Human Services (Medicaid) Capitol View Building, 201 Townsend Street, Lansing, MI 48913 1-800-642-3195 (toll free) 1-517-241-2966 (local) 1-800-649-3777 (TTY) www.michigan.gov/mdhhs
SPAP	Not Applicable
ADAP	Michigan AIDS Drug Assistance Program (MIDAP) Michigan Department of Health and Human Services Division of Health, Wellness and Disease Control, 109 Michigan Avenue 9th Floor, Lansing, MI 48913 1-888-826-6565 1-517-335-7723 (fax) www.michigan.gov/mdch/
MINNESOTA	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-524-9900 1-888-985-8775 (TTY) 1-833-868-4059 (fax)
SHIP	Minnesota State Health Insurance Assistance Program/Senior LinkAge Line 540 Cedar Street, PO Box 64976, St. Paul, MN 55164 1-800-333-2433 (toll free) www.health.state.mn.us/ship/

Exhibit A: State Agency Contact Information

SMO	Department of Human Services of Minnesota -MinnesotaCare P.O. Box 64838, St. Paul, MN 55164-0838 1-800-657-3672 (toll free) 1-651-297-3862 (local) 1-651-282-5100 (fax) www.mn.gov/dhs/
SPAP	Not Applicable
ADAP	Minnesota AIDS Drug Assistance Program P.O. Box 64972, St. Paul, MN 55164 1-651-431-2414 1-651-431-7414 (fax) www.mn.gov/dhs/
MISSISSIPPI	
QIO	KEPRO 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609 1-888-317-0751 1-855-843-4776 (TTY) 1-833-868-4058 (fax)
SHIP	MS Dept of Human Services - Division of Aging & Adult Services 200 South Lamar St., Jackson, Jackson, MS 39201 1-844-822-4622 (toll free) 1-601-359-4577 (local) 1-787-919-7291 (TTY) www.mdhs.ms.gov/adults-seniors/
SMO	Mississippi Division of Medicaid 550 High Street, Suite 1000, Jackson, MS 39201 1-800-421-2408 (toll free) 1-601-359-6050 (local) 1-601-359-6048 (fax) 1-228-206-6062 (Video Phone) www.medicaid.ms.gov/
SPAP	Not Applicable
ADAP	Mississippi AIDS Drug Assistance Program Office of STD/HIV Care and Services Division Post Office Box 1700, Jackson, MS 39215-1700 1-888-343-7373 1-601-362-4782(fax) http://msdh.ms.gov
MISSOURI	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-755-5580 1-888-985-9295 (TTY) 1-833-868-4061 (fax)
SHIP	CLAIM 1105 Lakeview Avenue, Columbia, MO 65201 1-800-390-3330 (toll free) 1-573-817-8320 (local) http://www.missouricclaim.org

Exhibit A: State Agency Contact Information

SMO	MO HealthNet (Medicaid) 615 Howerton Court, P.O. Box 6500, Jefferson City, MO 65102-6500 1-855-373-4636 (toll free) 1-573-751-3425 (local) 1-800-735-2966 (TTY) http://www.dss.mo.gov/fsd/index.htm
SPAP	Missouri RX Plan P.O. Box 6500, Jefferson City, MO 65102 1-800-375-1406 (toll free) www.morx.mo.gov/
ADAP	Missouri AIDS Drug Assistance Program Bureau of HIV, STD, and Hepatitis Missouri Department of Health & Senior Services P.O. Box 570, Jefferson City, MO 65102-0570 1-573-751-6439 1-573-751-6447 (fax) http://www.health.mo.gov/living/healthcondiseases/communicable/hivaids/casemgmt.php
MONTANA	
QIO	KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-317-0891 1-855-843-4776 (TTY) 1-833-868-4062 (fax)
SHIP	Montana State Health Insurance Assistance Program (SHIP) 2030 11th Ave, Helena, MT 59601 1-800-551-3191 (toll free) http://www.dphhs.mt.gov/sltc/aging/SHIP.aspx
SMO	State of Montana Department of Public Health and Human Services (Medicaid) 1400 Broadway Cogswell Building, P.O. Box 202951, Helena, MT 59601-8005 1-800-362-8312 (toll free) 1-406-444-4455 (local) 1-406-444-1861 (fax) http://www.dphhs.mt.gov/
SPAP	Montana Big Sky RX Program P.O. Box 202915, Helena, MT 59620 1-866-369-1233 (toll free- In State) 1-406-444-1233 (local) http://www.dphhs.mt.gov/MontanaHealthcarePrograms/BigSky.aspx
ADAP	Montana AIDS Drug Assistance Program Montana Department of Public Health and Human Services Cosswell Bldg. C – 211, 1400 Broadway, Helena, MT 59620-2951 1-406-444-3565 1-406-444-6842 (fax) http://www.dphhs.mt.gov/publichealth/hivstd/treatmentprogram.aspx
NEBRASKA	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-755-5580 1-888-985-9295 (TTY) 1-833-868-4061 (fax)

