

Group Name:
STATE OF GEORGIA 079/116 RX 83

Group Number: 12345

Print Date:

Quote Keys:
 Prospect:
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Market Office Name:

Additional Information:

PLEASE RETAIN THIS GROUP CONTRACT FOR YOUR RECORDS.



Evidence of Coverage:

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of Humana Medicare Employer PPO

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

Humana Medicare Employer PPO Member Services:

If you have any questions or need help, call the Customer Care Team (phone numbers can be found on the back of your membership card). We're available Monday through Friday from 8am to 9pm, Eastern time. Our phone system may answer your call after hours, and on Saturdays, Sundays, and some holidays; leave a message and we'll call back by the end of the next business day.

This Plan is offered by Humana Insurance Company / Humana Health Insurance Company of Florida, Inc. / Humana Insurance Company of New York / Humana Insurance of Puerto Rico, Inc. / Humana Medicare Employer PPO, referred throughout the *Evidence of Coverage* as "we," "us," or "our". Humana Medicare Employer PPO is referred to as "plan" or "our plan."

Humana is a Medicare Advantage organization with a Medicare contract.

This information may be available in a different format, including Spanish, large print, and audio tapes. Please call the Customer Care Team at the number on the back of your membership card if you need plan information in another format or language.

Esta informacion esta disponible en otro formato, incluyendo en ingles, en letra grande o en cintas de audio. Si necesita informacion del plan en otro idioma o en otro formato, llame al Equipo de Atencion al Cliente (los numeros de telefono pueden encontrarse en el reverso de su tarjeta de afiliacion).

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 the customer care number on the back of your ID card.

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Chapter 1. Getting started as a member of Humana Medicare Employer PPO

Tells what it means to be in a Medicare health plan and how to use this booklet. Tells about materials we will send you, your plan premium, your plan membership card, and keeping your membership record up to date.

Chapter 2. Important phone numbers and resources

Tells you how to get in touch with our plan (Humana Medicare Employer PPO) and with other organizations including Medicare, your plan sponsor, the State Health Insurance Assistance Program, the Quality Improvement Organization, Social Security, Medicaid (the state health insurance program for people with low incomes), programs that help people pay for their prescription drugs, and the Railroad Retirement Board.

Chapter 3. Using the plan's coverage for your medical services

Explains important things you need to know about getting your medical care as a member of our plan. Topics include using the providers in the plan's network and how to get care when you have an emergency.

Chapter 4. Medical benefits chart (what is covered and what you pay)

Gives the details about which types of medical care are covered and *not* covered for you as a member of our plan. Tells how much you will pay as your share of the cost for your covered medical care.

Chapter 5. Using the plan's coverage for your Part D prescription drugs

Explains rules you need to follow when you get your Part D drugs. Tells how to use the plan's Prescription Drug Guide (Formulary) to find out which drugs are covered. Tells which kinds of drugs are *not* covered. Explains several kinds of restrictions that apply to your coverage for certain drugs. Explains where to get your prescriptions filled. Tells about the plan's programs for drug safety and managing medications.

Chapter 6. What you pay for your Part D prescription drugs

Tells about the stages of drug coverage and how these stages affect what you pay for your drugs. Explains the cost-sharing for your Part D drugs and what you must pay for your share of your drugs. Tells about the late enrollment penalty.

Chapter 7. Asking the plan to pay its share of a bill you have received for covered services or drugs

Tells when and how to send a bill to us when you want to ask us to pay you back for our share of the cost for your covered services.

Chapter 8. Your rights and responsibilities

Explains the rights and responsibilities you have as a member of our plan. Tells what you can do if you think your rights are not being respected.

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Tells you step-by-step what to do if you are having problems or concerns as a member of our plan.

- Explains how to ask for coverage decisions and make appeals if you are having trouble getting the medical care or prescription drugs you think are covered by our plan. This includes asking us to make exceptions to the rules or extra restrictions on your coverage for prescription drugs, and asking us to keep covering hospital care and certain types of medical services if you think your coverage is ending too soon.
- Explains how to make complaints about quality of care, waiting times, customer service, and other concerns.

Chapter 10. Ending your membership in the plan

Tells when and how you can end your membership in the plan. Explains situations in which our plan is required to end your membership.

Chapter 11. Legal notices

Includes notices about governing law and about nondiscrimination.

Chapter 12. Definitions of important words

Explains key terms used in this booklet.

Chapter 13. State Specific Information

Chapter 1. Getting started as a member of Humana Medicare Employer PPO

SECTION 1 Introduction

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SECTION 1 Introduction

You are enrolled in Humana Medicare Employer PPO, which is a Medicare PPO.

You are covered by Medicare, and you have chosen to get your Medicare health care and your prescription drug coverage through our plan, Humana Medicare Employer PPO.

There are different types of Medicare Advantage plans. Humana Medicare Employer PPO is a Medicare Advantage PPO plan (PPO stands for Preferred Provider Organization). Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company.

What is the *Evidence of Coverage* booklet about?

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

This plan is offered by Humana Insurance Company / Humana Health Insurance Company of Florida, Inc./ Humana Insurance Company of New York / Humana Insurance of Puerto Rico, Inc./ Humana Medicare Employer PPO, referred throughout the Evidence of Coverage as "we", "us", or "our". Humana Medicare Employer PPO is referred to as "plan" or "our plan".

The word "coverage" and "covered services" refers to the medical care and services and the prescription drugs available to you as a member of Humana Medicare Employer PPO.

What does this Chapter tell you?

Look through Chapter 1 of this *Evidence of Coverage* to learn:

- What makes you eligible to be a plan member?
- What materials will you get from us?
- What is your plan premium and how can you pay it?
- What is your plan's service area?
- How do you keep the information in your membership record up to date?

What if you are new to Humana Medicare Employer PPO?

If you are a new member, then it's important for you to learn how the plan operates - what the rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* booklet.

If you are confused or concerned or just have a question, please contact our Customer Care Team (telephone number on the back of your membership card).

Legal information about the *Evidence of Coverage*

It's part of our contract with you

This *Evidence of Coverage* is part of our contract with you about how Humana Medicare Employer PPO covers your care. Other parts of this contract include your enrollment form, the *Drug Guide (Formulary)*, and any notices you receive from us about changes or extra conditions that can 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 Medicare Employer PPO coverage.

Medicare must approve our plan each year

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

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

Your eligibility requirements

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

- You live in our geographic service area
- -- *and* -- you are entitled to Medicare Part A
- -- *and* -- you are enrolled in Medicare Part B

What are Medicare Part A and Medicare Part B?

When you originally signed up for Medicare, you received information about how to get Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally covers services furnished by institutional providers such as hospitals, skilled nursing facilities or home health agencies.
- Medicare Part B is for most other medical services, such as physician's services and other outpatient services.

Here is the plan service area for Humana Medicare Employer PPO

If you plan to move out of the service area, please contact Customer Care.

The service area is described below:

Where is Humana Medicare Employer PPO available?

This plan is available in all municipalities and counties in the following states: **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:** You must live in one of these states or municipalities to join the plan.

SECTION 3 What other materials will you get from us?**Your plan membership card - Use it to get all covered care and drugs**

Now that you are a member of our Plan, you must use our membership card for services covered by this plan and prescription drug coverage at network pharmacies. While you are a member of our Plan and using our Plan services, you *must* use your plan membership card instead of your red, white, and blue Medicare card to get covered services, items and drugs. (See [Chapter 4](#) for information on covered services.) Keep your red, white, and blue Medicare card in a safe place in case you need it later. If you get covered services using your red, white, and blue Medicare card instead of using our membership card while you are a plan member, the Medicare Program won't pay for these services and you may have to pay the full cost yourself.

Please carry your membership card that we gave you at all times and remember to show your card when you get covered services, items and drugs. If your membership card is damaged, lost, or stolen, call Customer Care right away and we will send you a new card.

The *Provider Directory*: your guide to all providers in the plan's network

Every year that you are a member of our plan, we will send you either a new *Provider Directory* or an update to your *Provider Directory*. This directory lists our contracted providers.

What are "contracted providers"?

Contracted providers are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost-sharing as payment in full. We have arranged for these providers to deliver covered services to members in our plan.

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

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

If you don't have your copy of the *Provider Directory*, you can request a copy from Customer Care (telephone number on the back of your membership card). You may ask Customer Care for more information about our contracted providers, including their qualifications

The *Pharmacy Directory*: your guide to pharmacies in our network**What are "network pharmacies"?**

Our Pharmacy Directory gives you a complete list of our network pharmacies - that means all of the pharmacies that have agreed to fill covered prescriptions for our plan members.

Why do you need to know about network pharmacies?

You can use the Pharmacy Directory to find the network pharmacy you want to use. This is important because, with few exceptions, you must get your prescriptions filled at one of our network pharmacies if you want our plan to cover (help you pay for) them.

If you don't have the Pharmacy Directory, you can get a copy from Customer Care (contact information is on the back of your membership card). At any time, you can call Customer Care to get up-to-date information about changes in the pharmacy network. You can also find this information on our website at Humana.com.

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 Medicare Employer PPO. 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 Medicare Employer PPO Drug Guide.

We will send you a copy of the Drug Guide. The Drug Guide we send to 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 printed Drug Guide. If one of your drugs is not listed in the Drug Guide, you should visit our website or contact Customer Care to find out if we cover it. To get the most complete and current information about which drugs are covered, you can visit the plan's website (Humana.com) or call Customer Care (telephone number on the back of your membership card).

Reports with a summary of payments made for your prescription drugs

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

The SmartSummary tells you the total amount you have spent on your Part D prescription drugs and the total amount we have paid for each of your prescription drugs during the month. Chapter 6 (*What you pay for your Part D prescription drugs*) gives more information about the SmartSummary and how it can help you keep track of your drug coverage.

A SmartSummary is also available upon request. To get a copy, please contact Customer Care (telephone number on the back of your membership card).

SECTION 4 Your monthly premium for Humana Medicare Employer PPO

How much is your plan premium?

If you have a monthly premium for your Humana coverage through SHBP, please pay the monthly premium. If you have questions about the Plan premium or payment options, please call Customer Care (telephone number on the back of your membership card).

In some situations, your plan premium could be less

There are programs to help people with limited resources pay for their drugs. Chapter 2, Section 7 tells more about these programs. If you qualify for one of these programs, enrolling in the program might make your monthly plan premium lower.

If you are *already enrolled* and getting help from one of these programs, **some of the payment information 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" (LIS Rider), that tells you about your drug coverage. If you don't have this insert, please call Customer Care (telephone number on the back of your membership card) and ask for the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (LIS Rider).

In some situations, your plan premium could be more

Some members are required to pay a **late enrollment penalty** because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of 63 days or more when they didn't keep their coverage.

If you are required to pay the late enrollment penalty, the amount of your penalty depends on how long you waited before you enrolled in drug coverage or how many months you were without drug coverage after you became eligible. Chapter 6, Section titled *Do you have to pay the Part D "late enrollment penalty"?* explains the late enrollment penalty.

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, some plan members will be paying a premium for Medicare Part A and most plan members will be paying a premium for Medicare Part B. You must continue paying your Medicare Part B premium for you to remain as a member of the plan.

Some people pay an extra amount for Part D because of their yearly income. If your income is \$85,000 or above for an individual (or married individuals filing separately) or \$170,000 or above for married couples, you must pay an extra amount directly to the government (not the Medicare plan) for your Medicare Part D coverage.

- If you are required to pay the extra amount and you do not pay it, you will be disenrolled from the plan and lose prescription drug coverage.
- If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be.
- For more information about Part D premiums based on income, visit <http://www.medicare.gov> on the web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

- Your copy of *Medicare & You 2013* tells about these premiums in the section called "2013 Medicare Costs." This explains how the Part B premium differs for people with different incomes.
- Everyone with Medicare receives a copy of Medicare & You each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2013* from the Medicare website (<http://www.medicare.gov>). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

If you have a plan premium, please contact your plan sponsor for instructions on how to make payment

Your coverage is provided through a contract with your plan sponsor, who may be your current employer or former employer or union. Please contact your plan sponsor the State Health Benefit Plan at 1-800-610-1863 for information about your plan premium.

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 Extra Help or if you lose your eligibility for Extra Help during the year. If a member qualifies for Extra Help with their prescription drug costs, Extra Help will pay part of the member's monthly plan premium. So a member who becomes eligible for Extra Help during the year would begin to pay less toward their monthly premium. And a member who loses their eligibility during the year will need to start paying their full monthly premium. You can find out more about Extra Help in Chapter 2, Section 7.

SECTION 5 Please keep your plan membership record up to date

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

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

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

Call Customer Care to let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study

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

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

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

SECTION 6 We protect the privacy of your personal health information**We make sure that your health information is protected**

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

For more information about how we protect your personal health information, please go to the Chapter titled "Your rights and responsibilities" of this booklet.

SECTION 7 How other insurance works with our plan**Which plan pays first when you have other insurance?**

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

These 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
- Worker's compensation

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

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Customer Care (phone numbers are on the back of your ID card.) 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.

Chapter 2. Important phone numbers and resources

- SECTION 1** **Humana Medicare Employer PPO contacts**
(how to contact us, including how to reach Customer Care Team at the plan)
- SECTION 2** **Medicare (how to get help and information directly from the federal Medicare program)**
- SECTION 3** **State Health Insurance Assistance Program** (free help, information, and answers to your questions about Medicare)
- SECTION 4** **Quality Improvement Organization** (paid by Medicare to check on the quality of care for people with Medicare)
- SECTION 5** **Social Security**
- SECTION 6** **Medicaid (a joint Federal and state program that helps with medical costs for some people with limited income and resources)**
- SECTION 7** **Information about programs to help people pay for their prescription drugs**
- SECTION 8** **How to contact the Railroad Retirement Board**

SECTION 1 Humana Medicare Employer PPO
(how to contact us, including how to reach Customer Care Team at the plan)

How to contact our plan's Customer Care Team

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

Customer Care Team

CALL	Customer Care Team at the telephone number on the back of your membership card. Calls to this number are free. Customer Care also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment. Calls to this number are free.
WRITE	P.O. Box 14168, Lexington, KY 40512-4168.
WEBSITE	<u>Humana.com</u>

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

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

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

Coverage Decisions for Medical Care

CALL	Customer Care Team at the telephone number on the back of your membership card.
TTY	711 This number requires special telephone equipment. Calls to this number are free.
WRITE	Humana, P.O. Box 14168 Lexington, KY 40512-4168

For more information on asking for coverage decisions about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

How to contact us when you are making an appeal about your medical care

An appeal is a formal way of asking us to review and change a coverage decision we have made.

Appeals for Medical Care

CALL	Call Customer Care Team at the telephone number on the back of your membership card to request a standard appeal. 1-800-867-6601 to request an expedited appeal. Calls to this number are free.
TTY	711 This number requires special telephone equipment. Calls to this number are free
FAX	1-800-949-2961 for expedited appeals only.
WRITE	Humana Grievance and Appeal Dept. P.O. Box 14165, Lexington, KY 40512-4165

For more information on making an appeal about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

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

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.

Complaints about Medical Care

CALL	Call Customer Care Team at the telephone number on the back of your membership card. Calls to this number are free.
TTY	711 This number requires special telephone equipment. Calls to this number are free
FAX	1-800-949-2961 for expedited grievances only.

WRITE	Humana Grievance and Appeal Dept. P.O. Box 14165, Lexington, KY 40512-4165
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For more information on making a complaint about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

How to contact us when you are asking for a coverage decision about your Part D prescription drugs

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

Coverage Decisions for Part D Prescription Drugs

CALL	1-800-555-2546. 24 hours a day, 7 days a week. Calls to this number are free.
TTY	711 This number requires special telephone equipment. Calls to this number are free.
FAX	1-877-486-2621 for accepting expedited coverage determinations. Be sure to ask for a "fast", "expedited" or "24-hour" review.
WRITE	Humana Clinical Pharmacy Review, Attn: Medicare Part D Coverage Determinations, P.O. Box 33008, Louisville, KY 40232

For more information on asking for coverage decisions about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

How to contact us when you are making an appeal about your Part D prescription drugs

An appeal is a formal way of asking us to review and change a coverage decision we have made.

Appeals for Part D Prescription Drugs

CALL	Call Customer Care Team at the telephone number on the back of your membership card. 1-800-867-6601 for an expedited grievance. Calls to this number are free.
TTY	711 This number requires special telephone equipment. Calls to this number are free.
FAX	1-800-949-2961 for expedited grievances only.
WRITE	Humana Grievance and Appeal Dept. P.O. Box 14165, Lexington, KY 40512 4165
WEBSITE	<u>Humana.com</u>

For more information on making an appeal about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

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

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plans coverage or payment, you should look at the section above about making an appeal.)

Complaints about Part D prescription drugs

CALL	Call Customer Care Team at the telephone number on the back of your membership card. 1-800-867-6607 for an expedited grievance. Calls to this number are free.
TTY	711 This number requires special telephone equipment. Calls to this number are free.
FAX	1-800-949-2961 for expedited grievances only.

WRITE

Humana Grievance and Appeal Dept.
P.O. Box 14165, Lexington, KY 40512-4165

For more information on making a complaint about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

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

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 7 (*Asking the plan to pay its share of a bill you have received for medical services or drugs*).

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

Payment Requests

CALL

Call Customer Care Team at the telephone number on the back of your membership card. Calls to this number are free.

TTY

711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.

WRITE

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

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

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

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

Medicare

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.

WEBSITE <http://www.medicare.gov>
 This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage Plans and Medicare drug plans in your area. You can also find Medicare contacts in your state by selecting "Helpful Phone Numbers and Websites."

The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:

- Medicare Eligibility Tool: Provides Medicare eligibility status information. Select "Find Out if You're Eligible."
- Medicare Plan Finder: Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. Select "Health & Drug Plans" and then "Compare Drug and Health Plans" or "Compare Medigap Policies." These tools provide an estimate of what your out-of-pocket costs might be in different Medicare plans.

However, since you are a member of an employer/group plan, choosing a plan other than one through your employer/group coverage, could have significant implications. For more information, contact your plan sponsor.

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 at the number above and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you.

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

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state.

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

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

You may find contact information for the SHIP in your state in the state specific data sheets at the end of this Evidence of Coverage.

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

There is a Quality Improvement Organization in each state.

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

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

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

You can find contact information for the QIO in your state in the state specific data sheets at the end of this Evidence of Coverage.

SECTION 5 Social Security

The Social Security Administration is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens 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 and pay the Part B premium. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security

CALL 1-800-772-1213
 Calls to this number are free.
 Available 7:00 am to 7:00 pm, Monday through Friday.
 You can use our automated telephone services to get recorded information and conduct some business 24 hours a day.

TTY 1-800-325-0778
 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
 Calls to this number are free.
 Available 7:00 am to 7:00 pm, Monday through Friday.

WEBSITE <http://www.ssa.gov>

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

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

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

- Qualified Medicare Beneficiary (QMB): Helps pay Medicare Part A and Part B premiums and other cost-sharing (like deductibles, coinsurance, and copays.)
- Specified Low-Income Medicare Beneficiary (SLMB) and Qualifying Individual (QI): Helps pay Part B premiums.
- Qualified Disabled & Work Individuals (QDWI): Helps pay for Part A premiums

You can find contact information for Medicaid in your state in the state specific data sheets at the end of this Evidence of Coverage.

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

Medicare's "Extra Help" Program

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

People with limited income and resources may qualify for Extra Help. Some people automatically qualify for Extra Help and don't need to apply. Medicare mails a letter to people who automatically qualify for Extra Help.

You may be able to get Extra Help to pay for your prescription drug premiums and costs. To see if you qualify for getting Extra Help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 7 am. to 7 pm., Monday through Friday. TTY users should call 1-800-325-0778; or
- Your State Medicaid Office. (See Section 6 of this chapter for contact information)

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

At the pharmacy you can show proof of extra help by providing any of the following:

- A copy of your Medicaid card with your name and eligibility date during a month after June of the previous calendar year;
- One of the following letters from the Social Security Administration (SSA), showing extra help status (Important Information, Award Letter, Notice of Change or Notice of Action);
- A copy of a state document that confirms active Medicaid status during a month after June of the previous calendar year;
- A screen print from the state Medicaid system showing your Medicaid status during a month after June of the previous calendar year;
- A print out from the state electronic enrollment file showing Medicaid status during a month after June of the previous calendar year;
- Any other documentation provided by the state showing Medicaid status during a month after June of the previous calendar year;
- A letter from SSA showing that the individual receives SSI;
- A remittance from the facility showing Medicaid payment for a full calendar month for that individual during a month after June of the previous calendar year;
- A copy of a state document that confirms Medicaid payment on behalf of the individual to the facility for a full calendar month after June of the previous calendar year;
- A screen print from the State Medicaid systems showing that the individual's institutional status based on at least a full calendar month stay for Medicaid payment purposes during a month after June of the previous calendar year.

Please note that this extra help proof must be confirmed by a Pharmacist, CMS representative, State Medicaid official, or a Humana Sales Agent. The extra help proof must also reflect the date for the time period in question.

Once we have updated your information at the pharmacy, you can mail proof to the following address to maintain this copayment level: Humana, P.O. Box 14168, Lexington, KY 40512-4168.

We will also follow-up with you by letter requesting that the proof be mailed back within 30 days of the date of the letter.

If you have any questions, please feel free to call Customer Care (phone numbers are on the cover of this booklet).

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

Medicare Coverage Gap Discount Program

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs to Part D enrollees who have reached the coverage gap and are not already receiving "Extra Help". A 50 percent discount on the negotiated price (excluding the dispensing fee) is available for those brand name drugs from manufacturers that have agreed to pay the discount.

If you reach the coverage gap, we will automatically apply the discount when your pharmacy bills you for your prescription and your Smart Summary will show any discount provided. The amount discounted by the manufacturer counts toward your out-of-pocket costs as if you had paid this amount and moves you through the coverage gap.

You also receive some coverage for generic drugs. If you reach the coverage gap, the plan pays 14% of the price for generic drugs and you pay the remaining 86% of the price. The coverage for generic drugs works differently than the 50% discount for brand name drugs. For generic drugs, only the amount you pay counts toward your out-of-pocket costs and moves you through the coverage gap. Also, the dispensing fee is included as part of the cost of the drug.