Exhibit A: State Agency Contact Information

SHIP	Nebraska Senior Health Insurance Information Program (SHIIP) 1033 O Street, Suite 307, Lincoln, NE 68508 1-800-234-7119 (toll free) 1-402-471-2841(local) 1-800-833-7352 (toll free TTY) 1-800-234-7119 (llamada gratuita) http://www.doi.nebraska.gov/shiip/
SMO	Nebraska Department of Health and Human Services (Medicaid) P.O. Box 95026, Lincoln, NE 68509 1-855-632-7633 (toll free) 1-402-471-3121 (local) 1-800-833-7352 (TTY) 1-402-471-9209 (fax) http://www.dhhs.ne.gov/Pages/default.aspx
SPAP	Not Applicable
ADAP	Nebraska AIDS Drug Assistance Program Nebraska Department of Health & Human Services 301 Centennial Mall South, Lincoln, NE 68509 1-402-471-2101 1-402-553-5527 (fax) www.dhhs.ne.gov/Pages/Ryan-White.aspx
NEVADA	
QIO	Livanta BFCC-QIO Program 10820 Guilford Rd, Ste 202, Annapolis Junction, MD 20701 1-877-588-1123 (toll free) 1-833-868-4063 (fax) 1-855-887-6668 (TTY)
SHIP	State Health Insurance Assistance Program (SHIP) 1860 E Sahara Avenue, Suite 205, Las Vegas, NV 89104 1-800-307-4444 (toll free) 1-702-486-3478 (local) https://adsd.nv.gov/Programs/Seniors/SHIP/SHIP_Prog/
SMO	Department of Health and Human Services Division of Health Care Financing and Policy, 1100 E. William Street, Carson City, NV 89701 1-800-992-0900 (toll free) 1-702-631-7098 (local) www.dwss.nv.gov
SPAP	Nevada Senior Rx Program Nevada Senior Rx Dept of Health and Human Services 3416 Goni Road Suite D-132, Carson City, NV 89706 1-866-303-6323 (toll free) 1-775-687-4210 (local) http://adsd.nv.gov/Programs/Seniors/SeniorRx/SrRxProg/
ADAP	Nevada AIDS Drug Assistance Program Office of HIV/AIDS 4126 Technology Way Suite 200, Carson City, NV 89706 1-775-684-5928 1-775-684-4056 (fax) http://dpbh.nv.gov/Programs/HIV-Ryan/Ryan_White_Part_B_-_Home/

Exhibit A: State Agency Contact Information

NEW HAMPSHIRE	
QIO	KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-319-8452 1-855-843-4776 (TTY) 1-833-868-4055 (fax)
SHIP	NH SHIP - ServiceLink Aging and Disability Resource Center 129 Pleasant Street, Concord, NH 03301-3857 1-866-634-9412 (toll free) https://www.servicelink.nh.gov/medicare/index.htm
SMO	New Hampshire Medicaid 129 Pleasant Street, Concord, NH 03301 1-844-275-3447 (toll free) 1-603-271-4344 (local) 1-800-735-2964 (toll free TTY) www.dhhs.nh.gov/
SPAP	Not Applicable
ADAP	New Hampshire AIDS Drug Assistance Program DHHS- NH CARE Program, 29 Hazen Drive, Concord, NH 03301 1-800-852-3345 ext. 4502 1-603-271-4934 (fax) 1-603-271-4502 www.dhhs.nh.gov
NEW JERSEY	
QIO	Livanta BFCC-QIO Program 10820 Guilford Rd, Ste 202, Annapolis Junction, MD 20701 1-866-815-5440 (toll free) 1-833-868-4056 (fax) 1-866-868-2289 (TTY)
SHIP	State Health Insurance Assistance Program (SHIP) P.O. Box 715, Trenton, NJ 08625 0715 1-800-792-8820 (toll free) 1-877-222-3737 (out of state) http://www.state.nj.us/humanservices/doas/services/ship/index.html
SMO	NH Family Care P.O. Box 712, Trenton, NJ 08625-0712 1-800-356-1561 (toll free) 1-877-294-4356 (TTY) http://www.state.nj.us/humanservices/dmahs
SPAP	New Jersey Senior Gold Prescription Discount Program New Jersey Department of Health and Senior Services Senior Gold Discount Program, P.O. Box 715, Trenton, NJ 08625 1-800-792-9745 (toll free) http://www.state.nj.us/humanservices/doas/services/seniorgold/
ADAP	New Jersey AIDS Drug Assistance Program New Jersey ADDP Office, P.O. Box 722, Trenton, NJ 08625-0722 1-877-613-4533 1-609-588-7037 (fax) http://www.state.nj.us/health/aids

Exhibit A: State Agency Contact Information

NEW MEXICO	
QIO	KEPRO 5201 W. Kennedy Blvd., Suite 900, Tampa FL 33609 1-888-315-0636 1-855-843-4776 (TTY) 1-833-868-4060 (fax)
SHIP	New Mexico ADRC 2550 Cerrillos Road, Santa Fe, NM 87505 1-800-432-2080 (toll free) 1-505-476-4846 (local) www.nmaging.state.nm.us/
SMO	Department of Human Services of New Mexico P.O. Box 2348, Santa Fe, NM 87504-2348 1-888-997-2583 (toll free) 1-505-827-3100 (local) 1-800-432-6217 (Spanish) 1-855-227-5485 (TTY) www.newmexico.gov/
SPAP	Not Applicable
ADAP	New Mexico AIDS Drug Assistance Program, HIV Services Program 1190 S St. Francis Dr. Suite 2-1200, Santa Fe, NM 87502 1-505-476-3628 1-505-827-0561 (fax) www.nmhealth.org/about/phd/idb/hats/
NEW YORK	
QIO	Livanta BFCC-QIO Program 10820 Guilford Rd, Ste 202, Annapolis Junction, MD 20701 1-866-815-5440 1-833-868-4056 (fax) 1-866-868-2289 (TTY)
SHIP	Health Insurance Information Counseling and Assistance Program (HIICAP) 2 Empire State Plaza, Albany, NY 12223-1251 1-800-701-0501 (toll free) https://aging.ny.gov/health-insurance-information-counseling-and-assistance
SMO	New York State Department of Health (SDOH) (Medicaid), Office of Medicaid Management 800 North Pearl Street, Albany, NY 12204 1-800-541-2831 (toll free) 1-518-473-3782 (local) www.omig.ny.gov
SPAP	New York State Elderly Pharmaceutical Insurance Coverage (EPIC) EPIC P.O. Box 15018, Albany, NY 12212-5018 1-800-332-3742 (toll free) www.health.state.ny.us/nysdoh/epic/faq.htm
ADAP	New York AIDS Drug Assistance Program HIV Uninsured Care Programs Empire Station P.O. Box 2052, Albany, NY 12220 1-800-542-2437 (or 1-844-682-4058 (toll-free)) 1-518-459-0121 (TDD) www.health.ny.gov/diseases/aids/general/resources/adap

Exhibit A: State Agency Contact Information

NORTH CAROLINA	
QIO	KEPRO 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609 1-888-317-0751 1-855-843-4776 (TTY) 1-833-868-4058 (fax)
SHIP	Seniors' Health Insurance Information Program (SHIIP) 325 N. Salisbury Street, Raleigh, NC 27603 1-855-408-1212 (toll free) 1-919-807-6900 (local) 1-919-807-6901 (fax) http://www.ncdoi.com/SHIIP/Default.aspx
SMO	North Carolina, Division of Health Benefits (Medicaid) 2501 Mail Service Center, Raleigh, NC 27699-2501 1-800-662-7030 (toll free) 1-919-855-4100 (local) 1-919-733-6608 (fax) https://www.dma.ncdhhs.gov/
SPAP	North Carolina HIV SPAP 1902 Mail Service Center, Raleigh, NC 27699 1-877-466-2232 (toll free) 1-919-733-7301 (local) https://epi.dph.ncdhhs.gov/cd/hiv/hmap.html
ADAP	North Carolina AIDS Drug Assistance Program NC Department of Health and Human Services Division of Public Health Epidemiology Section Communicable Disease Branch 1907 Mail Service Center, Raleigh, NC 27699-1902 1-877-466-2232 (toll free) (in state) 1-919-733-0490 (fax) 1-877-466-2232 (toll free) http://epi.publichealth.nc.gov/cd/hiv/hmap.html
NORTH DAKOTA	
QIO	KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-317-0891 1-855-843-4776 (TTY) 1-833-868-4062 (fax)
SHIP	Senior Health Insurance Counseling (SHIC) North Dakota Insurance Department, 600 East Boulevard Ave. Bismarck, ND 58505-0320 1-888-575-6611 (toll free) 1-701-328-2440 (local) 1-701-328-4880 (fax) 1-800-366-6888 (TTY) www.nd.gov/ndins/shic
SMO	North Dakota Department of Human Resources 600 East Blvd. Ave, Dept. 325, Bismarck, ND 58505-0250 1-800-755-2604 (toll free) 1-701-328-7068 (local) 1-701-328-1544 (fax) 1-800-366-6888 (TTY) www.nd.gov/dhs/
SPAP	Not Applicable