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

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

If you are enrolled in a State Pharmacy Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (other than Extra Help), you still get the 50% discount on covered brand name drugs. The 50% discount is applied to the price of the drug before any SPAP or other coverage.

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

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

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

If you think that you have reached the coverage gap and did not get a discount when you paid for your brand name drug, you should review your next Explanation of Benefits notice. If the discount doesn't appear on your Explanation of Benefits, you should contact us to make sure that your prescription records are correct and up-to-date. If we don't agree that you are owed a discount, you can appeal. You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP) (telephone numbers are in "Exhibit A" in the back of this document) or by calling 1- 800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

State Pharmaceutical Assistance Programs

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

A State Pharmaceutical Assistance Program (SPAP) is a state organization that provides limited income and medically needy seniors and individuals with disabilities financial help for prescription drugs.

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

SECTION 8 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board

CALL	1-877-772-5772 Calls to this number are free. Available 9:00 am to 3:30 pm, Monday through Friday. If you have a touch-tone telephone, recorded information and automated services are available 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	http://www.rrb.gov

Chapter 3. Using the plan's coverage for your medical services

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

What are "contracted providers" and "covered services"?

Basic rules for getting your medical care that is covered by the plan

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

How to get care from specialists and other network providers

How to get care from out-of-network providers

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

Getting care if you have a medical emergency

Getting care when you have an urgent need for care

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

You can ask the plan to pay our share of the cost of your covered services

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

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

What is a "clinical research study"?

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

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

What is a religious non-medical health care institution?

What care from a religious non-medical health care institution is covered by our plan?

SECTION 7 Rules for ownership of durable medical equipment

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

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

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

What are "contracted providers" and "covered services"?

Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our plan:

- **"Providers"** are doctors and other health care professionals that the state licenses to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.
- **"Contracted providers"** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network generally bill us directly for care they give you. When you see a contracted provider, you usually pay only your share of the cost for their services.
- **"Covered services"** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4.

Basic rules for getting your medical care that is covered by the plan

As a Medicare plan, we must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

Humana Medicare Employer PPO will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this booklet).
- **The care you receive is considered medically necessary.** "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

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

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

How to get care from specialists and other contracted providers

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

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

We list the providers that participate with our plan in our Provider Directory. While you are a member of our plan you may use either contracted providers or out-of-network providers. However, your out-of-pocket costs may be higher if you use out-of-network providers, except for emergency care, or out-of-area dialysis services. See Chapter 4, Medical benefits chart (what is covered and what you pay) for more information on what your costs will be. You don't need to get a referral or prior authorization when you get care from out-of-network providers. See Chapter 4 Section 2 for information about which services require prior authorization. However, before getting services from out-of-network providers you may want to confirm with us that the services you are getting are covered by us and are medically necessary. If an out-of-network provider sends you a bill that you think we should pay, refer to Chapter 7 (Asking the plan to pay its share of a bill you have received for covered services) for information on how to ask us to pay that bill for you. We will pay your doctor for our share of the bill and will let you know what, if anything, you must pay.

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

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

Sometimes a specialist, clinic, hospital or other contracted provider you are using might leave the plan. If there is a change in your provider network, we will send you a letter notifying you of the change 30 days prior to the provider's date of termination. The notification describes the changes in your provider network and the effective date of the change. The written notification will contain specific information, depending on the type of provider that is leaving the network.

How to get care from out-of-network providers

As a member of our plan, you can choose to receive care from out-of-network providers. However, **if you use an out-of-network provider, your share of the costs for your covered services may be higher.** Here are other important things to know about using out-of-network providers:

- You can get your care from an out-of-network provider, however, that provider must be eligible to participate in Medicare. We cannot pay a provider who is not eligible to participate in Medicare. If you choose to receive care from a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they have not opted out of Medicare.
- You don't need to get a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers you may want to call Customer Care to confirm that the services you are getting are covered and are medically necessary. This is important because:
 - Without a pre-visit coverage decision, if we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. See Chapter 9 (*What to do if you have a problem or complaint*) to learn how to make an appeal.

- It is best to ask an out-of-network provider to bill the plan first. But, if you have already paid for the covered services, we will reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill that you think we should pay, you can send it to us for payment. See Chapter 7 (*Asking the plan to pay its share of a bill you have received for medical services or drugs*) for information about what to do if you receive a bill or if you need to ask for reimbursement.
- If you are using an out-of-network provider for emergency care, urgently needed care, or out-of-area dialysis, and your out-of-network cost-sharing is greater than your in-network cost-sharing, you may not have to pay a higher cost-sharing amount. See Section 3 for more information about these situations.

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

Getting care if you have a medical emergency

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

A "medical emergency" is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb.

The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. (contact information is on the back of your membership card.)

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere in the United States. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the medical benefits chart in Chapter 4 of this booklet.

You are covered for emergency care worldwide. See Chapter 4, Medical Benefits Chart (what is covered and what you pay) for more information. If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by our plan. If your emergency care is provided by non-contracted providers, we will try to arrange for contracted providers to take over your care as soon as your medical condition and the circumstances allow.

What if it wasn't a medical emergency?

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

However, after the doctor has said that it was *not* an emergency, the amount of cost-sharing that you pay will depend on whether you get the care from contracted providers or out-of-network providers. If you get the care from contracted providers, your share of the costs may be lower than if you get the care from out-of-network providers.

Getting care when you have an urgent need for care

What is "urgently needed care"?

"Urgently needed care" is a non-emergency, unforeseen medical illness, injury, or condition, that requires immediate medical care. Urgently needed care may be furnished by in-network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have.

What if you are in the plan's service area when you have an urgent need for care?

In most situations, if you are in the plan's service area and you use an out-of-network provider, you may pay a higher share of the costs for your care. If the circumstances are unusual or extraordinary, and contracted providers are temporarily unavailable or inaccessible, our plan will allow you to get covered services from an out-of-network provider at the lower in-network cost-sharing amount if your out-of-network cost sharing is greater than your in-network cost sharing.

The plan's Provider Directory will tell you which urgent care facilities in your area are in-network. This information can also be found online at Humana.com. For any other questions regarding urgently needed care, please contact Customer Care at the telephone number on the back of your ID card.

What if you are outside the plan's service area when you have an urgent need for care?

Suppose that you are temporarily outside our plan's service area, but still in the United States. If you have an urgent need for care, you probably will not be able to find or get to one of the providers in our plan's network. In this situation (when you are outside the service area and cannot get care from a contracted provider), our plan may cover urgently needed care that you get from any provider at the lower in-network cost-sharing amount.

Our plan does not cover urgently needed care or any other non-emergency care if you receive the care outside of the United States.

SECTION 4 What if you are billed directly for the full cost of your covered services?**You can ask the plan to pay our share of the cost of your covered services**

Sometimes when you get medical care, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you will want our plan to pay our share of the costs by reimbursing you for payments you have already made.

There may also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this bill to us so that we can pay our share of the costs for your covered medical services.

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

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

Humana Medicare Employer PPO covers all medical services that are medically necessary, are covered under Medicare, and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan covered services, or plan rules were not followed.

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

Chapter 9 (*What to do if you have a problem or complaint*) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Customer Care at the telephone number on the back of your membership card to get more information about how to do this.

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

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

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

What is a "clinical research study"?

A clinical research study is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Not all clinical research studies are open to members of our plan. Medicare first needs to approve the research study. If you participate in a study that Medicare has not approved, *you will be responsible for paying all costs for your participation in the study.*

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

If you participate in a Medicare-approved study, Original Medicare pays the doctors and other providers for the covered services you receive as part of the study. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in a Medicare-approved clinical research study, you do *not* need to get approval from our plan or your provider. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers.

Although you do not need to get our plan's permission to be in a clinical research study, **you do need to tell us before you start participating in a clinical research study.** Here is why you need to tell us:

1. We can let you know whether the clinical research study is Medicare-approved.
2. We can tell you what services you will get from clinical research study providers instead of from our plan.

If you plan on participating in a clinical research study, contact Customer Care (see Chapter 2, Section 1 of this *Evidence of Coverage*).

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

Once you join a Medicare-approved clinical research study, **Medicare will pay for the covered services you receive as part of the research study.** Medicare pays for routine costs of items and services. Examples of these items and services include the following:

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

Original Medicare pays most of the cost of the covered services you receive as part of the study. After Medicare has paid its share of the cost for these services, our plan will also pay for part of the costs. We will pay the difference between the cost-sharing in Original Medicare and your cost-sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan.

Here's an example of how the cost-sharing works: Let's say that you have a lab test that costs **\$100** as part of the research study. Let's also say that your share of the costs for this test is **\$20** under Original Medicare, but would be only **\$10** under our plan's benefits. In this case, Original Medicare would pay **\$80** for the test and we would pay another **\$10**. This means that you would pay **\$10**, which is the same amount you would pay under our plan's benefits.

In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the study and how much you owe. Please see the chapter titled **Asking the plan to pay its share of a bill you have received for covered medical services** for more information about submitting requests for payment.

When you are part of a clinical research study, **Medicare will *not* pay for any of the following:**

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

Do you want to know more?

You can get more information about joining a clinical research study by reading the publication "Medicare and Clinical Research Studies" on the Medicare website (<http://www.medicare.gov>). You can also call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 6 Rules for getting care covered in a "religious non-medical health care institution"**What is a religious non-medical health care institution?**

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility care. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. You may choose to pursue medical care at any time for any reason. This benefit is provided only for Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

What care from a religious non-medical health care institution is covered by our plan?

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

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

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

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in your home, our plan will cover these services only if your condition would ordinarily meet the conditions for coverage of services given by home health agencies that are not religious non-medical health care institutions.
- If you get services from this institution that are provided to you in a facility, the following condition applies:

- You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.

You are covered for an unlimited number of medically necessary inpatient hospital days. See Chapter 4.

SECTION 7 Rules for ownership of durable medical equipment

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

Durable medical equipment includes items such as oxygen equipment and supplies, wheelchairs, walkers, and hospital beds ordered by a provider for use in the home. Certain items, such as prosthetics, are always owned by the enrollee. In this section, we discuss other types of durable medical equipment that must be rented.

In Original Medicare, people who rent certain types of durable medical equipment own the equipment after paying co-payments for the item for 13 months. As a member of our plan, however, you will not acquire ownership of rented durable medical equipment items no matter how many copayments you make for the item while a member of our plan. Under certain limited circumstances we will transfer ownership of the durable medical equipment item. Call Customer Care to find out about the requirements you must meet and the documentation you need to provide.

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

If you switch to Original Medicare after being a member of our plan: If you did not acquire ownership of the durable medical equipment item while in our plan, you will have to make 13 new consecutive payments for the item while in Original Medicare in order to acquire ownership of the item. Your previous payments while in our plan do not count toward these 13 consecutive payments.

If you made payments for the durable medical equipment item under Original Medicare before you joined our plan, these previous Original Medicare payments also do not count toward the 13 consecutive payments. You will have to make 13 consecutive payments for the item under Original Medicare in order to acquire ownership. There are no exceptions to this case when you return to Original Medicare.

Chapter 4. Medical benefits chart (what is covered and what you pay)

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

What types of out-of-pocket costs do you pay for your covered services?

What is the maximum amount you will pay for certain covered medical services?

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

Your medical benefits and costs as a member of the plan

Getting care using our plan's traveler benefit

SECTION 3 What types of benefits are not covered by the plan?

Types of benefits we do *not* cover (exclusions)

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

This chapter focuses on your covered services and what you pay for your medical benefits. It includes a Medical Benefits Chart that gives a list of your covered services and tells how much you will pay for each covered service as a member of Humana Medicare Employer PPO. Later in this chapter, you can find information about medical services that are not covered. It also tells about limitations on certain services if applicable.

What types of out-of-pocket costs do you pay for your covered services?

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

- The "**deductible**" means the amount you must pay for certain medical services before our plan begins to pay its share
- A "**copayment**" means that you pay a fixed amount each time you receive a medical service. You pay a copayment at the time you get the medical service
- "**Coinsurance**" means that you pay a percent of the total cost of a medical service. You pay a coinsurance at the time you get the medical service

Some people qualify for state Medicaid programs to help them pay their out-of-pocket costs for Medicare. If you are enrolled in these programs, you may still have to pay a copayment for the service, depending on the rules in your state.

What is the maximum amount you will pay for certain covered medical services?

There is a limit to how much you have to pay out-of-pocket for certain covered health care services each year. After this level is reached, you will have 100% coverage and not have to pay any out-of-pocket costs for the remainder of the year for covered services. You will have to continue to pay your premium if your plan has a premium.

- During the year, if the amount that you spend on your deductible, copayments or coinsurance as a member of this plan goes over \$3500 for combined in network and out of network services, you will pay no further cost-share for in network and out of network services for the remainder of the policy.

NOTE: Please refer to the Medical Benefits Chart for services that do not apply toward your combined in network and out of network out-of-pocket maximum and you continue to pay your cost-share.

Paying your share of the cost when you get covered services

The "deductible" is the amount you must pay for certain health care services you receive before our Plan begins to pay its share of your covered services. You pay nothing for your combined annual deductible. Please refer to the following **benefits** chart for services that are excluded from your annual deductible.

SECTION 2 Use this *Medical Benefits Chart* to find out what is covered for you and how much you will pay**Your medical benefits and costs as a member of the plan**

The Medical Benefits Chart on the following pages lists the services Humana Medicare Employer, PPO covers and what you pay for each service. The services listed in the Medical Benefits Chart are covered only when all coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Except in the case of preventive services and screening tests, your services (including medical care, services, supplies, and equipment) *must* be medically necessary. Medically necessary means that the services are used for the diagnosis, direct care, and treatment of your medical condition and are not provided mainly for your convenience or that of your doctor.
- Some of the services listed in the Medical Benefits Chart are covered as in network services only if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from Humana Medicare Employer, PPO.
 - You never need approval in advance for out of network services from out of network providers.
 - While you don't need approval in advance for out of network services, you or your doctor can ask us to make a coverage decision in advance.
 - Covered services that need approval in advance to be covered as in network services are marked by a footnote in the Medical Benefits Chart. In addition, the following services not listed in the Medical Benefits Chart require approval in advance:

- Automatic Implantable Cardioverter Defibrillators (AICD)
- Pain Management Procedures
- Hyperbaric Therapy
- Infertility Testing and Treatment
- Uvulopalatopharyngoplasty (UPPP)
- Varicose Vein: Surgical Treatment and Sclerotherapy
- Ventricular Assist Devices

Our plan covers all Medicare-covered preventive services from a network provider at no cost to you. See the Medical Benefits Chart for more information about your share of the costs for these services when you receive them from non-network providers.

Services that are covered for you

What you must pay when you get these services

Inpatient Care

Inpatient hospital care

You are covered for unlimited number of days for medically necessary services.

Covered services include, but aren't limited to, the following:

- Semiprivate room or a private room if medically necessary
- Meals, including special diets
- Regular nursing services
- Costs of special care units (such as intensive or coronary care units)
- Drugs and medications
- Lab tests
- X-rays and other radiology services
- Necessary surgical and medical supplies
- Use of appliances, such as wheelchairs
- Operating and recovery room costs
- Physical therapy, occupational therapy, and speech therapy
- Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. If you are sent outside of your community for a transplant, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. Travel reimbursement requires a minimum of 100 miles one way to transplant center and is limited to \$10,000 per transplant
- Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need

Your inpatient benefits will begin on day one each time you are admitted or transferred to a specific facility type, including Inpatient Rehabilitation facilities, Long Term Acute Care (LTAC) facilities, Inpatient Acute Care facilities, and Inpatient Psychiatric facilities.

All transplant services must receive prior authorization.
Call 1-866-421-5663 (TTY# 711)
Monday-Friday 8:30 am-5 pm EST.

In Network

20% coinsurance

20% coinsurance for physician services while inpatient at a hospital

Humana Employer PPO Plan requires prior authorization for inpatient services. Call 1-800-523-0023, (TTY# 711)

Out of Network

20% coinsurance

20% coinsurance for physician services while inpatient at a hospital

Humana Employer PPO Plan requests prior authorization for inpatient services. Call 1-800-523-0023, (TTY# 711)

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • Physician services • Prior authorization is required for in network inpatient hospital care • Prior authorization is required for transplant services 	
<p>Inpatient mental health care</p>	
<p>Covered services include mental health care services that require a hospital stay. There is 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to mental health services provided in a psychiatric unit of a general hospital. The benefit days used under the Original Medicare program will count toward the 190-day lifetime reserve days when enrolling in a Medicare Advantage plan.</p>	<p>Your inpatient benefits will begin on day one each time you are admitted or transferred to a specific facility type, including Inpatient Rehabilitation facilities, Long Term Acute Care (LTAC) facilities, Inpatient Acute Care facilities, and Inpatient Psychiatric facilities.</p>
<ul style="list-style-type: none"> • Prior authorization is required for in network inpatient hospital care 	<p><u>In Network</u></p> <p>20% coinsurance</p> <p>20% coinsurance for physician services at an inpatient psychiatric hospital</p> <p>Humana Employer PPO Plan requires prior authorization for inpatient mental health care services. Call 1-800-523-0023, (TTY# 711)</p> <p><u>Out of Network</u></p> <p>20% coinsurance</p> <p>20% coinsurance for physician services at an inpatient psychiatric hospital</p> <p>Humana Employer PPO Plan requests prior authorization for inpatient mental health care services. Call 1-800-523-0023, (TTY# 711)</p>

Services that are covered for you

What you must pay when you get these services

Skilled nursing facility (SNF) care

For a definition of "skilled nursing facility", see the chapter titled "Definitions of Important Words" of this booklet. Skilled nursing facilities are sometimes called "SNFs".

You are covered for medically necessary days 1-100 for each benefit period. Prior hospital stay is not required. Covered services include the following:

- Semiprivate room or a private room if medically necessary
- Meals, including special diets
- Regular nursing services
- Physical therapy, occupational therapy, and speech therapy
- Drugs, including substances that are naturally present in the body, such as blood clotting factors
- Blood, including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need
- Medical and surgical supplies ordinarily provided by SNFs
- Laboratory tests ordinarily provided by SNFs
- X-rays and other radiology services ordinarily provided by SNFs
- Use of appliances, such as wheelchairs ordinarily provided by SNFs
- Physician services

Generally, you will get your SNF care from plan facilities. However, under certain conditions listed below, you may be able to pay in network cost-sharing for a facility that isn't a plan provider, if the facility accepts our plan's amounts for payment.

Per benefit period, you pay:

In Network

You pay nothing for days 1-10

\$50 copayment per day for days 11-100

You pay nothing for physician services at a skilled nursing facility

Humana Employer PPO Plan requires prior authorization for skilled nursing facility care services.

Call 1-800-523-0023, (TTY# 711)

Out of Network

You pay nothing for days 1-10

\$50 copayment per day for days 11-100

You pay nothing for physician services at a skilled nursing facility

Humana Employer PPO Plan requests prior authorization for skilled nursing facility care services.

Call 1-800-523-0023, (TTY# 711)

Services that are covered for you

- A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care)
- A SNF where your spouse is living at the time you leave the hospital
- Prior authorization is required for in network inpatient skilled nursing care

A new skilled nursing benefit period will begin on day one when you first enroll in a Humana Medicare Advantage plan, or you have been discharged from a skilled nursing facility (or not received inpatient skilled level of care) for 60 consecutive days.

What you must pay when you get these services

Inpatient services when the psychiatric or skilled nursing facility days are no longer covered

Once you have reached the coverage limits for inpatient psychiatric hospital or skilled nursing facility stays, the plan will no longer cover your stay in the psychiatric hospital or SNF. However, we will cover certain types of services that you receive while you are still in the hospital or the SNF.

Covered services include, but aren't limited to, the following:

- Physician services
- Tests (X-ray or lab tests)
- X-ray, radium, and isotope therapy including technician materials and services
- Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations

In Network

You are covered for these services according to Medicare guidelines when the psychiatric hospital or SNF days are not or are no longer covered.

20% coinsurance for physician services at an inpatient psychiatric hospital

You pay nothing for physician services at a skilled nursing facility

Out of Network

You are covered for these services according to Medicare guidelines when the psychiatric hospital or SNF days are not or are no longer covered.