Exhibit A: State Agency Contact Information

ADAP	North Dakota AIDS Drug Assistance Program, North Dakota Department of Health 2635 E. Main Avenue P.O. Box 5520, Bismarck, ND 58506-5520 1-701-328-2378 1-701-328-0338 1-800-472-2180 (toll free) www.ndhealth.gov/HIV
OHIO	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-524-9900 1-888-985-8775 (TTY) 1-833-868-4059 (fax)
SHIP	Ohio Senior Health Insurance Information Program (OSHIIP) 50 West Town Street, 3rd floor Suite 300, Columbus, OH 43215 1-800-686-1578 (toll free) 1-614-644-3745 (TTY) www.insurance.ohio.gov
SMO	Ohio Department of Medicaid (ODM) 50 West Town Street, Suite 400, Columbus, OH 43215 1-800-324-8680 (toll free) 1-614-466-1213 (local) www.medicaid.ohio.gov/
SPAP	Not Applicable
ADAP	Ohio HIV Drug Assistance Program (OHDAP) Ohio Department of Health HIV Care Services Section Ohio HIV Drug Assistance Program (OHDAP), 246 N. High Street, Columbus, OH 43215 1-800-777-4775 https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/Ryan-White-Part-B-HIV-Client-Services/AIDS-Drug-Assistance-Program/
OKLAHOMA	
QIO	KEPRO 5201 W. Kennedy Blvd, Suite 900, Tampa, FL 33609 1-888-315-0636 1-855-843-4776 (TTY) 1-833-868-4060 (fax)
SHIP	Oklahoma Medicare Assistance Program (MAP) Five Corporate Plaza 3625 NW 56th St., Suite 100, Oklahoma City, OK 73112 1-800-763-2828 (toll free) (in state only) 1-405-521-6628 (local) (out of state only) https://www.ok.gov/oid/Consumers/Information for Seniors/index.html
SMO	Oklahoma Health Care Authority (OHCA) (Medicaid) 4345 N. Lincoln Blvd., Oklahoma City, OK 73105 1-800-522-0310 (toll free) 1-405-522-7300 (local) 1-405-522-7100 (fax) http://www.okhca.org/
SPAP	Not Applicable

Exhibit A: State Agency Contact Information

ADAP	Oklahoma AIDS Drug Assistance Program HIV/STD Services Division Oklahoma State Department of Health 1000 N.E. Tenth St., Mail Drop 0308, Oklahoma City, OK 73117-1299 1-405-271-4636 1-405-271-5149 (fax) https://www.ok.gov/health/Prevention_and_Preparedness/HIV_STD_Service/index.html
OREGON	
QIO	KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-305-6759 1-855-843-4776 (TTY) 1-833-868-4064 (fax)
SHIP	Senior Health Insurance Benefits Assistance (SHIBA) P.O. Box 14480, Salem, OR 97309 1-800-722-4134 (toll free) 1-503-947-7979 (local) https://healthcare.oregon.gov/shiba/pages/index.aspx
SMO	Oregon Health Authority 500 Summer Street NE,E-15, Salem, OR 97301 1-800-375-2863 (toll free) 1-503-947-2340 (local) 1-503-947-5461 (fax) 1-503-945-6214 (TTY) www.oregon.gov/oha
SPAP	Not Applicable
ADAP	Oregon AIDS Drug Assistance Program (ADAP) CAREAssist Program 800 NE Oregon Street Suite 1105, Portland, OR 97232 1-971-673-0144 1-971-673-0177 (fax) http://www.public.health.oregon.gov/DiseasesConditions/HIVSTDViralHepatitis/HIVCareTreatment
PENNSYLVANIA	
QIO	Livanta BFCC-QIO Program 10820 Guilford Rd, Ste 202, Annapolis Junction, MD 20701 1-888-396-4646 1-888-985-2660 (TTY) 1-833-868-4057 (fax)
SHIP	APPRISE 555 Walnut Street, 5th Floor, Harrisburg, PA 17101-1919 1-800-783-7067 (toll free) 1-717-783-1550 (local) www.aging.state.pa.us
SMO	Pennsylvania Department of Human Services (Medicaid) 625 Forster St, Harrisburg, PA 17120 1-800-692-7462 (toll free) 1-800-451-5886 (TTY) www.dhs.pa.gov
SPAP	Pharmaceutical Assistance Contract for the Elderly (PACE) PACE/Pacenet Program, P.O. Box 8806, Harrisburg, PA 17105 1-800-225-7223 (toll free) 1-717-651-3600 (local) https://www.aging.pa.gov/aging-services/prescriptions/Pages/default.aspx