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces, trusses, artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, occupational therapy, and speech therapy 	<p>20% coinsurance for physician services at an inpatient psychiatric hospital</p> <p>You pay nothing for physician services at a skilled nursing facility</p>
<p>Home health agency care</p>	
<p>Covered services include the following:</p> <ul style="list-style-type: none"> • Part-time or intermittent skilled nursing and home health aid services. (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical social services • Medical equipment and supplies • Prior authorization is required for in network home health care 	<p><u>In Network</u></p> <p>You pay nothing</p> <p>Humana Employer PPO Plan requires prior authorization for home health services. Call 1-800-523-0023, (TTY# 711)</p> <p><u>Out of Network</u></p> <p>You pay nothing</p> <p>Humana Employer PPO Plan requests prior authorization for home health services. Call 1-800-523-0023, (TTY# 711)</p>

Services that are covered for you	What you must pay when you get these services
Hospice care	
<p>You may receive care from any Medicare-certified hospice program. Your hospice doctor can be a network provider or an out of network provider.</p>	<p><u>In Network</u> You pay nothing</p>
<p>Covered services include the following:</p> <ul style="list-style-type: none"> • Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by Original Medicare • Home care <p>Our Plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.</p>	<p><u>Out of Network</u> You pay nothing</p>
Outpatient Services	
Physician services, including doctor's office visits	
<p>Covered services include the following:</p> <ul style="list-style-type: none"> • Office visits, including medical and surgical care in a physician's office • Medical or surgical services furnished in a certified ambulatory surgical center or in a hospital outpatient • Consultation, diagnosis, and treatment by a specialist • Hearing and balance exams, if your doctor orders it to see if you need medical treatment • Telehealth office visits including consultation, diagnosis and treatment by a specialist • Second opinion by another plan provider prior to surgery • Outpatient hospital services 	<p><u>In Network</u></p> <p>\$25 copayment for each primary care physician office visit</p> <p>\$30 copayment for each specialist office visit</p> <p><u>Out of Network</u></p> <p>\$25 copayment for each primary care physician office visit</p> <p>\$30 copayment for each specialist office visit</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) 	
<p>Allergy serum and injections</p>	<p><u>In Network</u></p> <p>20% coinsurance for each primary care physician office visit</p> <p>20% coinsurance for each specialist office visit</p> <p><u>Out of Network</u></p> <p>20% coinsurance for each primary care physician office visit</p> <p>20% coinsurance for each specialist office visit</p>
<p>Chiropractic services (Routine)</p> <ul style="list-style-type: none"> • Limited to 20 visits per calendar year 	<p><u>In Network</u></p> <p>\$30 copayment for each specialist office visit with a \$75 maximum allowance per visit for a physical and manipulative therapy performed for maintenance rather than restoration</p> <p>\$25 copayment for each immediate care facility office visit with a \$75 maximum allowance per visit for a physical and manipulative therapy performed for maintenance rather than restoration</p>

Services that are covered for you	What you must pay when you get these services
	<p><u>Out of Network</u></p> <p>\$30 copayment for each specialist office visit with a \$75 maximum allowance per visit for a physical and manipulative therapy performed for maintenance rather than restoration</p> <p>\$25 copayment for each immediate care facility office visit with a \$75 maximum allowance per visit for a physical and manipulative therapy performed for maintenance rather than restoration</p>
Chiropractic services	
<p>Covered services include the following:</p> <ul style="list-style-type: none"> • Manual manipulation of the spine to correct subluxation • Limited to Medicare covered services 	<p><u>In Network</u></p> <p>\$20 copayment for each specialist office visit</p> <p>\$20 copayment for each immediate care facility office visit</p> <p><u>Out of Network</u></p> <p>\$20 copayment for each specialist office visit</p> <p>\$20 copayment for each immediate care facility office visit</p>
Podiatry services (Routine)	
<ul style="list-style-type: none"> • Limited to 6 visits per calendar year 	<p><u>In Network</u></p> <p>\$30 copayment for each specialist office visit</p>

Services that are covered for you	What you must pay when you get these services
	<p>\$25 copayment for each immediate care facility office visit</p> <p><u>Out of Network</u></p> <p>\$30 copayment for each specialist office visit</p> <p>\$25 copayment for each immediate care facility office visit</p>
Podiatry services	
<p>Covered services include the following:</p> <ul style="list-style-type: none"> • Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs • Limited to Medicare covered services 	<p><u>In Network</u></p> <p>\$30 copayment for each specialist office visit</p> <p>\$25 copayment for each immediate care facility office visit</p> <p><u>Out of Network</u></p> <p>\$30 copayment for each specialist office visit</p> <p>\$25 copayment for each immediate care facility office visit</p>
Outpatient mental health care	
<p>Covered services include the following:</p> <ul style="list-style-type: none"> • Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws 	<p><u>In Network</u></p> <p>\$25 copayment for each primary care physician office visit</p> <p>\$30 copayment for each specialist office visit</p>

Services that are covered for you	What you must pay when you get these services
<p>qualified mental health care professional as allowed under applicable state laws</p>	<p>office visit</p> <p>\$60 copayment for each outpatient hospital visit</p> <p>\$25 copayment for each immediate care facility visit</p> <p><u>Out of Network</u></p> <p>\$25 copayment for each primary care physician office visit</p> <p>\$30 copayment for each specialist office visit</p> <p>\$60 copayment for each outpatient hospital visit</p> <p>\$25 copayment for each immediate care facility visit</p>
<p>Partial hospitalization services</p> <ul style="list-style-type: none"> • "Partial hospitalization" is a structured program of active treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization • Prior authorization is required for in network partial hospitalization services 	<p><u>In Network</u></p> <p>\$60 copayment for each partial hospitalization visit</p> <p><u>Out of Network</u></p> <p>\$60 copayment for each partial hospitalization visit</p>
<p>Outpatient substance abuse services</p>	<p><u>In Network</u></p> <p>\$25 copayment for each primary care physician office visit</p> <p>\$30 copayment for each specialist office visit</p>

Services that are covered for you	What you must pay when you get these services
	<p>\$60 copayment for each outpatient hospital visit</p> <p>\$25 copayment for each immediate care facility visit</p> <p><u>Out of Network</u></p> <p>\$25 copayment for each primary care physician office visit</p> <p>\$30 copayment for each specialist office visit</p> <p>\$60 copayment for each outpatient hospital visit</p> <p>\$25 copayment for each immediate care facility visit</p>
<p>Outpatient surgery, including services provided at hospital facilities and ambulatory surgical centers</p> <ul style="list-style-type: none"> • Prior authorization is required for in network abdominoplasty, blepharoplasty, breast procedures, otoplasty, elective outpatient diagnostic cardiac catheterization, penile implant, rhinoplasty, septoplasty, obesity, and oral surgeries 	<p><u>In Network</u></p> <p>\$25 copayment for each primary care physician office visit</p> <p>\$30 copayment for each specialist office visit</p> <p>\$95 copayment for each ambulatory surgical center visit</p> <p>\$95 copayment for each outpatient hospital visit</p> <p>\$25 copayment for each immediate care facility visit</p> <p><u>Out of Network</u></p> <p>\$25 copayment for each primary care physician office visit</p>

Services that are covered for you	What you must pay when you get these services
	<p>\$30 copayment for each specialist office visit</p> <p>\$95 copayment for each ambulatory surgical center visit</p> <p>\$95 copayment for each outpatient hospital visit</p> <p>\$25 copayment for each immediate care facility visit</p>
<p>Ambulance services</p> <p>Covered services include the following:</p> <ul style="list-style-type: none"> • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation are contraindicated (could endanger the person’s health). The member’s condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary • Non-emergency transportation by ambulance is appropriate if it is documented that the member’s condition is such that other means of transportation are contraindicated (could endanger the person’s health) and that transportation by ambulance is medically required 	<p><u>In Network</u></p> <p>\$50 copayment per date of service regardless of the number of trips. Limited to Medicare-covered transportation</p> <p><u>Out of Network</u></p> <p>\$50 copayment per date of service regardless of the number of trips. Limited to Medicare-covered transportation</p>
<p>Emergency care</p>	<p>You do not pay the emergency room visit cost share if you are admitted to the hospital within 24 hours for the same condition.</p> <p><u>In Network</u></p>

Services that are covered for you	What you must pay when you get these services
	<p>\$50 copayment for emergency services in an emergency room</p> <p><u>Out of Network</u></p> <p>\$50 copayment for emergency services in an emergency room</p> <p>Worldwide: for emergency service outside of the U.S. and Puerto Rico, you pay a \$50 copayment. This benefit does not apply your combined annual out-of-pocket maximum.</p> <p>If you get authorized inpatient care at a non-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.</p>
<p>Urgently needed care</p> <p>You are covered for urgently needed care in the United States and its territories.</p>	<p><u>In Network</u></p> <p>\$25 copayment for each primary care physician office visit</p> <p>\$30 copayment for each specialist office visit</p> <p>\$25 copayment for each immediate care facility visit</p> <p><u>Out of Network</u></p> <p>\$25 copayment for each primary care physician office visit</p> <p>\$30 copayment for each specialist office visit</p>

Services that are covered for you	What you must pay when you get these services
	\$25 copayment for each immediate care facility visit
Outpatient rehabilitation services	
<p>Covered services include the following:</p> <ul style="list-style-type: none"> • Physical therapy • Occupational therapy • Speech language therapy • Cardiac rehabilitation services (not available at comprehensive outpatient rehabilitation facility) • Intensive cardiac rehabilitation services • Pulmonary rehabilitation services • Comprehensive Outpatient Rehabilitation Facility (CORF) services • Prior authorization is required for in network physical, occupational, and speech therapies 	<p><u>In Network</u></p> <p>\$30 copayment for each specialist office visit</p> <p>\$25 copayment for each comprehensive outpatient rehabilitation facility (CORF) visit</p> <p>\$25 copayment for each outpatient hospital visit</p> <p><u>Out of Network</u></p> <p>\$30 copayment for each specialist office visit</p> <p>\$25 copayment for each comprehensive outpatient rehabilitation facility (CORF) visit</p> <p>\$25 copayment for each outpatient hospital visit</p>
Medical supplies	
	<p><u>In Network</u></p> <p>20% coinsurance at a medical supply provider</p> <p>20% coinsurance at a pharmacy</p> <p><u>Out of Network</u></p> <p>20% coinsurance at a medical supply provider</p> <p>20% coinsurance at a pharmacy</p>

Services that are covered for you	What you must pay when you get these services
<p>Durable medical equipment and related supplies</p> <p>For definition of "durable medical equipment" see the chapter titled "Definitions of Important Words" of this booklet.</p> <p>Covered services include, but aren't limited to, the following:</p> <ul style="list-style-type: none"> • Wheelchairs • Crutches • Hospital beds • IV infusion pump • Oxygen equipment • Nebulizer • Walker • Prior authorization is required for in network cochlear and auditory brainstem implants, CPAP/BiPAP, CPM machines, cranial orthotics, electric beds, electric wheelchairs and scooters, high frequency chest compression vests, pain infusion pumps, stimulator devices (including bone growth, neuromuscular, and spinal cord), and any DME item over \$750 	<p><u>In Network</u></p> <p>20% coinsurance at a durable medical equipment provider</p> <p>20% coinsurance at a pharmacy</p> <p>Humana Employer PPO Plan requires prior authorization for durable medical equipment and related supplies. Call 1-800-523-0023, (TTY # 711)</p> <p><u>Out of Network</u></p> <p>20% coinsurance at a durable medical equipment provider</p> <p>20% coinsurance at a pharmacy</p> <p>Humana Employer PPO Plan requests prior authorization for durable medical equipment and related supplies. Call 1-800-523-0023, (TTY # 711)</p>
<p>Prosthetic devices and related supplies</p> <p>Devices, other than dental, that replace a body part or function.</p> <p>Covered services include, but aren't limited to, the following:</p> <ul style="list-style-type: none"> • Colostomy bags and supplies directly related to colostomy care • Pacemakers • Braces, prosthetic shoes, and artificial limbs • Breast prostheses, including a surgical brassiere after a mastectomy • Certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices 	<p><u>In Network</u></p> <p>20% coinsurance from a prosthetics provider</p> <p>Humana Employer PPO Plan requires prior authorization for prosthetic devices and related supplies. Call 1-800-523-0023, (TTY # 711)</p> <p><u>Out of Network</u></p>

Services that are covered for you	What you must pay when you get these services
<p>and repair and/or replacement of prosthetic devices</p> <ul style="list-style-type: none"> • Some coverage following cataract removal or cataract surgery. See "Vision Care" later in this section for more details • Prior authorization is required for in network prosthetic devices 	<p>20% coinsurance from a prosthetics provider</p> <p>Humana Employer PPO Plan requests prior authorization for prosthetic devices and related supplies. Call 1-800-523-0023, (TTY # 711)</p>
<p>Diabetes self-monitoring training</p>	
<p>For all people who have diabetes (insulin and non-insulin users).</p> <p>Covered services include the following:</p> <ul style="list-style-type: none"> • Self-management training is covered under certain conditions 	<p><u>In Network</u></p> <p>You pay nothing</p> <p><u>Out of Network</u></p> <p>You pay nothing</p>
<p>Diabetes self-monitoring supplies</p>	
<p>For all people who have diabetes (insulin and non-insulin users).</p> <p>Covered services include the following:</p> <ul style="list-style-type: none"> • Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors • One pair per plan year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes) for people with diabetes who have severe diabetic foot disease. Coverage includes fitting 	<p><u>In Network</u></p> <p>20% coinsurance from a durable medical equipment provider</p> <p>20% coinsurance from a pharmacy</p> <p><u>Out of Network</u></p> <p>20% coinsurance from a durable medical equipment provider</p> <p>20% coinsurance from a pharmacy</p>

Services that are covered for you	What you must pay when you get these services
<p>includes fitting</p> <ul style="list-style-type: none"> For persons at risk of diabetes, fasting plasma glucose tests are covered as often as medically necessary 	
<p>Medical nutrition therapy</p> <p>For people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by your doctor.</p> <p><u>In Network</u> You pay nothing</p> <p>We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician’s referral. A physician must prescribe these services and renew their referral yearly if your treatment is needed into another plan year.</p> <p><u>Out of Network</u> You pay nothing</p>	
<p>Kidney Disease Education Services</p> <p>Kidney Disease Education Services - Education to teach kidney care and help members make informed decisions about their care. For people with stage IV chronic kidney disease when referred by their doctor. We cover up to six sessions of kidney disease education services per lifetime.</p> <p><u>In Network</u> You pay nothing</p> <p><u>Out of Network</u> You pay nothing</p>	
<p>Advanced imaging</p> <ul style="list-style-type: none"> Prior authorization is required for in network CT scans, MRI, and MRA <p><u>In Network</u> \$25 copayment for each primary care physician office visit</p>	

Services that are covered for you	What you must pay when you get these services
	<p>\$35 copayment for each specialist office visit</p> <p>\$35 copayment for each freestanding radiological facility visit</p> <p>\$35 copayment for each outpatient hospital visit</p> <p><u>Out of Network</u></p> <p>\$25 copayment for each primary care physician office visit</p> <p>\$35 copayment for each specialist office visit</p> <p>\$35 copayment for each freestanding radiological facility visit</p> <p>\$35 copayment for each outpatient hospital visit</p>
<p>Nuclear medicine</p> <ul style="list-style-type: none"> Prior authorization is required for in network PET scans, PET scan registry (NOPR), and SPECT 	<p><u>In Network</u></p> <p>You pay nothing</p> <p><u>Out of Network</u></p> <p>You pay nothing</p>
<p>Outpatient diagnostic procedures and tests</p> <p>Covered services include the following:</p> <ul style="list-style-type: none"> Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need 	<p><u>In Network</u></p> <p>\$25 copayment for each primary care physician office visit</p> <p>\$30 copayment for each specialist office visit</p>

Services that are covered for you	What you must pay when you get these services
<p>need</p> <ul style="list-style-type: none"> • Surgical supplies, such as dressings • Supplies, such as splints and casts • X-rays • Other outpatient diagnostic tests • Prior authorization is required for in network molecular diagnostic/genetic testing 	<p>office visit</p> <p>You pay nothing for each freestanding radiological facility visit</p> <p>You pay nothing for each outpatient hospital visit</p> <p>\$25 copayment for each immediate care facility visit</p> <p><u>Out of Network</u></p> <p>\$25 copayment for each primary care physician office visit</p> <p>\$30 copayment for each specialist office visit</p> <p>You pay nothing for each freestanding radiological facility visit</p> <p>You pay nothing for each outpatient hospital visit</p> <p>\$25 copayment for each immediate care facility visit</p>
<p>Laboratory services</p>	<p><u>In Network</u></p> <p>\$25 copayment for each primary care physician office visit</p> <p>\$30 copayment for each specialist office visit</p> <p>You pay nothing for each freestanding laboratory visit</p> <p>You pay nothing for each outpatient hospital visit</p> <p>You pay nothing for each immediate care facility visit</p>

Services that are covered for you	What you must pay when you get these services
	<p><u>Out of Network</u></p> <p>\$25 copayment for each primary care physician office visit</p> <p>\$30 copayment for each specialist office visit</p> <p>You pay nothing for each freestanding laboratory visit</p> <p>You pay nothing for each outpatient hospital visit</p> <p>You pay nothing for each immediate care facility visit</p>
<p>Radiation therapy</p> <ul style="list-style-type: none"> • Prior authorization is required for in network radiation therapy 	<p><u>In Network</u></p> <p>\$30 copayment for each specialist office visit</p> <p>You pay nothing for each freestanding radiological facility visit</p> <p>You pay nothing for each outpatient hospital visit</p> <p><u>Out of Network</u></p> <p>\$30 copayment for each specialist office visit</p> <p>You pay nothing for each freestanding radiological facility visit</p>

Services that are covered for you	What you must pay when you get these services
	You pay nothing for each outpatient hospital visit
Vision - Medicare-covered services only	
<p>Covered services include the following:</p> <ul style="list-style-type: none"> • Outpatient physician services for eye care • For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant 	<p><u>In Network</u></p> <p>\$30 copayment for each specialist office visit</p> <p>You pay nothing for eyeglasses and contact lenses following cataract surgery with a \$75 dollar maximum allowance for glasses and lenses per year</p> <p><u>Out of Network</u></p> <p>\$30 copayment for each specialist office visit</p> <p>You pay nothing for eyeglasses and contact lenses following cataract surgery with a \$75 dollar maximum allowance for glasses and lenses per year</p>
Dental - Medicare-covered services only	
<p>Covered services include the following:</p> <ul style="list-style-type: none"> • Surgery of the jaw or related structures • Setting fractures of the jaw or facial bones • Extraction of teeth to prepare the jaw for radiation treatments or neoplastic disease • Services that would be covered when provided by a doctor 	<p><u>In Network</u></p> <p>\$30 copayment for each specialist office visit</p> <p><u>Out of Network</u></p> <p>\$30 copayment for each specialist office visit</p>
Hearing - Medicare-covered services only	
<p>Covered services include the following:</p>	<p><u>In Network</u></p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> Diagnostic hearing exams 	<p>\$30 copayment for each specialist office visit</p> <p><u>Out of Network</u></p> <p>\$30 copayment for each specialist office visit</p>
Preventive Care and Screening Tests	
<p>Abdominal aortic aneurysm screening</p> <p>A one-time screening ultrasound for people at risk. The plan only covers this screening if you get a referral for it as a result of your "Welcome to Medicare" physical exam.</p>	
<p>Annual wellness visit</p> <p>If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This exam is covered once every 12 months.</p> <p>Note: Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" exam. However, you don't need to have had a "Welcome to Medicare" exam to be covered for annual wellness visits after you've had Part B for 12 months.</p>	<p><u>In Network</u></p> <p>You pay nothing</p> <p><u>Out of Network</u></p> <p>You pay nothing</p>
<p>Bone mass measurements for qualified individuals that are at risk of bone loss or osteoporosis</p> <p>For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation</p>	
	<p><u>In Network</u></p> <p>You pay nothing</p>

Services that are covered for you	What you must pay when you get these services
<p>covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician’s interpretation of the results.</p>	<p><u>Out of Network</u> You pay nothing</p>
<p>Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)</p> <p>We cover 1 visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you’re eating well.</p>	<p><u>In Network</u> You pay nothing</p> <p><u>Out of Network</u> You pay nothing</p>
<p>Colorectal screening</p> <p>Covered services include the following:</p> <p>For people 50 and older, the following are covered:</p> <ul style="list-style-type: none"> • Flexible sigmoidoscopy (or screening barium enema as an alternative) once every 48 months if at high risk every 10years if no at high risk • Fecal occult blood test, every 12 months <p>For people at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> • Screening colonoscopy (or screening barium enema as an alternative) every 24 months <p>For people not at high risk of colorectal cancer, we cover:</p>	<p><u>In Network</u> You pay nothing</p> <p><u>Out of Network</u> You pay nothing</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy 	
<p>Diabetes screening</p>	
<ul style="list-style-type: none"> We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months 	<p><u>In Network</u> You pay nothing</p> <p><u>Out of Network</u> You pay nothing</p>
<p>HIV screening</p>	
<p>Covered services include the following:</p> <p>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:</p>	<p><u>In Network</u> You pay nothing</p>
<ul style="list-style-type: none"> One screening exam every 12 months <p>For women who are pregnant, we cover:</p> <ul style="list-style-type: none"> Up to three screening exams during a pregnancy 	<p><u>Out of Network</u> You pay nothing</p>
<p>Glaucoma testing</p>	
<ul style="list-style-type: none"> One screening exam every 12 months 	<p><u>In Network</u> You pay nothing</p> <p><u>Out of Network</u></p>

Services that are covered for you	What you must pay when you get these services
	You pay nothing
Immunizations	
Covered services include the following:	<u>In Network</u>
<ul style="list-style-type: none"> • Pneumonia vaccine • Flu shots once a year in the fall or winter • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • Other vaccines if you are at risk 	<p>You pay nothing</p> <p><u>Out of Network</u></p> <p>You pay nothing</p>
We also cover some vaccines under our outpatient prescription drug benefit.	
Mammography screening	
Covered services include the following:	<u>In Network</u>
<ul style="list-style-type: none"> • One baseline exam between the ages of 35 and 39 • One screening per year for women age 40 and older • Clinical breast exams once every 24 months 	<p>You pay nothing</p> <p><u>Out of Network</u></p> <p>You pay nothing</p>
Obesity screening and therapy to promote sustained weight loss	
<p>If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.</p>	<p><u>In Network</u></p> <p>You pay nothing</p> <p><u>Out of Network</u></p> <p>You pay nothing</p>
Pap test, pelvic exam, and clinical breast exam	
Covered services include the following:	<u>In Network</u>
<ul style="list-style-type: none"> • For all women: Pap tests and pelvic exams are covered once every 24 months 	You pay nothing

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months 	<p><u>Out of Network</u></p> <p>You pay nothing</p>
<p>Prostate cancer screening exams</p>	
<p>For men 50 and older covered services include the following:</p> <ul style="list-style-type: none"> Digital rectal exam once per year Prostate Specific Antigen (PSA) test once per year 	<p><u>In Network</u></p> <p>You pay nothing</p> <p><u>Out of Network</u></p> <p>You pay nothing</p>
<p>Cardiovascular disease testing</p>	
<p>Covered services include the following:</p> <p>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease)</p> <p>Covered once every 5 years</p>	<p><u>In Network</u></p> <p>You pay nothing</p> <p><u>Out of Network</u></p> <p>You pay nothing</p>
<p>Physical exams</p>	
<p>You are covered for one routine physical per year.</p> <p>Covered services include the following:</p> <ul style="list-style-type: none"> Counseling on diet, exercise, substance abuse, and injury prevention Height and weight measurement at intervals according to provider’s clinical discretion Blood pressure Vision screening at provider’s discretion 	<p><u>In Network</u></p> <p>You pay nothing</p> <p><u>Out of Network</u></p> <p>You pay nothing</p>
<p>Screening and counseling to reduce alcohol misuse</p>	
<p>We cover one alcohol misuse screening per year for adults with Medicare (including pregnant women) who misuse alcohol, but aren’t alcohol dependent.</p>	<p><u>In Network</u></p>

Services that are covered for you	What you must pay when you get these services
<p>women) who misuse alcohol, but aren't alcohol dependent.</p> <p>If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.</p>	<p>You pay nothing</p> <p><u>Out of Network</u></p> <p>You pay nothing</p>
<p>Depression Screening</p> <p>Covered once per year</p>	
<p>Screening for sexually transmitted infections (STIs) and counseling to prevent STIs</p> <p>We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy.</p> <p>We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.</p>	<p><u>In Network</u></p> <p>You pay nothing</p> <p><u>Out of Network</u></p> <p>You pay nothing</p>

Services that are covered for you	What you must pay when you get these services
<p>Smoking cessation Medicare - covered services only</p> <p>If you use tobacco, but do not have signs or symptoms of tobacco-related disease: we cover two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: we cover cessation counseling services. We cover two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits, however, you will pay the applicable inpatient or outpatient cost sharing.</p>	<p><u>In Network</u></p> <p>You pay nothing</p> <p><u>Out of Network</u></p> <p>You pay nothing</p>
<p>"Welcome to Medicare" Preventive Visit</p> <p>The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed.</p> <p>Important: We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.</p> <p>Note: Any lab or diagnostic procedures that are ordered are not covered under this benefit and you pay your plan cost sharing amount for those services separately.</p>	<p><u>In Network</u></p> <p>You pay nothing</p> <p><u>Out of Network</u></p> <p>You pay nothing</p>

Services that are covered for you	What you must pay when you get these services
Other Services	
<p>Renal (Kidney) dialysis</p> <p>Covered services include the following:</p> <ul style="list-style-type: none"> • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3) • Inpatient dialysis treatments (if you are admitted to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies. See "Durable medical equipment and related supplies" for details • Certain home support services (such as when medically necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply.) See "Home health agency care" for details 	
Chemotherapy drugs	<p><u>In Network</u></p> <p>20% coinsurance for each specialist office visit</p> <p>20% coinsurance for each outpatient hospital visit</p> <p><u>Out of Network</u></p> <p>20% coinsurance for each specialist office visit</p> <p>20% coinsurance for each outpatient hospital visit</p>

Services that are covered for you

What you must pay when you get these services

Medicare Part B prescription drugs

These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include:

- Drugs that usually aren't self-administered by the patient and are injected while you are getting physician services
- Drugs you take using durable medical equipment (such as nebulizers) that was authorized by the plan
- Clotting factors you give yourself by injection if you have hemophilia
- Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant
- Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug
- Antigens
- Certain oral anti-cancer drugs and anti-nausea drugs
- Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen^(R), Procrit^(R), Epoetin Alfa, Aranesp^(R), or Darbepoetin Alfa)
- Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases
- Prior authorization may be required for Part B drugs. Contact plan for details

In Network

20% coinsurance for Medicare Part B drugs in a pharmacy

20% coinsurance for administration of drugs in a physician's office

20% coinsurance for administration of drugs in a specialist's office

Out of Network

20% coinsurance for Medicare Part B drugs in a pharmacy

20% coinsurance for administration of drugs in a physician's office

20% coinsurance for administration of drugs in a specialist's office

Services that are covered for you

What you must pay when you get these services

Additional Benefits

Hearing - non-Medicare-covered routine services

You are covered for mandatory supplemental hearing benefits.