Exhibit A: State Agency Contact Information

ADAP	<p>Pennsylvania AIDS Drug Assistance Program (ADAP) Pennsylvania Department of Health Special Pharmaceutical Benefits Program 625 Forster Street, H&W Bldg, Rm 611 Harrisburg, PA 17120 1-800-922-9384 1-888-656-0372 (fax) www.health.pa.gov/My%20Health/Diseases%20and%20Conditions/E-H/HIV%20And%20AIDS%20Epidemiology/Pages/Special-Pharmaceutical-Benefits-Program.aspx#.V1IcIKPD9es</p>
PUERTO RICO	
QIO	<p>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/</p>
SHIP	<p>State Health Insurance Assistance Program (SHIP) P.O. Box 191179, San Juan, PR 00919-1179 1-877-725-4300 (toll free/llamada gratuita) 1-787-721-6121 (local) 1-787-919-7291 (TTY) https://agencias.pr.gov/agencias/oppea/educacion/Pages/ship.aspx</p>
SMO	<p>Administración de Seguros de Salud (ASES) P.O. Box 70184, San Juan, PR 00936-8184 1-787-641-4224 (local and toll free/llamada y línea gratuita) 1-787-625-6955 (TTY) 1-787-250-0990 (fax) www.medicaid.pr.gov</p>
SPAP	Not Applicable/No corresponde
ADAP	<p>Puerto Rico AIDS Drug, Copays and Coinsurance Assistance Program Departamento de Salud OCASET Programa Ryan White Parte B P.O. Box 70184, San Juan, PR 00936-8184 1-787-765-2929 1-787-766-7015 (fax) www.salud.gov.pr/Dept-de-Salud/Pages/Unidades-Operacionales/Secretaria-Auxiliar-de-Salud-Familiar-y-Servicios-Integrados/Division%20Central%20de%20Asuntos%20de%20SIDA%20y%20Enfermedades%20Transmisibles/Programa-Ryan-White.aspx</p>
RHODE ISLAND	
QIO	<p>KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-319-8452 1-855-843-4776 (TTY) 1-833-868-4055 (fax)</p>
SHIP	<p>Senior Health Insurance Program (SHIP) Rhode Island Department of Human Services, Division of Elderly Affairs 57 Howard Ave, Louis Pasteur Bldg. 2nd Floor, Cranston, RI 02920 1-888-884-8721 (local) 1-401-462-0740 (TTY) www.dea.ri.gov/</p>

Exhibit A: State Agency Contact Information

SMO	Executive Office of Health and Human Services Louis Pasteur Building, 57 Howard Avenue, Cranston, RI 02920 1-401-462-5274 (local) 1-855-697-4347 (toll free) 1-800-745-5555 (TTY) http://www.ohhs.ri.gov/contact/
SPAP	Rhode Island Pharmaceutical Assistance for the Elderly (RIPAE) Attn: RIPAE, Rhode Island Department of Elderly Affairs 74 West Road 2nd Floor, Hazard Building, Cranston, RI 02920 1-401-462-3000 (local) 1-401-462-0740 (local) 1-401-462-0740 (TTY) http://www.oha.ri.gov/
ADAP	Rhode Island AIDS Drug Assistance Program (ADAP) Executive Office of Health & Human Services, Virks Building 3 West Road, Suite 227, Cranston, RI 02920 1-401-462-3295 1-401-462-3297 (fax) www.health.ri.gov/diseases/hiv aids/about/stayinghealthy/
SOUTH CAROLINA	
QIO	KEPRO 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609 1-888-317-0751 1-855-843-4776 (TTY) 1-833-868-4058 (fax)
SHIP	(I-CARE) Insurance Counseling Assistance and Referrals for Elders 1301 Gervais Street, Suite 350, Columbia, SC 29201 1-800-868-9095 (toll free) 1-803-734-9900 (local) 1-803-734-9886 (fax) https://aging.sc.gov/
SMO	South Carolina Department of Health and Human Services (Medicaid) P.O. Box 8206, Columbia, SC 29202-8206 1-888-549-0820 (toll free) 1-803-898-2500 (local) 1-888-842-3620 (TTY) www.scdhhs.gov
SPAP	Not Applicable
ADAP	South Carolina AIDS Drug Assistance Program (ADAP) SC Drug Assistance Program/Direct Dispensing Program 3rd Floor, Mills Jarrett Box 101106, Columbia, SC 29211 1-800-856-9954 (toll free) http://www.scdhec.gov/Health/DiseasesandConditions/InfectiousDiseases/HIVandSTDs/AIDSDrugAssistancePlan

Exhibit A: State Agency Contact Information

SOUTH DAKOTA	
QIO	KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-317-0891 1-855-843-4776 (TTY) 1-833-868-4062 (fax)
SHIP	Senior Health Information and Insurance Education (SHIINE) 2300 W. 46th St., Sioux Falls, SD 57105 1-800-536-8197 (toll free) 1-605-336-7471 (fax) www.shiine.net
SMO	Department of Social Services of South Dakota 700 Governors Drive, Richard F. Kneip Bldg., Pierre, SD 57501-2291 1-800-597-1603 (toll free) 1-605-773-3165 (local) 1-800-305-9673 (Spanish) https://dss.sd.gov/
SPAP	Not Applicable
ADAP	South Dakota AIDS Drug Assistance Program (ADAP) Ryan White Part B CARE Program South Dakota Department of Health 615 E. 4th St., Pierre, SD 57501-1700 1-800-592-1861 1-605-773-5509 (fax) 1-605-773-3737 https://doh.sd.gov/diseases/infectious/ryanwhite
TENNESSEE	
QIO	KEPRO 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609 1-888-317-0751 1-855-843-4776 (TTY) 1-833-868-4058 (fax)
SHIP	Tennessee Commission on Aging & Disability -TN SHIP 502 Deaderick St, 9th Floor, Nashville, TN 37243-0860 1-877-801-0044 (toll free) 1-615-741-2056 (local) 1-800 848-0299 (toll free TDD) http://tnmedicarehelp.com/%20or%20http://www.tn.gov/aging/
SMO	TennCare (Medicaid) 310 Great Circle Road, Nashville, TN 37243 1-800-342-3145 (toll free) 1-877-779-3103 (toll free TTY) 1-855-259-0701 (Spanish) 1-615-532-7322 (fax) www.tn.gov/tennicare/
SPAP	Not Applicable
ADAP	Tennessee HIV Drug Assistance Program (HDAP) TN Department of Health, HIV/STD Program, 710 James Robertson Parkway, 4th Floor, Andrew Johnson Tower, Nashville, TN 37243 1-615-741-7500 1-800-525-2437 (toll free) www.tn.gov/health

Exhibit A: State Agency Contact Information

TEXAS	
QIO	<p>KEPRO 5201 W. Kennedy Dr., Suite 900, Tampa, FL 33609 1-888-315-0636 1-855-843-4776(TTY) 1-833-868-4060 (fax)</p>
SHIP	<p>Texas Department of Aging and Disability Services (HICAP) 1100 West 49th Street, Austin, TX 78756-3199 1-800-252-9240 (toll free) 1-800-735-2989 (toll free TTY) https://hhs.texas.gov/services/health/medicare</p>
SMO	<p>Texas Health and Human Services Commission (HHSC) Medicaid Program 4900 N. Lamar Blvd., Austin, TX 78751-2316 1-800-252-8263 (toll free) 1-512-424-6500 (local) 1-512-424-6597 (TTY) http://www.hhsc.state.tx.us</p>
SPAP	<p>Texas Kidney Health Care Program (KHC) Department of State Health Services MC 1938 P.O. Box 149347, Austin, TX 78714 1-800-222-3986 (toll free) 1-512-776-7150 (local) http://www.dshs.state.tx.us/kidney/default.shtm</p>
ADAP	<p>Texas AIDS Drug Assistance Program (ADAP) Texas HIV Medication Program, ATTN: MSJA, MC 1873 P.O. Box 149347, Austin, TX 78714 1-800-255-1090 (toll free) 1-512-533-3178 (fax) http://www.dshs.state.tx.us/hivstd/default.shtm</p>
UTAH	
QIO	<p>KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-317-0891 1-855-843-4776 (TTY) 1-833-868-4062 (fax)</p>
SHIP	<p>Senior Health Insurance Information Program (SHIP) 195 North 1950 West, Salt Lake City, UT 84116 1-800-541-7735 (toll free) 1-801-538-3910 (local) 1-801-538-4395 (fax) https://daas.utah.gov/seniors/</p>
SMO	<p>Utah Department of Health Medicaid Martha S. Hughes Cannon Building 288 North 1460 West, Salt Lake City, UT 84116 1-800-662-9651 (toll free) 1-801-538-6155 (local) 1-866-608-9422 (Spanish) 1-801-538-6805 (fax) https://medicaid.utah.gov/</p>
SPAP	Not Applicable