In Network

\$30 copayment for fitting/evaluation, routine hearing test up to 1 per year.

\$1000 maximum benefit coverage amount every 4 years for Hearing Aids (all types).

Out of Network

\$30 copayment for fitting/evaluation, routine hearing test up to 1 per year.

\$1000 maximum benefit coverage amount every 4 years for Hearing Aids (all types).

Vision - non-Medicare-covered routine services

You are covered for mandatory supplemental vision benefits.

In Network

\$30 copayment for Routine Exam up to 1 evaluation(s) per year.

\$125 maximum benefit coverage amount every 2 years for Contact Lenses, Eyeglasses - Lenses and Frames.

Out of Network

\$30 copayment for Routine Exam up to 1 evaluation(s) per year.

\$125 maximum benefit coverage amount every 2 years for Contact Lenses, Eyeglasses - Lenses and Frames.

Services that are covered for you

What you must pay when you get these services

Health and wellness education programs

HumanaFirst^(R) 24 Hour Nurse Advice Line

As a Humana member, you have access to health information, guidance, and support. Whether you have an immediate health concern or questions about a particular medical condition, call HumanaFirst for expert advice and guidance at no additional cost to you.

HumanaFirst^(R) 24 Hour Nurse Advice Line is available in all states.

Just call 1-800-622-9529, TTY 1-888-791-2008 to talk to a nurse.

Why call HumanaFirst?

You may not have health concerns or medical questions very often but when you do, call the HumanaFirst Nurse Advice Line. We're your health information and support team:

- If you need a refresher course in changing your bandage after a recent surgery
- If you've been diagnosed with a medical condition such as diabetes or cancer
- If you have a fever at 3:00 am in the morning

Well Dine Inpatient Meal Program

After your overnight stay in the hospital or nursing facility, you are eligible for ten nutritious, pre-cooked, frozen meals delivered to your door at no cost to you. To arrange for this service, simply call 1-866-96MEALS (1-866-966-3257) after your discharge and provide your Humana member ID number, and other basic information. A Humana representative will assist you in scheduling your delivery.

The Well Dine program is available in all states except Alaska and Hawaii.

Services that are covered for you

What you must pay when you get these services

SilverSneakers^(R) Fitness Program

You are covered for membership to a participating SilverSneakers^(R) fitness program.

The SilverSneakers^(R) Fitness Program is available in all states except Nevada and Pennsylvania.

Your benefits include:

- A basic fitness center membership at a participating location near you with access to the basic amenities
- Custom designed, low impact classes designed to improve your body's strength and flexibility
- On-site advisors to act as your contact for information and personalized service
- Social events
- Self directed SilverSneakers^(R) Steps program with focus on improving strength and mobility, available to members that are not located within a 15-mile radius of a fitness center

Silver & Fit^(TM) Fitness Program

You are covered for membership to a participating fitness club.

The Silver & Fit^(TM) Fitness Program is available only in Nevada and Pennsylvania.

Your benefits include:

- A basic fitness center membership at a participating location near you with access to the basic amenities
- Custom designed, low impact classes designed to improve your body's strength and flexibility
- Social events

QuitNet^(R) smoking cessation program

Comprehensive smoking cessation services include:

The QuitNet^(R) smoking cessation program is available in all states.

Services that are covered for you

- Web based or telephonic counseling/coaching
- QuitGuide, and QuitTips e-mail support
- Over-the-counter nicotine replacement therapy which includes; Nicoderm^(R) Patch, Nicorette^(R) Gum and Commit^(R) Lozenge products

You can enroll by phone at 1-888-572-4074 (TTY: 711), 8 am to 12 am, Monday through Friday, or 8:30 am to 5 pm, Saturday, Eastern Standard time. Or enroll online at quitnet.com/humana.

Humana Active Outlook^(R)

Medicare members benefit from exclusive lifestyle enrichment through our award-winning program. Medicare members get the following benefits of Humana Active Outlook at no additional cost.

Humana Active Outlook printed resources

- **HAO Magazine**, our quarterly award-winning publication with inspiring stories for active, fun, healthy living
- **Live It Up! Digest**, a quarterly publication to help members with chronic conditions manage their health

Humana Active Outlook Website

HumanaActiveOutlook.com, your Web source for custom health and wellness information and interactive tools.

What you must pay when you get these services

Humana Active Outlook^(R) (HAO) Magazine is available in all states.

Services that are covered for you

What you must pay when you get these services

Humana Active Outlook Classes and Seminars

Learn more about how you can live a healthier lifestyle! Join other members to learn about brain fitness, the right way to exercise, how to eat healthy, computers and technology, managing conditions, and understanding your healthcare experience in our local health and wellness classes in select communities. And don't miss out on our health education seminars, where you'll learn about condition-specific topics such as diabetes or osteoporosis. Watch presentations from experts, get a health screening, hear the latest information on health conditions, and talk with professionals who can answer your questions.

Heal! Personalized Health Programs
Condition-specific information on managing diabetes, cardiovascular health, cancer, COPD, weight, chronic conditions, and back health care.

Getting care using our plan's traveler benefit

You may get care when you are outside the service area. You may need to pay higher cost sharing for routine care from non-network providers, but you won't pay extra in a medical emergency or if your care is urgently needed. If you have questions about your medical costs when you travel, please call Customer Care Team.

You have access to providers in the Humana Choice network in all of our service areas. If you need urgently needed care or non-emergency care while traveling outside the plan's service area, call Customer Service. We'll tell you whether you're in one of our other Humana Choice service areas and help you find an in-network provider. You may see any provider you choose, but your out-of-pocket costs may be higher if you see an out-of-network provider.

SECTION 3 What types of benefits are not covered by the plan?**Types of benefits we do *not* cover (exclusions)**

This section tells you what kinds of benefits are "excluded." Excluded means that the plan doesn't cover these benefits.

The list below describes some services and items that aren't covered under any conditions and some that are excluded only under specific conditions.

If you get benefits that are excluded, you must pay for them yourself. We won't pay for the medical benefits listed in this section (or elsewhere in this booklet), and neither will Original Medicare. The only exception: If a benefit on the exclusion list is found upon appeal to be a medical benefit that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to the chapter titled "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" in this booklet.)

In addition to any exclusions or limitations described in the Benefits Chart, or anywhere else in this *Evidence of Coverage*, **the following items and services aren't covered under Original Medicare or by our plan:**

- Services considered not reasonable and necessary, according to the standards of Original Medicare, unless these services are listed by our plan as a covered services
- Experimental medical and surgical procedures, equipment and medications, unless covered by Original Medicare. However, certain services may be covered under a Medicare-approved clinical research study. See Chapter 3, Section 5 for more information on clinical research studies
- Surgical treatment for morbid obesity, except when it is considered medically necessary and covered under Original Medicare
- Private room in a hospital, except when it is considered medically necessary
- Private duty nurses
- Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television
- Full-time nursing care in your home
- Custodial care, unless it is provided with covered skilled nursing care and/or skilled rehabilitation services. Custodial care, or non-skilled care, is care that helps you with activities of daily living, such as bathing or dressing

- Homemaker services include basic household assistance, including light housekeeping or light meal preparation
- Fees charged by your immediate relatives or members of your household
- Meals delivered to your home except those included in the Well Dine benefit
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary
- Cosmetic surgery or procedures because of an accidental injury or to improve a malformed part of the body. However, all stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance
- Routine dental care, such as cleanings, filings, or dentures. However, non-routine dental care received at a hospital may be covered
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace or the shoes are for a person with diabetic foot disease
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease
- Radial keratotomy, LASIK surgery, vision therapy and other low vision aids. However, eyeglasses are covered for people after cataract surgery
- Outpatient prescription drugs including drugs for treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmia or hyporgasmia. *Please see your drug benefits for possible coverage details*
- Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies
- Acupuncture
- Naturopath services (uses natural or alternative treatments)
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when emergency services are received at VA hospital and the VA cost-sharing is more than the cost-sharing under our plan. We will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts
- Any services listed above that aren't covered will remain not covered even if received at an emergency facility

**Chapter 5. Using the plan's coverage for your
Part D prescription drugs**

SECTION 1 Introduction

This chapter describes your coverage for Part D drugs

Basic rules for the plan's Part D drug coverage

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

To have your prescription covered, use a network pharmacy

Finding network pharmacies

Using the plan's mail-order services

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

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

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

The "Drug Guide" tells which Part D drugs are covered

There are four "cost-sharing tiers" for drugs
on the Drug Guide

How can you find out if a specific drug is on the Drug Guide?

SECTION 4 There are restrictions on coverage for some drugs

Why do some drugs have restrictions?

What kinds of restrictions?

Do any of these restrictions apply to your drugs?

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

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

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

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

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

The Drug Guide can change during the year

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

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

Types of drugs we do not cover

SECTION 8 Show your plan membership card when you fill a prescription

Show your membership card

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SECTION 9 Part D drug coverage in special situations

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

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

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

SECTION 10 Programs on drug safety and managing medications

Programs to help members use drugs safely

Programs to help members manage their medications

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

For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, some information in this *Evidence of Coverage* 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" (LIS Rider), that tells you about your drug coverage. If you don't have this insert, please call Customer Care Team (telephone number on the back of your membership card) and ask for the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (LIS Rider).

SECTION 1 Introduction

This chapter describes your coverage for Part D drugs

This chapter explains rules for using your coverage for Part D drugs. The next chapter tells what you pay for Part D drugs (Chapter 6, *What you pay for your Part D prescription drugs*).

In addition to your coverage for Part D drugs, the Humana Medicare Employer Plan also covers some drugs under the plan's medical benefits:

- The plan covers drugs you are given during covered stays in the hospital or in a skilled nursing facility. Chapter 4 (*Medical benefits chart, what is covered and what you pay*) tells about the benefits and costs for drugs during a covered hospital or skilled nursing facility stay.
- 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. Chapter 4 (*Medical benefits chart, what is covered and what you pay*) tells about the benefits and costs for Part B drugs.

The two examples of drugs described above are covered by the plan's medical benefits. The rest of your prescription drugs are covered under the plan's Part D benefits.

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 use a network pharmacy to fill your prescription. (See Section 3, *Fill your prescriptions at a network pharmacy*.)

- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Drug Guide" for short). (See Section 3, *Your drugs need to be on the plan's drug guide.*)
- Your drug must be considered medically necessary. "Medically necessary" means that the drug is needed for the diagnosis or treatment of your medical condition and meets accepted standards of medical practice.

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

To have your prescription covered, use a network pharmacy

In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies.

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

Preferred pharmacies are pharmacies in our network where the plan has negotiated lower cost-sharing for members for covered drugs than at non-preferred network pharmacies. However, you will usually have lower drug prices at both preferred and non-preferred pharmacies than at out-of-network pharmacies. You may go to either of these types of network pharmacies to receive your covered prescription drugs.

Finding network pharmacies

How do you find a network pharmacy in your area?

You can look in your *Pharmacy Directory*, visit our website (Humana.com), or call our Customer Care Team (telephone number on the back of your membership card). Choose whatever is easiest for you.

You may go to any of our network pharmacies. However, you will usually pay less for your covered drugs if you use a preferred network pharmacy rather than a non-preferred network pharmacy. The Provider Directory will tell you which of the pharmacies in our network are preferred network pharmacies. If you switch from one network pharmacy to another, and you need a refill of a drug you have been taking, you can ask to either have a new prescription written by a provider or to have your prescription transferred to your new network pharmacy.

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

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. Or if the pharmacy you have been using changes from being a preferred network pharmacy to a non-preferred network pharmacy, you may want to switch to a new pharmacy. To find another network pharmacy in your area, you can get help from our Customer Care Team (telephone number on the back of your membership card) or use the *Pharmacy Directory*.

What if you need a specialized pharmacy?

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term-care facility. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. Residents may get prescription drugs through the facility's pharmacy as long as it is part of our network. If your long-term care pharmacy is not in our network, please contact Customer Care Team (telephone number on the back of your membership card).
- 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 certain drugs that are restricted by the FDA to certain locations, require extraordinary handling, provider coordination, or education on its use. (Note: This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Pharmacy Directory* or call Customer Care Team (telephone number on the back of your membership card).

Using the plan's mail-order services

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

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

To get order forms and information about filling your prescriptions by mail, please contact our Customer Care Team (telephone number on the back of your membership card).

Usually a mail-order pharmacy order will get to you in no more than 14 days. We recommend that you discuss with your physician the option of writing a prescription for a 30-day supply to fill at a network retail pharmacy along with your prescription for a mail-order, in case your order is delayed.

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 of maintenance drugs on 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. Some of these retail pharmacies may agree to accept the mail-order cost-sharing amount for a long-term supply of maintenance drugs. Other retail pharmacies may not agree to accept the mail-order cost-sharing amounts for an extended supply of maintenance drugs. In this case you will be responsible for the difference in price. Your *Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call our Customer Care Team (telephone number on the back of your membership card) for more information.
2. For certain kinds of drugs, you can use the plan's network mail-order services. These drugs are marked as mail-order drugs on our plan's Drug Guide. Our plan's mail-order service requires you to order at least a 30-day supply of the drug and no more than a 90-day supply. (See above, Using the plan's mail-order services.)

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

Your prescription might be covered in certain situations

We have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- **If you need a prescription because of a medical emergency**
 - We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care. In this situation, you will have to pay the full cost (rather than paying just your copayment or coinsurance) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a paper claim form. If 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 an in-network pharmacy and what the out-of-network pharmacy charged for your prescription. (Chapter 7, Section 2 explains how to ask the plan to pay you back.)

- **If you need coverage while 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 preferred prescription home delivery service (mail-order) or through a retail network pharmacy that offers an extended supply. If you are traveling outside of your plan's service area but within the United States and territories and become ill, or run out of your prescription drugs, call Customer Care Team (telephone number on the back of your membership card) 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.
 - You may be responsible for paying the difference between what we would pay for a prescription filled at an in-network pharmacy and what the out-of-network pharmacy charged for your prescription. You can ask us to reimburse you for our share of the cost by submitting a paper claim form. (Chapter 7, Section 2 explains how to ask the plan to pay you back.)
- **Please recognize, however, that multiple non-emergency occurrences of out-of-network pharmacy claims will result in claim denials. In addition, we cannot pay for any stolen medications or prescriptions that are filled by pharmacies outside the United States and territories, even for a medical emergency.**

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

We will cover your prescription at an out-of-network pharmacy if at least one of the following applies:

- If you are unable to get a covered drug in a timely manner because there is no network pharmacy within a reasonable driving distance providing 24-hour service.
- If you are trying to fill a covered prescription drug that is not regularly stocked at a network retail or mail-order pharmacy (these drugs include orphan drugs or other specialty pharmaceuticals).
- If you get a covered prescription drug from an institutional based pharmacy while a patient in an emergency room, provider based clinic, outpatient surgery clinic, or other outpatient setting.
- If you are automatically enrolled in our plan because you are Medicaid eligible and have a seven-month retroactive enrollment period.
- If you become evacuated due to a state or federal emergency disaster declaration or other public health emergency declaration and cannot readily find an in-network pharmacy.

In these situations, please check first with our Customer Care Team (telephone number on the back of your membership card) to see if there is a network pharmacy nearby.

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 paying your normal share of the cost) when you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 7, Section 2 explains how to ask the plan to pay you back.)

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

The "Drug Guide" tells which Part D drugs are covered

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

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the plan's Drug Guide.

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

We will generally cover a drug on the plan's Drug Guide as long as you follow the other coverage rules explained in this chapter and the drug is medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the diagnosis or treatment of your medical condition and meet accepted standards of medical practice.

The Drug Guide includes both brand-name and generic drugs

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

What is *not* on 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 information about this, see Section 7 in this chapter).
- In other cases, we have decided not to include a particular drug on the Drug Guide.

There are four "cost-sharing tiers" for drugs on the Drug Guide

Every drug on 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 and Preferred Generic:** Generic drugs that are usually available at the lowest cost share
- **Tier 2 - Preferred Brand:** Brand prescription drugs that Humana Group Medicare usually offers at a lower cost to you than non-preferred brand drugs
- **Tier 3 - Non-Preferred Brand:** Brand prescription drugs that Humana Group Medicare usually offers at a higher cost to you than preferred brands
- **Tier 4 - Specialty Tier:** Some injectables and other higher-cost drugs

Please review Chapter 6 for all drug pricing information for your plan

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

How can you find out if a specific drug is on the Drug Guide?

You have three ways to find out:

1. Check the most recent Drug Guide we sent you in the mail.
2. Visit the plan's website (Humana.com). The Drug Guide on the website is always the most current.
3. Call Customer Care Team (telephone number on the back of your membership card) to find out if a particular drug is on the plan's Drug Guide or to ask for a copy of the list.

SECTION 4 There are restrictions on coverage for some drugs

Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

In general, our rules encourage you get a drug that works for your medical condition and is safe and effective. Whenever a safe, lower-cost drug will work medically just as well as a higher-cost drug, the plan's rules are designed to encourage you and your doctor to use that lower-cost option. We also need to comply with Medicare's rules and regulations for drug coverage and cost sharing.

What kinds of restrictions?

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

Restricting brand name drugs when a generic version is available.

A "generic" drug works the same as a brand-name drug, but usually costs less. When a generic version of a brand-name drug is available, our network pharmacies must provide you the generic version. However, if your doctor has told us the medical reason that the generic drug will not work for you, then we will cover the brand-name drug. (Your share of the cost may be greater for the brand-name drug than for the generic drug.)

Getting plan approval in advance

For certain drugs, you or your doctor need to get approval from the plan before we will agree to cover the drug for you. This is called "prior authorization." Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

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

Quantity limits

For certain drugs, we limit the amount of the drug that you can have. For example, the plan might limit how many refills you can get, or 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.

Do any of these restrictions apply to your drugs?

The plan's Drug Guide includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug Guide. For the most up-to-date information, call Customer Care Team (telephone number on the back of your membership card) or check our website (Humana.com).

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

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

Suppose there is a prescription drug you are currently taking, or one that you and your doctor think you should be taking. We hope that your drug coverage will work well for you, but it's possible that you might have a problem. For example:

- **What if the drug you want to take is not covered by the plan?** 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.
- **What if the drug is covered, but there are extra rules or restrictions on coverage for that drug?** As explained in Section 4, some of the drugs covered by the plan have extra rules to restrict their use. For example, you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. Or there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period.
- **What if the drug is covered, but it is in a cost-sharing tier that makes your cost sharing more expensive than you think it should be?** The plan puts each covered drug into one of four different cost-sharing tiers. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

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

- If your drug is not on the Drug Guide or if your drug is restricted, see below 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, in this section go to (What can you do if your drug is in a cost-sharing tier you think is too high) to learn what you can do.

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

If your drug is not on the Drug Guide or is restricted, here are things you can do:

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply). This will give you and your provider time to change to another drug or to file a request to have the drug covered.
- You can request an exception and ask the plan to cover the drug in the way you would like it to be covered.

You may be able to get a temporary supply

Under certain circumstances, the plan can offer a temporary supply of a drug to you when your drug is not on the Drug Guide or when it is restricted in some way. Doing this gives you time to talk with your doctor about the change in coverage and figure out what to do.

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

1. The change to your drug coverage must be one of the following types of changes:

- The drug you have been taking is no longer on the plan's Drug Guide.
- -- or -- the drug you have been taking is now restricted in some way (Section 4 in this chapter tells about restrictions).

2. You must be in one of the situations described below:

- **For those members who were in the plan last year and aren't in a long-term care facility:**

We will cover a temporary supply of your drug one time only during the first 90 days of the plan year. This temporary supply will be for a maximum of 30 days, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.

- **For those members who are new to the plan and aren't in a long-term care facility:**

We will cover a temporary supply of your drug one time only during the first 90 days of your membership in the plan. This temporary supply will be for a maximum of 30 days, or less if your prescription is written for fewer days.

- **For those who are new members, and are residents in a long-term care facility:**

We will cover a temporary supply of your drug during the first 90 days of your membership in the plan. The first supply will be for a maximum of 31 days, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in the plan.

- **For those members who were in the plan last year and a resident in a long-term care facility:**

We will cover a temporary supply of your current drug therapy during the first 90 days of the calendar year. This temporary supply will be for a maximum of 31 days, or less if your prescription is written for fewer days. If needed, we will cover two additional refills during your first 90 days in the plan.

- **For those who have been a member of the plan for more than 90 days, and are a resident of a long-term care facility and need a supply right away:**

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

- **Transition Supply for Current Members:**

Throughout the plan year, you may have a change in your treatment setting due to the level of care you require. Such transitions include:

- Members who are discharged from a hospital or Skilled Nursing Facility to a home setting.
- Members who are admitted to a hospital or Skilled Nursing Facility from a home setting.
- Members who transfer from one Skilled Nursing Facility to another and are served by a different pharmacy.
- Members who end their Skilled Nursing Facility Medicare Part A (where payments include all pharmacy charges) and who need to now use their Part D plan benefit.
- Members who give up Hospice Status and revert back to standard Medicare Part A and B coverage.
- Members discharged from chronic psychiatric hospitals with highly individualized drug regimens.

For these changes in treatment settings, Humana will cover up to a 31-day temporary supply of a Part D covered drug when your prescription is filled at a network pharmacy. If you change treatment settings multiple times within the same month, you may have to request an exception or prior authorization and receive approval for continued coverage of your drug. Humana will review these requests for continuation of therapy on a case-by-case basis when you are stabilized on a drug regimen which, if altered, is known to have risks.

Transition policy

We want to be sure that you, as a new or existing member, safely transition into the 2013 plan year. In 2013 You may not be able to receive your current drug therapy if the drug:

- Is not in our Drug Guide
or
- Requires prior authorization because of quantity limits, step therapy requirements, or confirmation of your clinical history

Cost-sharing for Drugs Provided through the Transition Policy

If you're eligible for the low-income subsidy (LIS) in 2013, your copayment or coinsurance for a temporary supply of drugs provided during your transition period won't exceed your LIS limit. If you don't receive LIS, your copayment or coinsurance will be based on your plan's approved drug cost-sharing tiers.

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

Beginning January 1, 2013, when you have limited ability to receive your current prescription therapy:

- We will cover a one-time, 30-day supply of a Part D-covered drug unless the prescription is written for less than 30 days during the first 90 days of your eligibility.
- After you have your 30-day supply, you'll receive a letter that explains the temporary nature of the transition medication supply. After you receive the letter, talk to your provider and decide if you should switch to an alternative drug or request an exception or prior authorization. We may not pay for refills of temporary supply drugs until an exception or prior authorization has been requested and approved.

Transition Supply for Residents of Long-Term Care Facilities

We assist members in long-term care facilities who transition between plans, have both Medicare and full Medicaid benefits, or submit an exception or an appeal request. For long-term care residents, we will cover up to a 31-day supply and two additional refills of a Part D-covered drug. This coverage is offered anytime during the first 90 days of your eligibility when your current prescription therapy is filled at a long-term care pharmacy.

If your ability to receive your drug therapy is limited - but you're past the first 90 days of membership in your plan - we will cover up to a 31-day emergency supply of a Part D-covered drug so you can continue therapy while you pursue an exception or prior authorization.

Transition Supply for Current Members

Throughout the plan year, you may have a change in your treatment setting due to the level of care you require. Such transitions include:

- Members discharged from a hospital or skilled nursing facility to a home setting.
- Members admitted to a hospital or skilled nursing facility from a home setting.
- Members who transfer from one skilled nursing facility to another and serviced by a different pharmacy.
- Members who end their skilled nursing facility Medicare Part A stay - where payments include all pharmacy charges - and who need to now use their Part D plan benefit.
- Members who give up hospice status and revert back to standard Medicare Part A and B coverage.

- Members discharged from chronic psychiatric hospitals with highly individualized drug regimens.

For these changes in treatment settings, we will cover up to a 31-day supply of a Part D-covered drug when your prescription is filled at a pharmacy. If you change treatment settings multiple times within the same month, you may have to request an exception or prior authorization and receive approval for continued coverage of your drug.

We will review these requests for continuation of therapy on a case-by-case basis when you have a stabilized drug regimen that, if altered, is known to have risks.

Transition Extension

We make arrangements to continue to provide necessary drugs to you via an extension of the transition period, on a case-by case basis, when your exception request or appeal has not been processed by the end of your transition period.

Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics (P&T) committee has oversight of our Part D Drug Guide and associated policies. The P&T committee designed these policies for certain Part D drugs. The policies are designed to make sure the drug is used based on medically accepted clinical guidelines for indications where the drug has been proven safe and effective and is prescribed according to manufacturer recommendations.

After you receive your temporary supply of a Part D drug, your medication may require medical review if:

- It's not in the Drug Guide
or
- It requires prior authorization due to quantity limits, step therapy requirements, or confirmation of your clinical history

If you're stabilized on a drug not in the Drug Guide or a drug requiring prior authorization or have tried other drug alternatives, your provider can provide us with a statement of your clinical history to help with the prior authorization or exception request process.

Public Notice of Transition Policy

This Transition Policy is available on our website, Humana.com, in the same area where the Part D Formulary is displayed.

To ask for a temporary supply, call Customer Care Team (telephone number on the back of your membership card).

During the time when you are getting a temporary supply of a drug, you should talk with your doctor or other prescriber to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your doctor can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. The sections below tell you more about these options.

You can change to another drug

Start by talking with your provider. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call Customer Care Team (telephone number on the back of your membership card) to ask for a list of covered drugs that treat the same medical condition. This list can help your provider to find a covered drug that might work for you.

You can request an exception

You and your doctor can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If your doctor or other prescriber says that you have medical reasons that justify asking us for an exception, your doctor or other prescriber can help you request an exception to the rule.

For example, you can ask the plan to cover a drug even though it is not on the plan's Drug Guide. Or you can ask the plan to make an exception and cover the drug without restrictions.

If you are a current member and a drug you are taking will be removed from the formulary or restricted in some way for next year, we will allow you to request a formulary exception in advance for next year. We will tell you about any change in the coverage for your drug for the following year. You can then ask us to make an exception and cover the drug in the way you would like it to be covered for the following year. We will give you an answer to your request for an exception before the change takes effect.

If you and your doctor or other prescriber want to ask for an exception, Chapter 9, Section 6 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

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

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

You can change to another drug

Start by talking with your provider. Perhaps there is a different drug in a lower cost-sharing tier that might work just as well for you. You can call Customer Care Team (telephone number on the back of your membership card) to ask for a list of covered drugs that treat the same medical condition. This list can help your provider to find a covered drug that might work for you.

You can file an exception

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 the drug. If your doctor or other provider says that you have medical reasons that justify asking us for an exception, your doctor can help you request an exception to the rule.

If you and your provider want to ask for an exception, Chapter 9, Section 6 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

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

The Drug Guide can change during the year

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

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

In almost all cases, we must get approval from Medicare for changes we make to the plan's Drug Guide.

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

How will you find out if your drug's coverage has been changed?

If there is a change to coverage *for a drug you are taking*, the plan will send you a notice to tell you. Normally, we will let you know at least 60 days ahead of time.

Once in a while, a drug is suddenly recalled because it's been found to be unsafe or for other reasons. If this happens, the plan will immediately remove the drug from the Drug Guide. We will let you know of this change right away. Your doctor will also know about this change, and can work with you to find another drug for your condition.

Do changes to your drug coverage affect you right away?

If any of the following types of changes affect a drug you are taking, the change will not affect you until the beginning of the next plan year if you stay in the plan:

- If we move your drug into a higher cost-sharing tier.
- If we put a new restriction on your use of the drug.
- If we remove your drug from the Drug Guide, but not because of a sudden recall or because a new generic drug has replaced it.

If any of these changes happens for a drug you are taking, then the change won't affect your use or what you pay as your share of the cost until the beginning of the next plan year. Until that date, you probably won't see any increase in your payments or any added restriction to your use of the drug. However, at the beginning of the next plan year, the changes will affect you.

In some cases, you will be affected by the coverage change before the end your plan year:

- If a brand-name drug you are taking is replaced by a new generic drug, the plan must give you at least 60 days' notice or give you a 60-day refill of your brand-name drug at a network pharmacy.
 - During this 60-day period, you should be working with your doctor to switch to the generic or to a different drug that we cover.
 - Or you and your doctor or other prescriber can ask the plan to make an exception and continue to cover the brand-name drug for you. For information on how to ask for an exception, see Chapter 9 (*What to do if you have a problem or complaint*).
- Again, if a drug is suddenly recalled because it's been found to be unsafe or for other reasons, the plan will immediately remove the drug from the Drug Guide. We will let you know of this change right away.
 - Your doctor will also know about this change, and can work with you to find another drug for your condition.

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

Types of drugs we do not cover

This section tells you what kinds of prescription drugs are "excluded." Excluded means that the plan doesn't cover these types of drugs because the law doesn't allow any Medicare drug plan to cover them.

If you get drugs that are excluded, you must pay for them yourself. We won't pay for the drugs that are listed in this section (unless our plan covers certain excluded drugs). The only exception: If the requested drug is found upon appeal to be a drug that is not excluded under Part D and we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to Chapter 9, Section 6 in this booklet.)

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

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
- Generally, coverage for "off-label use" is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor. If the use is not supported by any of these reference books, then our plan cannot cover its "off-label use."

Also, by law, these categories of drugs are not covered by Medicare drug plans unless we offer enhanced drug coverage, for which you may be charged additional premium:

- Non-prescription drugs (also called over-the-counter drugs).
- Drugs when used to promote fertility.
- Drugs when used for the relief of cough or cold symptoms.
- Drugs when used for cosmetic purposes or to promote hair growth.
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.
- Drugs when used for 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 towards qualifying you for the Catastrophic Coverage Stage. (The Catastrophic Coverage Stage is described in Chapter 6, Section 7 of this booklet.). Your cost for certain erectile dysfunction drugs, benzodiazepines, and barbiturates will depend on the drug tier which these certain drugs fall into. Please refer to the benefit chart in Chapter 6 for your drug tier cost shares. These prescription drugs are available in at least 30-day supply and not more than a 90-day supply.

In addition, if you are **receiving extra help from Medicaid** to pay for your prescriptions, the extra help will not pay for the drugs not normally covered. (Please refer to your formulary or call Customer Care Team for more information.) However, 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.

SECTION 8 Show your plan membership card when you fill a prescription

Show your membership card

To fill your prescription, show your plan membership card at the network pharmacy you choose. When you show your plan membership card, the network pharmacy will automatically bill the plan for *our* share of your covered prescription drug cost. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription.

What if you don't have your membership card with you?

If you don't have your plan membership card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information.

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

SECTION 9 Part D drug coverage in special situations

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 drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this section that tell about the rules for getting drug coverage. Chapter 6 (*What you pay for your Part D prescription drugs*) gives more information about drug coverage and what you pay.

Please Note: When you enter, live in, or leave a skilled nursing facility, you are entitled to a special enrollment period. During this time period, you can switch plans or change your coverage at any time. (Chapter 10, *Ending your membership in the plan*, tells you when and how you can leave our plan and join a different Medicare plan.)

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

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

Check your *Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Customer Care.

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

If you need a drug that is not on our Drug Guide or is restricted in some way, the plan will cover a **temporary supply** of your drug during the first 90 days of your membership. The first supply will be for a maximum of 31 day supply, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in the plan.

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

During the time when you are getting a temporary supply of a drug, you should talk with your doctor or other prescriber to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your doctor can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If you and your doctor want to ask for an exception, Chapter 9, Section 6 tells what to do.

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

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

In general, if you are currently employed, the prescription drug coverage you get from us will be *secondary* to your employer or retiree group coverage. That means your group coverage would pay first.

Special note about "creditable coverage":

Each year your employer or retiree group should send you a notice by November 15, that tells if your prescription drug coverage for the next calendar year is "creditable" and the choices you have for drug coverage.

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

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

SECTION 10 Programs on drug safety and managing medications

Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one provider who prescribes their drugs.

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

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

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

Programs to help members manage their medications

We have programs that can help our members with special situations. For example, some members have several complex medical conditions or they may need to take many drugs at the same time, or they could have very high drug costs.

These programs are voluntary and free to members. A team of pharmacists and doctors developed the programs for us. The programs can help make sure that our members are using the drugs that work best to treat their medical conditions and help us identify possible medication errors.

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 your participation in the program.

Chapter 6. What you pay for your Part D prescription drugs

SECTION 1 Introduction

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

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

What are the four drug payment stages?

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

We send you a monthly report called the "SmartSummary"

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

SECTION 4 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

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

A table that shows your costs for a 30-day supply of a drug

A table that shows your costs for a long-term 90-day supply of a drug

You stay in the Initial Coverage Stage until your total true out-of-pocket drug costs for the year reach \$4750

SECTION 5 During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs

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

SECTION 6 What you pay for vaccinations depends on how and where you get them

Our plan has separate coverage for the vaccine medication itself and for the cost of giving you the vaccination shot

You may want to call our Customer Care Team before you get a vaccination

SECTION 7 Do you have to pay the Part D "late enrollment penalty"?

What is the Part D "late enrollment penalty"?

How much is the Part D late enrollment penalty?

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

What can you do if you disagree about your late enrollment penalty?

SECTION 8 Do you have to pay an extra Part D amount because of your income?

Who pays an extra Part D amount because of income?

How much is the extra Part D amount?

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

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

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

For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, some information in this *Evidence of Coverage* 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" (LIS Rider), that tells you about your drug coverage. If you don't have this insert, please call our Customer Care Team (telephone number on the back of your membership card) and ask for the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (LIS Rider).

SECTION 1 Introduction**Use this chapter together with other materials that explain your drug coverage**

This chapter focuses on what you pay for your Part D prescription drugs. To keep things simple, we use "drug" in this chapter to mean a Part D prescription drug. As explained in Chapter 5, some drugs are covered under Original Medicare or are excluded by law. Some excluded drugs may be covered by our plan if you have purchased supplemental drug coverage.

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

- **The plan's *Drug Guide (Formulary)*.** To keep things simple, we call this the "Drug Guide."
 - This Drug Guide tells which drugs are covered for you.
 - It also tells which of the four "cost-sharing tiers" the drug is in and whether there are any restrictions on your coverage for the drug.
 - If you need a copy of the Drug Guide, call our Customer Care Team (telephone number on the back of your membership card). You can also find the Drug Guide on our website at Humana.com. The Drug Guide on the website is always the most current.
- **Chapter 5 of this booklet.** Chapter 5 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 5 also tells which types of prescription drugs are not covered by our plan.
- **The plan's *Provider Directory*.** In most situations you must use a network pharmacy to get your covered drugs (see Chapter 5 for the details). The Provider Directory has a list of pharmacies in the plan's network and it tells how you can use the plan's mail-order service to get certain types of drugs. It also explains how you can get a long-term supply of a drug (such as filling a prescription for a three month's supply).

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

What are the four drug payment stages?

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

<i>Yearly Deductible Stage</i>	<i>Initial Coverage Stage</i>	<i>Coverage Gap Stage</i>	<i>Catastrophic Coverage Stage</i>
This stage does not apply to your plan	<p>The plan pays its share of the cost of your drugs and you pay your share of the cost.</p> <p>You stay in this stage until your true out-of-pocket costs for the year total \$4750 .</p> <p>(Details are in Section 4 of this chapter.)</p>	This stage does not apply to your plan	<p>Once you have paid enough for your drugs to move on to this last payment stage, the plan will pay most of the cost of your drugs for the rest of the year.</p> <p>(Details are in Section 5 of this chapter.)</p>

As shown in this summary of the four payment stages, whether you move on to the next payment stage depends on how much you and/or the plan spends for your drugs while you are in each stage.

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

We send you a monthly report called the "SmartSummary"

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

- We keep track of how much you have paid. This is called your "**out-of-pocket**" cost.
- We keep track of your "**total drug costs.**" This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.

Our plan will prepare a written report called the *SmartSummary* when you have had one or more prescriptions filled. It includes:

- **Information for that month.** This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year.** This is called "year-to-date" information. It shows you the total drug costs and total payments for your drugs since the year began.

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

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

- **Show your membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2 of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
 - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.
 - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
 - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.

Send us information about the payments others have made for you. Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. For example, payments made by an AIDS drug assistance program, the Indian Health Service, and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.

- **Check the written report we send you.** When you receive a *SmartSummary* in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call our Customer Care Team (telephone number on the back of your membership card). Be sure to keep these reports. They are an important record of your drug expenses.

SECTION 4 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share**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 share of the cost will vary depending on the drug and where you fill your prescription.

The plan has four cost-sharing tiers

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

- **Tier 1 - Generic or Preferred Generic:** Generic drugs that are usually available at the lowest cost share
- **Tier 2 - Preferred Brand:** Brand prescription drugs that Humana Group Medicare usually offers at a lower cost to you than non-preferred brand drugs
- **Tier 3 - Non-Preferred Brand:** Brand prescription drugs that Humana Group Medicare usually offers at a higher cost to you than preferred brands
- **Tier 4 - Specialty Tier:** Some injectables and other higher-cost drugs

Please review Section 4 of this chapter for all drug pricing information for your plan

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

Your pharmacy choices

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

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

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

A table that shows your costs for a 30-day supply of a drug

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

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

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

The chart lists information for more than one of our plans. The name of the plan you are in is listed on the front page of this booklet. If you aren't sure which plan you are in or if you have any questions, call our Customer Care Team (telephone number on the back of your membership card).

Your share of the cost when you get a 30-day supply (or less) of a covered Part D prescription drug from:

	Network pharmacy	The plan's mail-order service	Network long-term care pharmacy	Out-of-network pharmacy (coverage is limited to certain situations; see Chapter 5 for details)
Cost-Sharing Tier 1 (Generic or Preferred Generic)	\$15	\$15	\$15	\$15 plus the difference between network drug costs and non-network drug costs
Cost-Sharing Tier 2 (Preferred Brand)	\$45	\$45	\$45	\$45 plus the difference between network drug costs and non-network drug costs
Cost-Sharing Tier 3 (Non-Preferred Brand)	\$85	\$85	\$85	\$85 plus the difference between network drug costs and non-network drug costs
Cost-Sharing Tier 4 (Specialty Tier)	\$85	\$85	\$85	\$85 plus the difference between network drug costs and non-network drug costs

A table that shows your costs for a long-term 90-day supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. This can be up to a 90-day supply. (For details on where and how to get a long-term supply of a drug, see Chapter 5.)

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

The chart lists information for more than one of our plans. The name of the plan you are in is listed on the front page of this booklet. If you aren't sure which plan you are in or if you have any questions, call our Customer Care Team (telephone number on the back of your membership card).

Your share of the cost when you get a long-term 90-day supply of a covered Part D prescription drug from:

	Network pharmacy	The plan's mail-order service
Cost-Sharing Tier 1 (Generic or Preferred Generic)	\$45	\$37.50
Cost-Sharing Tier 2 (Preferred Brand)	\$135	\$112.50
Cost-Sharing Tier 3 (Non-Preferred Brand)	\$255	\$212.50
Cost-Sharing Tier 4 (Specialty Tier)	Not Available	Not Available

You stay in the Initial Coverage Stage until your true out-of-pocket drug costs for the year reach \$4750

You stay in the Initial Coverage Stage until your true out-of-pocket for the prescription drugs you have filled and refilled reaches the \$4750 limit for the Initial Coverage Stage.

Your true out-of-pocket drug cost is based on what you have paid:

- **What you have paid** for all the covered drugs you have gotten since you started with your first drug purchase of the year. (See Section 5 for more information about how Medicare calculates your out-of-pocket costs.) This includes:

- The total you paid as your share of the cost for your drugs during the Initial Coverage Stage.

The *SmartSummary* that we send to you will help you keep track of how much you and the plan have spent for your drugs during the year. Many people do not reach the \$4750 true out-of-pocket limit in a year.

We will let you know if you reach this \$4750 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage.

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

*When you add up your out-of-pocket costs, you **can include** the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 5 of this booklet):*

- 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 under another Medicare prescription drug plan before you joined our plan.

It matters who pays:

- If you make these payments yourself, they are included in your out-of-pocket costs.
- These payments are *also included* if they are made on your behalf by certain other individuals or organizations. This includes payments for your drugs made by a friend or relative, by most charities, or by a State Pharmaceutical Assistance Program that is qualified by Medicare. Payments made by "Extra Help" from Medicare are also included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of \$4750 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*

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

- The amount you pay for your monthly premium.
- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Prescription drugs covered by Part A or Part B.
- 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 insurance plans and government-funded health programs such as TRICARE, the Veterans Administration, the Indian Health Service, or AIDS Drug Assistance Programs.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example Workers' Compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan. Call our Customer Care Team (telephone number on the back of your membership card).

SECTION 5 During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs

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

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the \$4750 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

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

Option 1:

- **Your share** of the cost for a covered drug will be either coinsurance or a copayment, whichever is the *larger* amount:
 - *-either* - coinsurance of 5% of the cost of the drug
 - *-or* - \$2.65 copayment for a generic drug or a drug that is treated like a generic
Or a \$6.60 copayment for all other drugs.
- Our plan pays the rest of the cost.

SECTION 6 What you pay for vaccinations depends on how and where you get them

Our plan has separate coverage for the vaccine medication itself and for the cost of giving you the vaccination shot

Our plan provides coverage of a number of vaccines. There are two parts to our coverage of vaccinations:

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

What do you pay for a vaccination?