Exhibit A: State Agency Contact Information

ADAP	Utah AIDS Drug Assistance Program (ADAP) Utah Department of Health Bureau of Epidemiology 288 North 1460 West Box 142104, Salt Lake City, UT 84114-2104 1-801-538-6191 1-801-538-9913 (fax) http://health.utah.gov
VERMONT	
QIO	KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-319-8452 1-855-843-4776 (TTY) 1-833-868-4055 (fax)
SHIP	State Health Insurance Assistance Program (SHIP) 476 Main Street Suite #3, Winooski VT 05404 1-800-642-5119 (toll free) 1-(802) 865-0360 (local) www.vermont4a.org/
SMO	Agency of Human Services of Vermont Center Building 280 State Drive, Waterbury, VT 05671 1-800-250-8427 (toll free) 1-802-871-3008 (local) 1-802-879-5962 (fax) www.humanservices.vermont.gov/
SPAP	VPharm 312 Hurricane Lane, Suite 201, Williston, VT 05495 1-800-250-8427 (toll free) www.greenmountaincare.org/prescription
ADAP	Vermont Medication Assistance Program (VMAP) Vermont Department of Health, Vermont Medication Assistance Program 108 Cherry Street- PO BOX 70, Burlington, VT 05402 1-802-951-4005 1-802-863-7314 www.healthvermont.gov/prevent/aids/aids_index.aspx
VIRGINIA	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-396-4646 1-888-985-2660 (TTY) 1-833-868-4057 (fax)
SHIP	Virginia Insurance Counseling and Assistance Program (VICAP) 1610 Forest Avenue, Suite 100, Henrico, VA 23229 1-800-552-3402 (toll free) 1-804-662-9333 (local) 1-804-552-3402 (toll free TTY) www.vda.virginia.gov
SMO	Department of Medical Assistance Services 600 East Broad Street, Suite 1300, Richmond, VA 23219 1-804-786-7933 (local) 1-855-242-8282 (toll free) 1-888-221-1590 (TTY) www.dmas.virginia.gov/

Exhibit A: State Agency Contact Information

SPAP	Virginia HIV SPAP HCS Unit, 1st Floor James Madison Building 109 Governor Street, Richmond, VA 23219 1-855-362-0658 (toll free) http://166.67.66.226/epidemiology/DiseasePrevention/Programs/ADAP/
ADAP	Virginia AIDS Drug Assistance Program (ADAP) Virginia Department of Health, HCS Unit, James Madison Building 1st Floor, 109 Governor Street, Richmond, VA 23219 1-855-362-0658 1-804-864-8050 www.vdh.virginia.gov/epidemiology/DiseasePrevention/Programs/ADAP/forms.htm
WASHINGTON	
QIO	KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-305-6759 1-855-843-4776 (TTY) 1-833-868-4064 (fax)
SHIP	Statewide Health Insurance Benefits Advisors (SHIBA) P.O. Box 40255, Olympia, WA 98504-0255 1-800-562-6900 (toll free) 1-360-586-0241 (TTY) www.insurance.wa.gov/shiba
SMO	Washington State Health Care Authority (Medicaid) Cherry Street Plaza 626 8th Avenue SE, P.O. Box 45531, Olympia, WA 98501 1-800-562-3022 (toll free) www.hca.wa.gov/
SPAP	Not Applicable
ADAP	Washington State AIDS Drug Assistance Program (ADAP) Early Intervention Program (EIP) Client Services, P.O. Box 47841, Olympia, WA 98504 1-877-376-9316 (in Washington state) 1-360-664-2216 (fax) 1-360-236-3426 http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/HIVAIDS/HIVCareClientServices/ADAPandEIP
WEST VIRGINIA	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-396-4646 1-888-985-2660 (TTY) 1-833-868-4057 (fax)

Exhibit A: State Agency Contact Information

SHIP	West Virginia State Health Insurance Assistance Program (WV SHIP) 1900 Kanawha Blvd. East, Charleston, WV 25305 1-877-987-4463 (toll free) 1-304-558-3317 (local) 1-304-558-0004 (fax) www.wvship.org
SMO	West Virginia Department of Health & Human Resources Medicaid 350 Capitol Street, Room 251, Charleston, WV 25301-3709 1-800-642-8589 (toll free) 1-304-558-1700 (local) www.dhhr.wv.gov/bms
SPAP	Not Applicable
ADAP	West Virginia AIDS Drug Assistance Program (ADAP) Jay Adams, HIV Care Coordinator, P.O. Box 6360, Wheeling, WV 26003 1-304-232-6822 http://oeps.wv.gov/rwp/pages/default.aspx
WISCONSIN	
QIO	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701 1-888-524-9900 1-888-985-8775 (TTY) 1-833-868-4059 (fax)
SHIP	WI State Health Ins. Assist. Program (SHIP) 1 West Wilson Street, Madison, WI 53703 1-800-242-1060 (toll free) 711 or 1-800-947-3529 (TTY) www.dhs.wisconsin.gov/benefit-specialists/ship.htm
SMO	Wisconsin Department of Health Services 1 West Wilson Street, Madison, WI 53703 3445 1-800-362-3002 (toll free) 1-608-266-1865 (local) 1-800-947-3529 (TTY) www.dhs.wisconsin.gov
SPAP	Wisconsin SeniorCare P.O. Box 6710, Madison, WI 53716 1-800-657-2038 (toll free) www.dhs.wisconsin.gov/seniorcare/
ADAP	Wisconsin AIDS Drug Assistance Program (ADAP) Division of Public Health, Attn: ADAP, P.O. Box 2659, Madison, WI 53701 1-800-991-5532 1-608-266-1288 (fax) 1-608-267-6875 www.dhs.wisconsin.gov/aids-hiv/resources/overviews/AIDS_HIV_drug_reim.htm

Exhibit A: State Agency Contact Information

WYOMING	
QIO	<p>KEPRO 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131 1-888-317-0891 (toll free) 1-855-843-4776 (TTY) 1-833-868-4062 (fax)</p>
SHIP	<p>Wyoming State Health Insurance Information Program (WSHIIP) 106 W Adams, Riverton, WY 82501 1-800-856-4398 (toll free) 1-307-856-6880 (local) www.wyomingseniors.com</p>
SMO	<p>Wyoming Department of Health 2300 Capital Ave, Suite 401, Hathaway Bldg., Cheyenne, WY 82002 1-866-571-0944 (toll free) 1-307-777-7656 (local) 1-307-777-7439 (fax) www.health.wyo.gov/</p>
SPAP	Not Applicable
ADAP	<p>Wyoming AIDS Drug Assistance Program (ADAP) Wyoming Department of Health, Communicable Disease Unit 6101 Yellowstone Rd. Suite 510, Cheyenne, WY 82002 1-307-777-5856 1-307-777-5279 www.health.wyo.gov/publichealth/communicable-disease-unit/hivaids/</p>

Notice of Non-Discrimination

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate or exclude people because of their race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services. Humana Inc.:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
 - Qualified interpreters
 - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids, or language assistance services contact **877-320-1235 (TTY: 711)**. Hours of operation: 8 a.m. – 8 p.m., Eastern time. If you believe that Humana Inc. has not provided these services or discriminated on the basis of race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services, you can file a grievance in person or by mail or email with Humana Inc.'s Non-Discrimination Coordinator at P.O. Box 14618, Lexington, KY 40512-4618, **877-320-1235 (TTY: 711)**, or **accessibility@humana.com**. If you need help filing a grievance, Humana Inc.'s Non-Discrimination Coordinator can help you.

You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>**, or by mail or phone at:

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

California members:

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

This notice is available at **www.humana.com/legal/non-discrimination-disclosure**.

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-320-1235 (TTY: 711). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-320-1235 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-877-320-1235 (听障专线：711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-877-320-1235 (聽障專線：711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-320-1235 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-320-1235 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-877-320-1235 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-320-1235 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-877-320-1235 (TTY: 711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-320-1235 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بخططنا الصحية أو خطة الأدوية الموصوفة لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على (TTY: 711) 1-877-320-1235. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं। एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-320-1235 (TTY: 711) पर फोन करें। कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है। यह एक मुफ्त सेवा है।

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-320-1235 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-320-1235 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-320-1235 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-320-1235 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康保険と処方薬プランに関するご質問にお答えするために、無料の通訳サービスをご用意しています。通訳をご用命になるには、1-877-320-1235 (TTY: 711) にお電話ください。日本語を話す者が支援いたします。これは無料のサービスです。