What you pay for a vaccination depends on three things:

1. **The type of vaccine** (what you are being vaccinated for).
 - Some vaccines are considered medical benefits. You can find out about your coverage of these vaccines by going to Chapter 4, *Medical benefits chart (what is covered and what you pay)*.
 - Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's *Drug Guide*.
2. **Where you get the vaccine medication.**
3. **Who gives you the vaccination shot.**

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

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

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

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

- You will have to pay the pharmacy the amount of your coinsurance or copayment for the vaccine itself.
- Our plan will pay for the cost of giving you the vaccination shot.

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

- When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 7 of this booklet (Asking the plan to pay its share of a bill you have received for medical services or drugs).
- You will be reimbursed the amount you paid less your normal coinsurance or copayment for the vaccine (including administration) less any difference between the amount the doctor charges and what we normally pay. (If you are in Extra Help, we will reimburse you for this difference.)

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

- You will have to pay the pharmacy the amount of your coinsurance or copayment for the vaccine itself.
- When your doctor gives you the vaccination shot, you will pay the entire cost for this service. You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7 of this booklet.

- You will be reimbursed the amount charged by the doctor less any cost-sharing amount that you need to pay for the vaccine less any difference between the amount the doctor charges and what we normally pay. (If you are in Extra Help, we will reimburse you for this difference.)

You may want to call our Customer Care Team before you get a vaccination

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call our Customer Care Team (telephone number on the back of your membership card) whenever you are planning to get a vaccination.

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

SECTION 7 Do you have to pay the Part D "late enrollment penalty"?

What is the Part D "late enrollment penalty"?

You may pay a financial penalty if you did not enroll in a plan offering Medicare Part D drug coverage when you first became eligible for this drug coverage or you experienced a continuous period of 63 days or more when you didn't keep your prescription drug coverage. The amount of the penalty depends on how long you waited before you enrolled in drug coverage after you became eligible or how many months after 63 days you went without drug coverage.

The penalty is added to your monthly premium. (Members who choose to pay their premium every three months will have the penalty added to their three-month premium.) When you first enroll in Humana Group Medicare Plan, we let you know the amount of the penalty.

How much is the Part D late enrollment penalty?

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

- First count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months in which you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn't have creditable coverage. For our example, let's say it is 14 months without coverage, which 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 2012 this average premium amount was \$31.08. This amount may change for 2013.

- You multiply together the two numbers to get your monthly penalty and round it to the nearest 10 cents. In the example here it would be 14 percent times \$31.94, which equals \$4.47, which rounds to \$4.50. This amount would be added to the monthly premium for someone with a late enrollment penalty.

There are three important things to note about this monthly premium penalty:

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

If you are eligible for Medicare and are under 65, any late enrollment penalty you are paying will be eliminated when you attain age 65. After age 65, your late enrollment penalty is based only on the months you do not have coverage after your Age 65 Initial Enrollment Period.

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

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

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

- You already have prescription drug coverage at least as good as Medicare's standard drug coverage. Medicare calls this "**creditable drug coverage**." Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Speak with your insurer or your human resources department to find out if your current drug coverage is as at least as good as Medicare's.
- If you were without creditable coverage, you can avoid paying the late enrollment penalty if you were without it for less than 63 days in a row.
- If you didn't receive enough information to know whether or not your previous drug coverage was creditable.

- You lived in an area affected by Hurricane Katrina at the time of the hurricane (August 2005) - and - you signed up for a Medicare prescription drug plan by December 31, 2006 - and - you have stayed in a Medicare prescription drug plan.
- You are receiving "Extra Help" from Medicare.

What can you do if you disagree about your late enrollment penalty?

If you disagree about your late enrollment penalty, you can ask us to review the decision about your late enrollment penalty. Call our Customer Care Team (telephone number on the back of your membership card) to find out more about how to do this.

SECTION 8 Do you have to pay an extra Part D amount because of your income?

Who pays an extra Part D amount because of income?

Most people pay a standard monthly Part D premium. However, some people pay an extra amount because of their yearly income. If your income is \$85,000 or above for an individual (or married individuals filing separately) or \$170,000 or above for married couples, you must pay an extra amount directly to the government for your Medicare Part D coverage.

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

How much is the extra Part D amount?

If your modified adjusted gross income (MAGI) as reported on your IRS tax return is above a certain amount, you will pay an extra amount in addition to your monthly plan premium.

The chart below shows the extra amount based on your income.

If you filed an individual tax return and your income in 2010 was:	If you were married but filed a separate tax return and your income in 2010 was:	If you filed a joint tax return and your income in 2010 was:	This is the monthly cost of your extra Part D amount (to be paid in addition to your plan premium)
Equal to or less than \$85,000	Equal to or less than \$85,000	Equal to or less than \$170,000	\$0
Greater than \$85,000 and less than or equal to \$107,000		Greater than \$170,000 and less than or equal to \$214,000	\$11.60
Greater than \$107,000 and less than or equal to \$160,000		Greater than \$214,000 and less than or equal to \$320,000	\$29.90
Greater than \$160,000 and less than or equal to \$214,000	Greater than \$85,000 and less than or equal to \$129,000	Greater than \$320,000 and less than or equal to \$428,000	\$48.30
Greater than \$214,000	Greater than \$129,000	Greater than \$428,000	\$66.60

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

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

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

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

Chapter 7. Asking the plan to pay its share of a bill you have received for covered services or drugs

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

If you pay our plan's share of the cost of your covered services or drugs, or if you receive a bill, you can ask us for payment

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

How and where to send us your request for payment

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

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

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

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

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

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

If you pay our plan's share of the cost of your covered services or drugs, or if you receive a bill, you can ask us for payment

Sometimes when you get medical care or a prescription drug, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our plan to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs that are covered by our plan.

There may also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

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

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

When you received care from a provider who is not part of our network, you are only responsible for paying your share of the cost, not for the entire cost. (Your share of the cost may be higher for an out-of-network provider than for a contracted provider.) You should ask the provider to bill the plan for our share of the cost.

- If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
- At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
 - If the provider is owed anything, we will pay the provider directly.
 - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.
- **Please note:** While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. We cannot pay a provider who is not eligible to participate in Medicare. If the provider is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive.

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

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

- You only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.
- Whenever you get a bill from a contracted provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a contracted provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

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

If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. (We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to Chapter 5 to learn more.)

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

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

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

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

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

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

- For example, the drug may not be on the plan's Prescription Drug Guide (*Formulary*); or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 9 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has information about how to make an appeal.

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

How and where to send us your request for payment

Send us your request for payment, along with your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.

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

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

Please be sure to contact the Customer Care Team if you have any questions. If you don't know what you owe, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

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

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

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and decide whether to pay it and how much we owe.

- If we decide that the medical care or drug is covered and you followed all the rules for getting the care or drug, we will pay for our share of the cost. If you have already paid for the service or drug, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services. Chapter 5 explains the rules you need to follow for getting your Part D prescription drugs.)
- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

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

If you think we have made a mistake in turning down your request for payment, or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details on how to make this appeal, go to Chapter 9 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*). The appeals process is a legal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 9. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then after you have read Section 4, you can go to the section in Chapter 9 that tells what to do for your situation:

- If you want to make an appeal about getting paid back for a medical service, go to Section 5 in Chapter 9.
- If you want to make an appeal about getting paid back for a drug, go to Section 6 of Chapter 9.

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

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

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

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

1. When you buy the drug for a price that is lower than the plan's price

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

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

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

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

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

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

Chapter 8. Your rights and responsibilities

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

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

We must treat you with fairness and respect at all times

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

We must protect the privacy of your personal health information.

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

We must support your right to make decisions about your care

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

What can you do if you think you are being treated unfairly or your rights are not being respected?

How to get more information about your rights

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

What are your responsibilities?

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

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

To get information from us in a way that works for you, please call the Customer Care Team (phone numbers are on the back of your membership card).

Our plan has people and free language 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 if you need it. If you are eligible for Medicare because of disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you.

If you have any trouble getting information from our plan because of problems related to language or disability, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and tell them that you want to file a complaint. TTY users call 1-877-486-2048.

We must treat you with fairness and respect at all times

Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

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** 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call the Customer Care Team (phone numbers are on the back of your membership card). If you have a complaint, such as a problem with wheelchair access, the Customer Care Team can help.

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

As a member of our plan, you have the right to choose a provider in the plan's network to provide and arrange for your covered services (Chapter 3 explains more about this). Call the Customer Care Team to learn which doctors are accepting new patients (phone numbers are on the back of your membership card).

You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

You have the right to choose a provider in the plan's network. Call the Customer Care Team to learn which doctors are accepting new patients (phone numbers are on the back of your membership card). You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

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

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

We must protect the privacy of your personal health information

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

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

How do we protect the privacy of your health information?

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

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

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

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

If you have questions or concerns about the privacy of your personal health information, please call the Customer Care Team (phone numbers are on the back of your membership card).

Notice of Privacy Practices for your personal health information

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

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

Relationships are built on trust. One of the most important elements of trust is respect for an individual's privacy. We at Humana value our relationship with you, and we take your personal privacy seriously.

This notice explains Humana's privacy practices, our legal responsibilities, and your rights concerning your personal and health information. We follow the privacy practices described in this notice and will notify you of any changes.

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

What is personal and health information?

Personal and health information - from now on referred to as "information" - includes both medical information and individually identifiable information, like your name, address, telephone number, or Social Security number. The term "information" in this notice includes any personal and health information created or received by a health care provider or health plan that relates to your physical or mental health or condition, providing health care to you, or the payment for such health care.

How does Humana protect my information?

In keeping with federal and state laws and our own policy, Humana has a responsibility to protect the privacy of your information. We have safeguards in place to protect your information in various ways including:

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

How does Humana use and disclose my information?

We must use and disclose your information:

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

We have the right to use and disclose your information:

- To a doctor, a hospital, or other health care provider so you can receive medical care
- For payment activities, including claims payment for covered services provided to you by health care providers and for health plan premium payments
- For health care operation activities, including processing your enrollment, responding to your inquiries and requests for services, coordinating your care, resolving disputes, conducting medical management, improving quality, reviewing the competence of health care professionals, and determining premiums
- For performing underwriting activities
- To your plan sponsor to permit them to perform plan administration functions such as eligibility, enrollment and disenrollment activities. We may share summary level health information about you with your plan sponsor in certain situations such as to allow your plan sponsor to obtain bids from other health plans. We will not share detailed health information to your plan sponsor unless you provide us your permission or your plan sponsor has certified they agree to maintain the privacy of your information
- To contact you with information about health-related benefits and services, appointment reminders, or about treatment alternatives that may be of interest to you
- To your family and friends if you are unavailable to communicate, such as in an emergency

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

Will Humana use my information for purposes not described in this notice?

In all situations other than described in this notice, Humana will request your written permission before using or disclosing your information. You may revoke your permission at any time by notifying us in writing. We will not use or disclose your information for any reason not described in this notice without your permission.

What does Humana do with my information when I am no longer a Humana member or I do not obtain coverage through Humana?

Your information may continue to be used for purposes described in this notice when your membership is terminated or you do not obtain coverage through Humana. After the required legal retention period, we destroy the information following strict procedures to maintain the confidentiality.

What are my rights concerning my information?

The following are your rights with respect to your information:

- **Access** - You have the right to review and obtain a copy of your information that may be used to make decisions about you, such as claims and case or medical management records. You also may receive a summary of this health information. If you request copies, we may charge you a fee for each page, a per hour charge for staff time to locate and copy your information, and postage.
- **Alternate Communications** - You have the right to receive confidential communications of information in a different manner or at a different place to avoid a life-threatening situation. We will accommodate your request if it is reasonable.
- **Amendment** - You have the right to request an amendment of information we maintain about you if you believe the information is wrong or incomplete. We may deny your request if we did not create the information, we do not maintain the information, or the information is correct and complete. If we deny your request, we will give you a written explanation of the denial.
- **Disclosure** - You have the right to receive a listing of instances in which we or our business associates have disclosed your information for purposes other than treatment, payment, health plan operations, and certain other activities. We maintain this information and make it available to you for a period of six years at your request. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
- **Notice** - You have the right to receive a written copy of this notice any time you request.
- **Restriction** - You have the right to ask to restrict uses or disclosures of your information. We are not required to agree to these restrictions, but if we do, we will abide by our agreement. You also have the right to agree to or terminate a previously submitted restriction.

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 privacy rights request forms. You may obtain any of the forms by:

- Contacting us at 1-866-861-2762 at any time
- Accessing our Website at [Humana.com](https://www.humana.com) and going to the Privacy Practices link
- E-mailing us at privacyoffice@humana.com

Send completed request form to:

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

What should I do if I believe my privacy has been violated?

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

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

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

The following affiliates and subsidiaries also adhere to Humana's privacy policies and procedures:

American Dental Plan of North Carolina, Inc.
American Dental Providers of Arkansas, Inc.
CarePlus Health Plans, Inc.
Cariten Insurance Company.
Cariten Health Plan.
CompBenefits Company.
CompBenefits Dental, Inc.
CompBenefits Insurance Company.
CompBenefits of Alabama, Inc.
CompBenefits of Georgia, Inc.
CorpHealth, Inc. dba LifeSynch.
Corphealth Provider Link, Inc.
DentiCare, Inc.
Emphesys Insurance Company.
Emphesys, Inc.
HumanaDental Insurance Company.
Humana AdvantageCare Plan, Inc. fna Metcare Health Plans, Inc.
Humana Benefit Plan of Illinois, Inc. fna OSF Health Plans, Inc.
Humana Employers Health Plan of Georgia, Inc.
Humana Health Benefit Plan of Louisiana, Inc.
Humana Health Insurance Company of Florida, Inc.

Humana Health Plan of California, Inc.
Humana Health Plan of Ohio, Inc.
Humana Health Plan of Texas, Inc.
Humana Health Plan, Inc.
Humana Health Plans of Puerto Rico, Inc.
Humana Insurance Company.
Humana Insurance Company of Kentucky.
Humana Insurance Company of New York.
Humana Insurance of Puerto Rico, Inc.
Humana MarketPOINT, Inc.
Humana MarketPOINT of Puerto Rico, Inc.
Humana Medical Plan, Inc.
Humana Medical Plan of Michigan, Inc.
Humana Medical Plan of Pennsylvania, Inc.
Humana Medical Plan of Utah, Inc.
Humana Pharmacy, Inc.
Humana Pharmacy Solutions, Inc.
Humana Wisconsin Health Organization Insurance Corporation.
Managed Care Indemnity, Inc.
Preferred Health Partnership of Tennessee, Inc.
The Dental Concern, Inc.
The Dental Concern, Ltd.

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

As a member of our plan, you have the right to get several kinds of information from us. (As explained above in Section 1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

If you want any of the following kinds of information, please call the Customer Care Team (phone numbers are on the back of your membership card):

- **Information about our plan.** This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare Advantage health plans.
- **Information about our contracted providers including our network pharmacies.**
 - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
 - For a list of the providers in the plan's network, see the Provider Directory.

- For a list of the pharmacies in the plan's network, see the Provider Directory.
- For more detailed information about our providers or pharmacies, you can call the Customer Care Team (phone numbers are on the back of your membership card) or visit our website at Humana.com.
- **Information about your coverage and rules you must follow in using your coverage.**
 - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
 - To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 of this booklet plus the plan's *Prescription Drug Guide(Formulary)*. These chapters, together with the *Prescription Drug Guide*, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
 - If you have questions about the rules or restrictions, please call the Customer Care Team (phone numbers are on the back of your membership card).
- **Information about why something is not covered and what you can do about it.**
 - If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provide or pharmacy.
 - If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 9 of this booklet. It gives you the details about how to ask the plan for a decision about your coverage and how to make an appeal if you want us to change our decision. (Chapter 9 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
 - If you want to ask our plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 7 of this booklet.

Humana has a quality improvement (QI) program that focuses on clinical and preventive care and administrative functions of the health plan. You may obtain a written quality improvement (QI) program description by contacting Humana by calling 1-800-4-HUMANA (1-800-448-6262). For a report on how goals are being met in individual markets, or to provide input into the quality improvement (QI) Program, mail a request to the following address: Humana Quality Management Department, Progress Report, 321 West Main, WFP 20, Louisville, KY 40202.

We must support your right to make decisions about your care**You have the right to know your treatment options and participate in decisions about your health care**

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

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

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 9 of this booklet tells how to ask the plan for a coverage decision.

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

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

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

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

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

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

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

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

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with the state agency that handles advance directives.

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

At Humana, a process called utilization management (UM) is used to determine whether a service or treatment is covered according to national medical guidelines. Humana does not reward doctors and other individuals for denying coverage or withholding service. In fact, utilization management actually helps Humana make sure you get the preventive care and medically necessary services you need.

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

If you have any problems or concerns about your covered services or care, Chapter 9 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints.

As explained in Chapter 9, what you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do - ask for a coverage decision, make an appeal, or make a complaint - **we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call the Customer Care Team (phone numbers are on the back of your membership card).

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

Is it about something else?

If you think 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 the Customer Care Team** (phone numbers are on the back of your membership card).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or, you can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

How to get more information about your rights

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

- You can **call the Customer Care Team** (phone numbers are on the back of your membership card).

- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare**.
 - You can visit the Medicare website ([http:// www.medicare.gov](http://www.medicare.gov)) to read or download the publication "Your Medicare Rights & Protections."
 - 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

What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call the Customer Care Team (phone numbers are on the back of your membership card). We're here to help.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered services.
 - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
 - Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.
- ***If you have any other health insurance coverage or prescription drug coverage besides our plan, you are required to tell us. Please call the Customer Care Team to let us know.***
 - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "**coordination of benefits**" because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We'll help you with it.
- ***Tell your doctor and other health care providers that you are enrolled in our plan. Show your plan membership card whenever you get your medical care or Part D prescription drugs.***
- ***Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.***
 - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.

- Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
- If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- ***Be considerate.*** *We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.*
- ***Pay what you owe.*** *As a plan member, you are responsible for these payments:*
 - If you have a monthly plan premium, you must pay your plan premiums to continue being a member of our plan.
 - For some of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your medical services. Chapter 6 tells what you must pay for your Part D prescription drugs.
 - If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
 - If you are required to pay a late enrollment penalty, you must pay the penalty to remain a member of the plan.
 - If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a member of the plan.
- ***Tell us if you move.*** *If you are going to move, it's important to tell us right away. Call the Customer Care Team (phone numbers are on the back of your membership card).*
 - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
 - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
- ***Call the Customer Care Team for help if you have questions or concerns.*** *We also welcome any suggestions you may have for improving our plan.*

- Phone numbers and calling hours for the Customer Care Team are on the back of your membership card.
- For more information on how to reach us, including our mailing address, please see Chapter 2.

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

BACKGROUND

SECTION 1 Introduction

What to do if you have a problem or concern

What about the legal terms?

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

Where to get more information and personalized assistance

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

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

COVERAGE DECISIONS AND APPEALS

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

Asking for coverage decisions and making appeals: the big picture

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

Which section of this chapter gives the details for your situation?

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

This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care

Step-by-step: How to ask for a coverage decision (how to ask our plan to authorize or provide the medical care coverage you want)

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

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

What if you are asking our plan to pay you for our share of a bill you have received for medical care?

SECTION 6 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

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

What is an exception?

Important things to know about asking for exceptions

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

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

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

SECTION 7 How to ask us to cover a longer hospital stay if you think the doctor is discharging you too soon

During your hospital stay, you will get a written notice from Medicare that tells you about your rights

Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date

Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

What if you miss the deadline for making your Level 1 Appeal?

SECTION 8 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

This section is about three services only: Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

We will tell you in advance when your coverage will be ending

Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time

Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time

What if you miss the deadline for making a Level 1 Appeal?

SECTION 9 Taking your appeal to Level 3 and beyond

Levels of Appeal 3, 4 and 5 for Medical Service Appeals

Levels of Appeal 3, 4 and 5 for Part D Drug Appeals

MAKING COMPLAINTS

**SECTION 10 How to make a complaint about quality of care, waiting times,
Customer Care Team, or other concerns**

What kinds of problems are handled by the complaint process?

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

Step-by-step: Making a complaint

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

You can also tell Medicare about your complaint

BACKGROUND

SECTION 1 Introduction

What to do if you have a problem or concern

Please call us first

Your health and satisfaction are important to us. When you have a problem or concern, we hope you'll try an informal approach first: Please call Customer Care Team (contact information is on the back of your membership card). We will work with you to try to find a satisfactory solution to your problem.

You have rights as a member of our plan and as someone who is getting Medicare. We pledge to honor your rights, to take your problems and concerns seriously, and to treat you with respect.

Two formal processes for dealing with problems

Sometimes you might need a formal process for dealing with a problem you are having as a member of our plan.

This chapter explains two types of formal processes for handling problems:

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

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

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

What about the legal terms?

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

To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says "making a complaint" rather than "filing a grievance," "coverage decision" rather than "organization determination" or "coverage 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

Where to get more information and personalized assistance

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

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program**. This government program has trained counselors in every state. The program is not connected with our plan 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.

Their services are free. You will find phone numbers in Chapter 13 of this booklet.

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

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

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

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

If you have a problem or concern and you want to do something about it, you don't need to read this whole chapter. You just need to find and read the parts of this chapter that apply to your situation. The guide that follows will help.

To figure out which part of this chapter tells what to do for your problem or concern,
START HERE

Is your problem or concern about your benefits and coverage?

(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)

YES	NO
Go on to Section 4: "A guide to the basics of coverage decisions and making appeals."	Skip ahead to Section 10 at the end of this chapter: "How to make a complaint about quality of care, waiting times, Customer Care Team or other concerns."

COVERAGE DECISIONS AND APPEALS

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

Asking for coverage decisions and making appeals: the big picture

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

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. We make a coverage decision for you whenever we decide what is covered for you and how much we will pay. You can also contact the plan and ask for a coverage decision. For example, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay:

- Usually, there is no problem. We decide the service or drug is covered and pay our share of the cost.

- But in some cases we might decide the service or drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

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

When you make an appeal, we (with different reviewers than those who made the original unfavorable decision) review the coverage decision we have made to check to see if we were being fair and following all of the rules properly. When we have completed the review we give you our decision.

If we say no to all or part of your Level 1 Appeal, your case will automatically go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to our plan (In some situations, your case will be automatically sent to the independent organization for a Level 2 appeal. If this happens, we will let you know. In other situations, you will need to ask for a Level 2 appeal.). If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through several more levels of appeal.

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

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

- **You can call us at Customer Care Team** (contact information is on the back of your membership card).
- **To get free help from an independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter).
- **You should consider getting your doctor or other provider involved if possible, especially if you want a "fast" or "expedited" decision.** In most situations involving a coverage decision or appeal, your doctor or other provider must explain the medical reasons that support your request. Your doctor or other prescriber can't request every appeal. He/she can request a coverage decision and a Level 1 Appeal with the plan. To request any appeal after Level 1, your doctor or other prescriber must be appointed as your "representative" (see below about "representatives").
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.

- There may be someone who is already legally authorized to act as your representative under State law.
- If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Customer Care Team and ask for the form to give that person permission to act on your behalf. The form must be signed by you and by the person who you would like to act on your behalf. You must give our plan a copy of the signed form. (The form is also available on Medicare’s website at <http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf>.)
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Which section of this chapter gives the details for your situation?

There are four different types of situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

Section 5 of this chapter	Section 6 of this chapter	Section 7 of this chapter	Section 8 of this chapter
"Your medical care: How to ask for a coverage decision or make an appeal"	"Your Part D prescription drugs: How to ask for a coverage decision or make an appeal"	"How to ask us to cover a longer hospital stay if you think the doctor is discharging you too soon"	"How to ask us to keep covering certain medical services if you think your coverage is ending too soon" (<i>Applies to these services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services</i>)

If you’re still not sure which section you should be using, please call Customer Care Team (contact information is on the back of your membership card). You can also get help or information from government organizations such as your State Health Insurance Assistance Program (Chapter 13, of this booklet has the phone numbers for this program).

SECTION 5 **Your medical care: How to ask for a coverage decision or make an appeal**

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

This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care

This section is about your benefits for medical care and services. (but does not cover Part D drugs; please see Section 6 for Part D drug appeals) These are the benefits described in Chapter 4 of this booklet: *Medical benefits chart (what is covered and what you pay)*. To keep things simple, we generally refer to "medical care coverage" or "medical care" in the rest of this section, instead of repeating "medical care or treatment or services" every time.

This section tells what you can do if you are in any of the five following situations:

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.
2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan.
3. You have received medical care or services that you believe should be covered by the plan, but we have said we will not pay for this care.
4. You have received and paid for medical care or services that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care.
5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.
 - **NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services**, you need to read a separate section of this chapter because special rules apply to these types of care. Here's what to read in those situations:
 - Chapter 9, Section 7: *How to ask for a longer hospital stay if you think you are being asked to leave the hospital too soon.*
 - Chapter 9, Section 8: *How to ask our plan to keep covering certain medical services if you think your coverage is ending too soon.* This section is about three services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.

- For *all other* situations that involve being told that medical care you have been getting will be stopped, use this section (Section 5) as your guide for what to do.

Which of these situations are you in?		
Do you want to find out whether our plan will cover the medical care or services you want?	Has our plan already told you that we will <u>not</u> cover or pay for a medical services in the way you want it to be covered or paid for?	Do you want to ask our plan to pay you back for medical care or services you have already received and paid for?
You need to ask our plan to make a coverage decision for you. (see Section 5 of this Chapter)	You can make an appeal . (This means you are asking us to reconsider.) (see Section 5 of this Chapter)	You can send us the bill. (see Section 5 of this Chapter)

Step-by-step: How to ask for a coverage decision

(how to ask our plan to authorize or provide the medical care coverage you want)

Legal Terms	When a coverage decision involves your medical care, it is called an " organization determination. "
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Step 1: You ask our plan to make a coverage decision on the medical care you are requesting. If your health requires a quick response, you should ask us to make a "**fast decision.**"

Legal Terms	A "fast decision" is called an " expedited decision. "
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How to request coverage for the medical care you want

- Start by writing, or faxing our plan to make your request for us to provide coverage for the medical care you want. You, or your doctor, or your representative can do this.
- For the details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact our plan when you are asking for a coverage decision about your medical care.*

Generally we use the standard deadlines for giving you our decision

When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. **A standard decision means we will give you an answer within 14 days** after we receive your request.

- **However, we can take up to 14 more calendar days** if you ask for more time, or if we need information (such as medical records) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing.
- If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

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

- **A fast decision means we will answer within 72 hours.**
 - **However, we can take up to 14 more calendar days** if we find that some information is missing that may benefit you, or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing.
 - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.) We will call you as soon as we make the decision.
- **To get a fast decision, you must meet two requirements:**
 - You can get a fast decision only if you are asking for coverage for medical care you have not yet received. (You cannot get a fast decision if your request is about payment for medical care you have already received.)
 - You can get a fast decision only if using the standard deadlines could cause serious *harm to your health or hurt your ability to function*.
- **If your doctor tells us that your health requires a "fast decision," we will automatically agree to give you a fast decision.**
 - If you ask for a fast decision on your own, without your doctor's support, our plan will decide whether your health requires that we give you a fast decision.

- If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead).
- This letter will tell you that if your doctor asks for the fast decision, we will automatically give a fast decision.
- The letter will also tell how you can file a "fast complaint" about our decision to give you a standard decision instead of the fast decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

Step 2: Our plan considers your request for medical care coverage and we give you our answer.

Deadlines for a "fast" coverage decision

- Generally, for a fast decision, we will give you our answer **within 72 hours**.
 - As explained above, we can take up to 14 more calendar days under certain circumstances. If we take extra days, it is called "an extended time period."
 - If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints see section 10 of this chapter.)
 - If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5 of this Chapter tells how to make an appeal.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our decision, we will provide the coverage by the end of that extended period.
- **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.

Deadlines for a "standard" coverage decision

- Generally, for a standard decision, we will give you our answer **within 14 days of receiving your request**.
 - We can take up to 14 more calendar days ("an extended time period") under certain circumstances.

- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints see section 10 of this chapter.)
- If we do not give you our answer within 14 days (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5 of this Chapter tells how to make an appeal.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 14 days after we received your request. If we extended the time needed to make our decision, we will provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

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

- If our plan says no, you have the right to ask us to reconsider - ' and perhaps change - this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.
- If you decide to make appeal, it means you are going on to Level 1 of the appeals process (see Section 5 of this Chapter.).

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

Legal Terms	An appeal to the plan about a medical care coverage decision is called a plan " reconsideration. "
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Step 1: You contact our plan and make your appeal. If your health requires a quick response, you must ask for a "**fast appeal.**"

What to do

- **To start an appeal you, your representative, or in some cases your doctor must contact our plan.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 look for section called, *How to contact our plan when you are making an appeal about your medical care.*
- **Make your standard appeal in writing by submitting a signed request.** You may also ask for an appeal by calling us at the phone number shown in Chapter 2, Section 1 (*How to contact our plan when you are making an appeal about your medical care.*).

- If you have someone appealing our decision for you other than your doctor, your appeal must include an Appointment of Representative form authorizing this person to represent you. (To get the form, call Customer Care and ask for the "Appointment of Representative" form. It is also available on Medicare's website at <http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf> or on our website at <http://apps.humana.com/marketing/documents.asp?file=639132>.) 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 within 44 days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be sent to the Independent Review Organization for dismissal.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information if you like.**
 - You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
 - If you wish, you and your doctor may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal" (you can make a request by calling us)

Legal Terms	A "fast appeal" is also called an " expedited reconsideration. "
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- If you are appealing a decision our plan made about coverage for care you have not yet received, you and/or your doctor will need to decide if you need a "fast appeal."
- The requirements and procedures for getting a "fast appeal" are the same as those for getting a "fast decision." To ask for a fast appeal, follow the instructions for asking for a fast decision. (These instructions are given earlier in this section.)
- If your doctor tells us that your health requires a "fast appeal", we will give you a fast appeal.

Step 2: Our plan considers your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were being fair and following all the rules when we said no to your request.

- We will gather more information if we need it. We may contact you or your doctor to get more information.

Deadlines for a "fast" appeal

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to do so.
 - However, if you ask for more time, or if we need to gather more information that may benefit you, we **can take up to 14 more days**.
 - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 72 hours.
- **If our answer is no to part or all of what you requested**, we will send you a written denial notice informing you that we have sent your appeal to the Independent Review Organization for a Level 2 Appeal.

Deadlines for a "standard" appeal

- If we are using the standard deadlines, we must give you our answer **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. We will give you our decision sooner if your health condition requires us to.
 - However, if you ask for more time, or if we need to gather more information that may benefit you, we **can take up to 14 more calendar days**.
 - If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints see section 10 of this chapter.)
 - If we do not give you an answer by the deadline above (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 30 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 denial notice informing you that we have sent your appeal to the Independent Review Organization for a Level 2 Appeal.

Step 3: If our plan says no to your appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were being fair when we said no to your appeal, **our plan is required to send your appeal to the "Independent Review Organization."** When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

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

If our plan says no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision our plan made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms	The formal name for the "Independent Review Organization" is the " Independent Review Entity. " It is sometimes called the " IRE. "
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Step 1: The Independent Review Organization reviews your appeal.

- **The Independent Review Organization is an outside, independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- We will send the information about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file. We are allowed to charge a fee for copying and sending this information to you.**
- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

If you had a "fast" appeal at Level 1, you will also have a "fast" appeal at Level 2

- If you had a fast appeal to our plan at Level 1, the review organization must give you an answer to your Level 2 Appeal **within 72 hours** of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more days.**

*If you had a "standard" appeal at Level 1, you will also have a "**standard**" appeal at Level 2*

- If you made a standard appeal to our plan at Level 1, the review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more days**.

Step 2: The Independent Review Organization gives you their answer.

The Independent Review Organization will tell you its decision in writing and explain the reasons for it.

- **If the review organization says yes to part or all of what you requested**, we must authorize the medical care coverage within 72 hours or provide the service within 14 days after we receive the decision from the review organization.
- **If this organization says no to your appeal**, it means they agree with our plan that your request for coverage for medical care should not be approved. (This is called "upholding the decision." It is also called "turning down your appeal.")
 - The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process. For example, to continue and make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you got after your Level 2 Appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

What if you are asking our plan to pay you for our share of a bill you have received for medical care?

If you want to ask our plan for payment for medical care, start by reading Chapter 7 of this booklet: *Asking the plan to pay its share of a bill you have received for medical services or drugs*. Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from our plan

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 4 of this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service (see Chapter 4: *Medical benefits chart (what is covered and what you pay)*). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: *Using the plan's coverage for your medical services*).

We will say yes or no to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care. Or, if you haven't paid for the services, we will send the payment directly to the provider. When we send the payment, it's the same as saying *yes* to your request for a coverage decision.)
- If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why. (When we turn down your request for payment, it's the same as saying *no* to your request for a coverage decision.)

What if you ask for payment and we say that we will not pay?

If you do not agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in Section 5 of this Chapter. Go to this part for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement we must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)

- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

SECTION 6 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

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

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

Your benefits as a member of our plan include coverage for many outpatient prescription drugs. Medicare calls these outpatient prescription drugs "Part D drugs." You can get these drugs as long as they are included in our plan's *Drug Guide (Formulary)* and the use of the drug is a medically accepted indication. (A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 4 for more information about a medically accepted indication.)

- **This section is about your Part D drugs only.** To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time.
- For details about what we mean by Part D drugs, the *Drug Guide*, rules and restrictions on coverage, and cost information, see Chapter 5 (*Using our plan's coverage for your Part D prescription drugs*) and Chapter 6 (*What you pay for your Part D prescription drugs*).

Part D coverage decisions and appeals

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

Legal Terms	An initial coverage decision about your Part D drugs is called a "coverage decision".
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Here are examples of coverage decisions you ask us to make about your Part D drugs:

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

- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on the plan’s *Drug Guide* but we require you to get approval from us before we will cover it for you.)
 - Please note: If your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

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

This section tells you both how to ask for coverage decisions and how to request an appeal. Use this guide to help you determine which part has information for your situation:

Which of these situations are you in?			
<i>Request a Coverage Decision</i>			<i>Make an Appeal:</i>
Do you want to ask us to make an exception to the rules or restrictions on our plan’s coverage of a drug?	Do you want to ask us to cover a drug for you? (For example, if we cover the drug but we require you to get an approval from us first.)	Do you want to ask us to pay you back for a drug you have already received and paid for?	Has our plan already told you we will <u>not</u> cover or pay for a drug in the way that you want it to be covered or paid?
You can ask us to make an exception. (This is a type of coverage decision.) (see Section 6 of this Chapter)	You can ask us for a coverage decision. (see Section 6 of this Chapter)	You can ask us to pay you back. (This is a type of coverage decision.) (see Section 6 of this Chapter)	You can make an appeal. (This means you are asking us to reconsider.) (see Section 6 of this Chapter)

What is an exception?

If a drug is not covered in the way you would like it to be covered, you can ask the plan to make an "exception." An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

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

1. **Covering a Part D drug for you that is not on our plan's *Drug Guide (Formulary)*.**

Legal Terms	Asking for coverage of a drug that is not on the Drug Guide is sometimes called asking for a "formulary exception."
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- If we agree to make an exception and cover a drug that is not in the Drug Guide, you will need to pay the cost-sharing amount that applies to drugs in the Non-Preferred Brand tier. You cannot ask for an exception to the copayment or co-insurance amount we require you to pay for the drug.

2. **Removing a restriction on the plan's coverage for a covered drug.** There are extra rules or restrictions that apply to certain drugs on the plan's Prescription *Drug Guide* (for more information, go to Chapter 5 and look for Section 5).

Legal Terms	Asking for removal of a restriction on coverage for a drug is sometimes called asking for a "formulary exception."
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- The extra rules and restrictions on coverage for certain drugs include:
 - *Being required to use the generic version* of a drug instead of the brand-name drug.
 - *Getting plan approval in advance* before we will agree to cover the drug for you. (This is sometimes called "prior authorization.")
 - *Being required to try a different drug first* before we will agree to cover the drug you are asking for. (This is sometimes called "step therapy.")
 - *Quantity limits*. For some drugs, there are restrictions on the amount of the drug you can have.
- If our plan agrees to make an exception and waive a restriction for you, you can ask for an exception to the copayment or co-insurance amount we require you to pay for the drug.

3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on the plan's Drug Guide is in one of four cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

Legal Terms	Asking to pay a lower preferred price for a covered non-preferred drug is sometimes called asking for a "tiering exception."
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- If your drug is in the Non-Preferred Brand tier you can ask us to cover it at the cost-sharing amount that applies to drugs in the Preferred Brand tier. Also, if your generic drug is in the Preferred Brand Drugs tier you can ask us to cover it at the cost-sharing amount that applies to the Preferred Generic and Generic Tier. This would lower your share of the cost for the drug.
- You cannot ask us to change the cost-sharing tier for any drug in the Specialty tier.

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 written 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.

Our plan can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. Section 6 of this Chapter tells how to make an appeal if we say no.

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

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

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

What to do

- **Request the type of coverage decision you want.** Start by writing, or faxing our plan to make your request. You, your representative, or your doctor (or other prescriber) can do this. For the details, go to Chapter 2, Section 1 and look for the section called, *How to contact our plan when you are asking for a coverage decision about your Part D prescription drugs*. Or if you are asking us to pay you back for a drug, go to the section called, *Where to send a request that asks us to pay for our share of the cost for medical care or a drug you have received*.
- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.
- **If you want to ask our plan to pay you back for a drug**, start by reading Chapter 7 of this booklet: *Asking the plan to pay its share of a bill you have received for medical services or drugs*. Chapter 7 describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- **If you are requesting an exception, provide the "doctor's statement."** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "doctor's statement.") Your doctor or other prescriber can fax or mail the statement to our plan. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing the signed statement. See Section 6 of this Chapter for more information about exception requests.

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

Legal Terms	A "fast decision" is called an " coverage determination. "
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- When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard decision means we will give you an answer within 72 hours after we receive your doctor's statement. A fast decision means we will answer within 24 hours.
- **To get a fast decision, you must meet two requirements:**
 - You can get a fast decision only if you are asking for a *drug you have not yet received*. (You cannot get a fast decision if you are asking us to pay you back for a drug you are already bought.)
 - You can get a fast decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.

- **If your doctor or other prescriber tells us that your health requires a "fast decision," we will automatically agree to give you a fast decision.**
- If you ask for a fast decision on your own (without your doctor's or other prescriber's support), our plan will decide whether your health requires that we give you a fast decision.
- If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead).
- This letter will tell you that if your doctor or other prescriber asks for the fast decision, we will automatically give a fast decision.
- The letter will also tell how you can file a complaint about our decision to give you a standard decision instead of the fast decision you requested. It tells how to file a "fast" complaint, which means you would get our answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see Section 10 of this chapter.)

Step 2: Our plan considers your request and we give you our answer.

Deadlines for a "fast" coverage decision

- If we are using the fast deadlines, we must give you our answer **within 24 hours**.
 - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no.

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

- If we are using the standard deadlines, we must give you our answer **within 72 hours**.

- Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
- If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested -**
 - If we approve your request for coverage, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

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 organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

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

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

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

Legal Terms	When you start the appeals process by making an appeal, it is called the "first level of appeal" or a "Level 1 Appeal." An appeal to the plan about a Part D drug coverage decision is called a plan "redetermination."
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Step 1: You contact our plan and make your Level 1 Appeal. If your health requires a quick response, you must ask for a **"fast appeal."**

What to do

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

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

Legal Terms	A "fast appeal" is also called an "expedited redetermination."
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- If you are appealing a decision our plan 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 decision" in Section 6 of this chapter.

Step 2: Our plan considers your appeal and we give you our answer.

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

Deadlines for a "fast" appeal

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires it.
 - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 72 hours.
- **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 to appeal our decision.

Deadlines for a "standard" appeal

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal. 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. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested -**
 - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we receive your appeal.
 - If we approve a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive your appeal request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

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

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

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

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

Legal Terms	The formal name for the "Independent Review Organization" is the " Independent Review Entity. " It is sometimes called the " IRE. "
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Step 1: To make a Level 2 Appeal, you must contact the Independent Review Organization and ask for a review of your case.

- If our plan says no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.
- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file.** We are allowed to charge a fee for copying and sending this information to you.
- You have a right to give the Independent Review Organization additional information to support your appeal.

Step 2: The Independent Review Organization does a review of your appeal and gives you an answer.

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

Deadlines for "fast" appeal at Level 2

- If your health requires it, ask the Independent Review Organization for a "fast appeal."
- If the review organization agrees to give you a "fast appeal," the review organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.
- **If the Independent Review Organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

Deadlines for "standard" appeal at Level 2

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal.
- **If the Independent Review Organization says yes to part or all of what you requested -**
 - If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
 - If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.")

To continue and make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

Step 3: If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about the plan's coverage for your hospital care, including any limitations on this coverage, see Chapter 4 of this booklet: *Medical benefits chart (what is covered and what you pay)*.

During your hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for care you may need after you leave.

- The day you leave the hospital is called your "**discharge date**." Our plan's coverage of your hospital stay ends on this date.
- When your discharge date has been decided, your doctor or the hospital staff will let you know.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This section tells you how to ask.

During your hospital stay, you will get a written notice from Medicare that tells about your rights

During your hospital stay, you will be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital is supposed to give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call Customer Care Team. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, TTY users should call 1-877-486-2048.

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you about your rights as a hospital patient, including:

- Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be involved in any decisions about your hospital stay, and know who will pay for it.
- Where to report any concerns you have about quality of your hospital care.
- Your right to appeal your discharge decision if you think you are being discharged from the hospital too soon.

Legal Terms	The written notice from Medicare tells you how you can " request an immediate review. " Requesting an immediate review is a formal, legal way to ask for a delay in your discharge date so that your hospital care will be covered for a longer time. (Section 7.2 below tells how to make this appeal.)
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2. **You must sign the written notice to show that you received it and understand your rights.**

- You or someone who is acting on your behalf must sign the notice. (Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.)
- Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice **does not mean** you are agreeing on a discharge date.

3. **Keep your copy** of the signed notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.

- If you sign the notice more than 2 days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
- To look at a copy of this notice in advance, you can call Customer Care Team or 1-800 MEDICARE (1-800-633-4227 or TTY: 1-877-486-2048). You can also see it online at http://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp

Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date

If you want to ask for your hospital services to be covered by our plan for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Care Team (contact information is on the back of your membership card). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

Step 1: Contact the Quality Improvement Organization in your state and ask for a "fast review" of your hospital discharge. You must act quickly.

Legal Terms	A "fast review" is also called an " immediate review " or an " expedited review ."
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What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care professionals who are paid by the Federal government. These experts are not part of our plan. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare.

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare*) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 13, of this booklet.)

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than your planned discharge date**. (Your "planned discharge date" is the date that has been set for you to leave the hospital.)

- If you meet this deadline, you are allowed to stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision on your appeal from the Quality Improvement Organization.
- If you do *not* meet this deadline, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 7.

Ask for a "fast review":

- You must ask the Quality Improvement Organization for a "**fast review**" of your discharge. Asking for a "fast review" means you are asking for the organization to use the "fast" deadlines for an appeal instead of using the standard deadlines.

Legal Terms	A " fast review " is also called an " immediate review " or an " expedited review ."
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Step 2: The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and our plan has given to them.
- During this review process, you will also get a written notice that gives your planned discharge date and explains the reasons why your doctor, the hospital, and our plan think it is right (medically appropriate) for you to be discharged on that date.

Legal Terms	This written explanation is called the " Detailed Notice of Discharge ." You can get a sample of this notice by calling Customer Care Team or 1-800-MEDICARE (1-800-633-4227, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.) Or you can get see a sample notice online at http://www.cms.hhs.gov/BNI/
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Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the review organization says *yes* to your appeal, **our plan must keep providing your covered hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See Chapter 4 of this booklet).

What happens if the answer is no?

- If the review organization says *no* to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, **our plan's coverage for your hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to "Level 2" of the appeals process.

Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If we turn down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

- **Our plan must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **Our plan must continue providing coverage** for your hospital care for as long as it is medically necessary.
- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

- It means they agree with the decision they made to your Level 1 Appeal and will not change it. This is called "upholding the decision."
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

What if you miss the deadline for making your Level 1 Appeal?

You can appeal to our plan instead

As explained in Section 7, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. ("Quickly" means before you leave the hospital and no later than your planned discharge date). If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 Alternate Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to our plan, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Legal Terms	A "fast" review (or "fast appeal") is also called an "expedited" review (or "expedited appeal").
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Step 1: Contact our plan and ask for a "fast review."

- For details on how to contact our plan, go to Chapter 2, Section 1 and look for the section called, *How to contact our plan when you are making an appeal about your medical care.*
- **Be sure to ask for a "fast review."** This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: Our plan does a "fast" review of your planned discharge date, checking to see if it was medically appropriate.

- During this review, our plan takes a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- In this situation, we will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: Our plan gives you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If our plan says yes to your fast appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)

- **If our plan says no to your fast appeal**, we are saying that your planned discharge date was medically appropriate. Our coverage for your hospital services ends as of the day we said coverage would end.
 - If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

Step 4: If our plan says *no* to your fast appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were being fair when we said no to your fast appeal, **our plan is required to send your appeal to the "Independent Review Organization."** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: How to make a Level 2 *Alternate* Appeal

If our plan says no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision our plan made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms	The formal name for the "Independent Review Organization" is the " Independent Review Entity. " It is sometimes called the " IRE. "
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Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 10 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an outside, independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.

- **If this organization says *yes* to your appeal**, then our plan must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan's coverage of your hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal**, it means they agree with our plan that your planned hospital discharge date was medically appropriate. (This is called "upholding the decision." It is also called "turning down your appeal.")
 - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

This section is about three services only:
**Home health care, skilled nursing facility care, and
Comprehensive Outpatient Rehabilitation Facility
(CORF) services**

This section is about the following types of care *only*:

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a "skilled nursing facility," see Chapter 12, *Definitions of important words*.)
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 12, *Definitions of important words*.)

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see Chapter 4 of this booklet: *Medical benefits chart (what is covered and what you pay)*.

When our plan decides it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *our plan will stop paying its share of the cost for your care*.

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask.

We will tell you in advance when your coverage will be ending

1. **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, the agency or facility that is providing your care will give you a notice.
 - The written notice tells you the date when our plan will stop covering the care for you.
 - The written notice also tells what you can do if you want to ask our plan to change this decision about when to end your care, and keep covering it for a longer period of time.

Legal Terms	In telling what you can do, the written notice is telling how you can request a " Fast track appeal. " Requesting a fast-track appeal is a formal, legal way to ask our plan to change the coverage decision we have made about when to stop your care. (Section 8 tells how you can make an appeal.)
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Legal Terms	The written notice is called the " Notice of Medicare Non-Coverage. " To get a sample copy, call Customer Care Team or 1-800-MEDICARE (1-800-633-4227, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.). Or see a copy online at http://www.cms.hhs.gov/BNI/
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2. **You must sign the written notice to show that you received it.**
 - You or someone who is acting on your behalf must sign the notice. (Section 4 tells how you can give written permission to someone else to act as your representative.)
 - Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with the plan that it's time to stop getting the care.

Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 10 of this chapter tells you how to file a complaint.)
- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Care Team (contact information is on the back of your membership card). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.

Step 1: Make your Level 1 Appeal: contact the Quality Improvement Organization in your state and ask for a review. You must act quickly.

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care experts who are paid by the Federal government. These experts are not part of our plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of medical care.

How can you contact this organization?

- The written notice you received tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 13, of this booklet.)

What should you ask for?

- Ask this organization to do an independent review of whether it is medically appropriate for our plan to end coverage for your medical services.

Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal *no later than noon of the day after you receive the written notice telling you when we will stop covering your care.*
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 8 of this Chapter.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- During this review process, you will also get a written notice from the plan that gives our reasons for wanting to end the plan's coverage for your services.

Legal Terms	This notice explanation is called the " Detailed Explanation of Non-Coverage. "
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Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.

What happens if the reviewers say yes to your appeal?

- If the reviewers say *yes* to your appeal, then **our plan must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see Chapter 4 of this booklet).

What happens if the reviewers say no to your appeal?

- If the reviewers say *no* to your appeal, then **your coverage will end on the date we have told you.** Our plan will stop paying its share of the costs of this care.

- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- This first appeal you make is "Level 1" of the appeals process. If reviewers say *no* to your Level 1 Appeal - and you choose to continue getting care after your coverage for the care has ended - then you can make another appeal.
- Making another appeal means you are going on to "Level 2" of the appeals process.

Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time

If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If we turn down your Level 2 Appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end.

Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes to your appeal?

- **Our plan must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **Our plan must continue providing coverage** for the care for as long as it is medically necessary.

- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision they made to your Level 1 Appeal and will not change it. (This is called "upholding the decision." It is also called "turning down your appeal.")
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

What if you miss the deadline for making your Level 1 Appeal?

You can appeal to our plan instead

As explained in Section 8, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different*.

Step-by-Step: How to make a Level 1 Alternate Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to our plan, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Here are the steps for a Level 1 Alternate Appeal:

Legal Terms	A "fast" review (or "fast appeal") is also called an " expedited " review (or " expedited appeal ").
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Step 1: Contact our plan and ask for a "fast review."

- For details on how to contact our plan, go to Chapter 2, Section 1 and look for the section called, *How to contact our plan when you are making an appeal about your medical care*.

- **Be sure to ask for a "fast review."** This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: Our plan does a "fast" review of the decision we made about when to stop coverage for your services.

- During this review, our plan takes another look at all of the information about your case. We check to see if we were being fair and following all the rules when we set the date for ending the plan's coverage for services you were receiving.
- We will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review. (Usually, if you make an appeal to our plan and ask for a "fast review," we are allowed to decide whether to agree to your request and give you a "fast review." But in this situation, the rules require us to give you a fast response if you ask for it.)

Step 3: Our plan gives you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If our plan says yes to your fast appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If our plan says no to your fast appeal,** then your coverage will end on the date we have told you and our plan will not pay after this date. Our plan will stop paying its share of the costs of this care.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If our plan says *no* to your fast appeal, your case will *automatically* go on to the next level of the appeals process.

- To make sure we were being fair when we said no to your fast appeal, **our plan is required to send your appeal to the "Independent Review Organization."** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: How to make a Level 2 Alternate Appeal

If our plan says no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision our plan made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms	The formal name for the "Independent Review Organization" is the " Independent Review Entity. " It is sometimes called the " IRE. "
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Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 1 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an outside, independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- **If this organization says yes to your appeal,** then our plan must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says no to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it. (This is called "upholding the decision." It is also called "turning down your appeal.")
 - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 Taking your appeal to Level 3 and beyond

Levels of Appeal 3, 4, and 5 for Medical Service Appeals

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

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

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

Level 3 Appeal	A judge who works for the Federal government will review your appeal and give you an answer. This judge is called an "Administrative Law Judge."
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- **If the answer is yes, the appeals process over** - We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
 - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the judge's decision.
 - If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- **If the answer is no, the appeals process *may* or *may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal	The Medicare Appeals Council will review your appeal and give you an answer. The Medicare Appeals Council works for the Federal government.
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- **If the answer is yes, or if the Medicare Appeals Council denies our request to review a favorable Level 3 Appeal decision, the appeals process *may* or *may not* be over** - We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you.
 - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the Medicare Appeals Council's decision.
 - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Medicare Appeals Council denies the review request, the appeals process *may* or *may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you might be able to continue to the next level of the review process. It depends on your situation. If the Medicare Appeals Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal	A judge at the Federal District Court will review your appeal. This is the last stage of the appeals process.
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- This is the last step of the administrative appeals process.

Levels of Appeal 3, 4, and 5 for Part D Drug Appeals

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

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

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

Level 3 Appeal	A judge who works for the Federal government will review your appeal and give you an answer. This judge is called an "Administrative Law Judge."
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- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved. We must authorize or provide the drug coverage that was approved by the Administrative Law Judge within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you might be able to continue to the next level of the review process. It depends on your situation. Whenever the reviewer says no to your appeal, the notice you get will tell you whether the rules allow you to go on to another level of appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal

Level 4 Appeal	The Medicare Appeals Council will review your appeal and give you an answer. The Medicare Appeals Council works for the Federal government.
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- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved. We must authorize or provide the drug coverage that was approved by the Medicare Appeals Council within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you might be able to continue to the next level of the review process. It depends on your situation. Whenever the reviewer says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal	A judge at the Federal District Court will review your appeal. This is the last stage of the appeals process.
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- This is the last step of the appeals process.

MAKING COMPLAINTS

SECTION 10 How to make a complaint about quality of care, waiting times, Customer Care Team, or other concerns

?

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

What kinds of problems are handled by the complaint process?

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

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

Quality of your medical care

- Are you unhappy with the quality of the care you have received (including care in the hospital)?

Respecting your privacy

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

Disrespect, poor Customer Care Team, or other negative behaviors

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

Waiting times

- Are you having trouble getting an appointment, or waiting too long to get in?
- Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by Customer Care Team or other staff at our plan?
- Examples include waiting too long on the phone, in the waiting room, in the exam room, or when getting a prescription.

Cleanliness

- Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?

Information you get from our plan

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

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

The process of asking for a coverage decision and making appeals is explained in Sections 4-9 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

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

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

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

Legal Terms	What this section calls a " complaint " is also called a " grievance. " Another term for " making a complaint " is " filing a grievance. " Another way to say " using the process for complaints " is " using the process for filing a grievance. "
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Step-by-step: Making a complaint

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

- **Usually, calling Customer Care Team is the first step.** If there is anything else you need to do, Customer Care Team 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 do this, it means that we will use our *formal procedure* for answering grievances. Here's how it works:

Grievance process

You or your representative may file your concerns in writing or verbally.

Please follow the grievance process described below:

When filing a grievance, please provide the following information:

Your name, address, telephone number, and member identification number; you or your authorized representative's signature and the date signed; a summary of the grievance and any previous contact with us; and a description of the action you are requesting. If you or your authorized representative require assistance in preparing and submitting your written grievance, contact our Customer Care Team at the number shown in Chapter 2 of this booklet.

You may request an expedited (fast) grievance if:

- You disagree with our decision to extend the timeframe to make an initial (standard) organization/coverage determination or reconsideration.
- We deny your request for a 72-hour/fast (expedited) organization/coverage determination or reconsiderations/redeterminations.
- We deny your request for a 72-hour/fast (expedited) appeal.

If you mail the request for an expedited grievance, we will provide oral acknowledgement upon receipt. We will make a determination within 24 hours of receipt of your request.

- **Whether you call or write, you should contact Customer Care Team right away.** The complaint must be made within 60 days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a "fast response" to a coverage decision or appeal, we will automatically give you a "fast" complaint.** If you have a "fast" complaint, it means we will give you **an answer within 24 hours.**

Legal Terms	What this section calls a "fast complaint" is also called a "fast grievance."
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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. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered in 30 days, but we may take up to 44 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 do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

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

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

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

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to our plan).
 - To find the name, address, and phone number of the Quality Improvement Organization in your state, look in Chapter 13, of this booklet. If you make a complaint to this organization, we will work together with them to resolve your complaint.
 - 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.
- **Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to our plan and also to the Quality Improvement Organization.

You can also tell Medicare about your complaint

You can submit a complaint about Humana directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

- If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

Chapter 10. Ending your membership in the plan

SECTION 1 Ending your Membership

This chapter focuses on ending your membership in our plan

Voluntarily ending your membership

Until your membership ends, you must keep getting your Medicare services through our Plan or you will have to pay for them yourself.

We cannot ask you to leave the Plan because of your health

Involuntarily ending you membership

You have the right to make a complaint if we end your membership in our Plan

SECTION 1 Ending your Membership**This chapter focuses on ending your membership in our plan**

Ending your membership in our Plan may be voluntary (your own choice) or involuntary (not your own choice):

- You might leave our Plan because you have decided that you want to leave.
- There are also limited situations where we are required to end your membership. For example, if you move permanently out of our geographic service area.

Voluntarily ending your membership

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 the Customer Care Team or your plan sponsor before you disenroll.

Until your membership ends, you must keep getting your Medicare services through our Plan or you will have to pay for them yourself.

If you leave our Plan, it may take some time for your membership to end and your new way of getting Medicare to take effect.

While you are waiting for your membership to end, you are still a member and must continue to get your care as usual through our Plan.

If you must receive services outside of your Plan's limitations, neither we nor the Medicare program will pay for these services, with just a few exceptions. If you have any questions, please call the Customer Care Team at the number listed on the back of your membership card.

If you happen to be hospitalized on the day your membership ends, please call the Customer Care Team to find out if your hospital care will be covered by our Plan. If you have any questions about leaving our Plan, please call the Customer Care Team at the number listed on the back of your membership card.

We cannot ask you to leave the Plan because of your health.

We cannot ask you to leave your health plan for any health-related reasons. If you ever feel that you are being encouraged or asked to leave our Plan because of your health, you should call 1-800-MEDICARE (1-800-633-4227), which is the national Medicare help line. TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Involuntarily ending your membership

If any of the following situations occur, we will end your membership in our Plan:

- If you move out of the service area or are away from the service area for more than 6 months in a row. If you plan to move or take a long trip, please call the Customer Care Team to find out if the place you are moving to or traveling to is in our Plan's service area. If you move permanently out of our geographic service area, or if you are away from our service area for more than six months in a row you cannot remain a member of the Plan. In these situations, if you do not leave on your own, we must end your membership ("disenroll" you).
- If you do not stay continuously enrolled in Medicare A and B.
- If you become incarcerated. (Go to prison)
- If you give us information on your enrollment request that you know is false or deliberately misleading, and it affects whether or not you can enroll in our Plan.
- If you behave in a way that is disruptive, to the extent that your continued enrollment seriously impairs our ability to arrange or provide medical care for you or for others who are members of our Plan. We cannot make you leave our Plan for this reason unless we get permission first from Medicare.
- If you let someone else use your plan membership card to get medical care. If you are disenrolled for this reason, CMS may refer your case to the Inspector General for additional investigation.

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 will tell you our reasons in writing and explain how you may file a complaint against us if you want to.

Chapter 11. Legal notices

- SECTION 1** **Notice about governing law**
- SECTION 2** **Notice about nondiscrimination**
- SECTION 3** **Notice of coordination of benefits**
- SECTION 4** **Notice of subrogation and third-party recovery**

SECTION 1 Notice about governing law

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

SECTION 2 Notice about nondiscrimination

We don't discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage Plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

SECTION 3 Notice of coordination of benefits

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

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

Who pays first when you have other coverage?

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

Employer and employee organization group health plans

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

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

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

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

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

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

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

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

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

Employer and employee organization group health plans for people with End Stage Renal Disease ("ESRD")

If you are or become eligible for Medicare because of ESRD and have coverage under an employer or employee organization group health plan, either directly or through your spouse, your group health plan is responsible for providing primary health benefits to you for the first thirty (30) months after you become eligible for Medicare due to your ESRD. We will provide secondary coverage to you during this time, and we will provide primary coverage to you thereafter. If you are already on Medicare because of age or disability when you develop ESRD, we will provide primary coverage.

Workers' Compensation and similar programs

If you have suffered a job-related illness or injury and workers' compensation benefits are available to you, workers' compensation must provide its benefits first for any healthcare 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 (including, but not limited to, the government of Puerto Rico compulsory automobile insurance, known as ACAA) are available to you, the "Med Pay," no-fault, automobile, accident, or liability coverage carrier must provide its benefits first for any healthcare 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. Humana will not seek recovery from any portion of an award that is appropriately designated by the court as payment for losses other than medical services (e.g., property losses).

Where we provide benefits in the form of services, we shall be entitled to reimbursement on the basis of the reasonable value of the benefits provided.

Non-duplication of benefits

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

If we do provide benefits to you before any other type of health coverage you may have, we may seek recovery of those benefits in accordance with the Medicare Secondary Payer rules. Please also refer to the Subrogation and third-party recovery 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 and Other Health Benefits: Your Guide to WHO PAYS FIRST." It is CMS Pub. No. 02179. Be sure to consult the most current version. Other details are explained in the Medicare Secondary Payer rules, such as the way the number of persons employed by an employer for purposes of the coordination of benefits rules is to be determined. The rules are published in the Code of Federal Regulations.

Appeal rights

If you disagree with any decision or action by our plan in connection with the coordination of benefits and payment rules outlined above, you must follow the procedures explained in Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) in this Evidence of Coverage.

SECTION 4 Notice of subrogation and third-party recovery

Subrogation

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, 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.

If we make any payment to you or on your behalf for covered services, we are entitled to be fully subrogated to any and all rights you have against any person, entity, or insurer that may be responsible for payment of medical expenses and/or benefits related to your injury, illness, or condition. We are entitled to exercise the same rights of subrogation and recovery that are accorded to the Medicare Program under the Medicare Secondary Payer rules.

Once we have made a payment for covered services, we shall have a lien on the proceeds of any judgment, settlement, or other award or recovery you receive, including but not limited to the following:

1. Any award, settlement, benefits, or other amounts paid under any workers' compensation law or award;
2. Any and all payments made directly by or on behalf of a third-party tortfeasor or person, entity, or insurer responsible for indemnifying the third-party tortfeasor;
3. Any arbitration awards, payments, settlements, structured settlements, or other benefits or amounts paid under an uninsured or underinsured motorist coverage policy; or

4. Any other payments designated, earmarked, or otherwise intended to be paid to you as compensation, restitution, or remuneration for your injury, illness, or condition suffered as a result of the negligence or liability of a third party.

You agree to cooperate with us and any of our representatives and to take any actions or steps necessary to secure our lien, including but not limited to:

1. Responding to requests for information about any accidents or injuries;
2. Responding to our requests for information and providing any relevant information that we have requested; and
3. Participating in all phases of any legal action we commence in order to protect our rights, including but not limited to participating in discovery, attending depositions, and appearing and testifying at trial.

In addition, you agree not to do anything to prejudice our rights, including but not limited to assigning any rights or causes of action that you may have against any person or entity relating to your injury, illness, or condition without our prior express written consent. Your failure to cooperate shall be deemed a breach of your obligations, and we may institute a legal action against you to protect our rights.

Reimbursement

We are also entitled to be fully reimbursed for any and all benefit payments we make to you or on your behalf that are the responsibility of any person, organization, or insurer. Our right of reimbursement is separate and apart from our subrogation right, and is limited only by the amount of actual benefits paid under our plan. You must immediately pay to us any amounts you recover by judgment, settlement, award, recovery, or otherwise from any liable third party, his or her insurer, to the extent that we paid out or provided benefits for your injury, illness, or condition during your enrollment in our plan.

Antisubrogation rules do not apply

Our subrogation and reimbursement rights shall have first priority, to be paid before any of your other claims are paid. Our subrogation and reimbursement rights will not be affected, reduced, or eliminated by the "made whole" doctrine or any other equitable doctrine.

We are not obligated to pursue subrogation or reimbursement either for our own benefit or on your behalf. Our rights under Medicare law and this Evidence of Coverage shall not be affected, reduced, or eliminated by our failure to intervene in any legal action you commence relating to your injury, illness, or condition.

Chapter 12. Definitions of important words

Advanced Imaging Services - Computed Tomography Imaging (CT/CAT) Scan, Magnetic Resonance Angiography (MRA), Magnetic Resonance Imaging (MRI), and Positron Emission Tomography (PET) Scan.

Allowed Amount - Individual charge determined by a carrier for a covered medical service or supply.

Ambulatory Surgical Center - A freestanding facility that provides medical surgical procedures on an outpatient basis for the prevention, diagnosis, and treatment of an injury or illness. This facility is staffed by physicians and provides treatment by, or under, the supervision of physicians as well as nursing care. This type of facility does not provide inpatient room and board and is Medicare-certified and licensed by the proper authority.

Appeal - An appeal is something you do if you disagree with a decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with a decision to stop services that you are receiving. For example, you may ask for an appeal if our Plan doesn't pay for a drug, item, or service you think you should be able to receive. Chapter 9 explains appeals, including the process involved in making an appeal.

Balance Billing - A situation in which a provider (such as a doctor or hospital) bills a patient more than the plan's cost-sharing amount for services. As a member of Humana, you only have to pay the plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" you. See Chapter 7, Section 1 for more information about balance billing.

Benefit Period - The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. For our plan, you will have a benefit period for skilled nursing facility benefits. For some plans, this may also include the inpatient hospital benefit if the plan has a deductible associated with that benefit.

A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period will accumulate one day for each day you are inpatient at a SNF (or hospital if applicable). The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the SNF (or hospital if applicable) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

Brand Name Drug - A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage - The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent \$4,750 in covered drugs during the covered year.

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

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

Combined Maximum Out-of-Pocket Amount - If your plan has this feature, this is the most you will pay in a year for all Part A and Part B services from both network providers and out-of-network providers.

Comprehensive Outpatient Rehabilitation Facility (CORF) - A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech-language pathology services, and home environment evaluation services.

Computed Tomography Imaging (CT/CAT) Scan - Combines the use of a digital computer together with a rotating X-ray device to create detailed cross-sectional images of different organs and body parts.

Contracted Rate - The rate the network provider and/or pharmacy has agreed to accept for covered services and/or prescription drugs.

Copayment - An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription. A copayment is usually a set amount, rather than a percentage. For example, you might pay \$10 or \$20 for a doctor's visit or prescription.

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

Cost-Sharing Tier - Every drug on the list of covered drugs is in one of the 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 medical service or drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the service or 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 if you disagree. Coverage determinations are called "coverage decisions" in this booklet. Chapter 9 explains how to ask us for a coverage decision.

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

Covered Services - The general term we use to mean all of the health care services and supplies that are covered by our Plan.

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

Custodial Care - Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care is personal care that can be provided by people who don't have professional skills or training, such as help with activities of daily living like bathing, dressing, eating, getting in or out of bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. In most cases, Medicare doesn't pay for custodial care.

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

Deductible - The amount you must pay before our plan begins to pay its share of your covered medical services or drugs.

Diagnostic Mammogram - A radiological procedure furnished to a man or woman with signs or symptoms of breast disease.

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

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

Durable Medical Equipment - Certain medical equipment that is ordered by your doctor for use in the home. Examples are walkers, wheelchairs, or hospital beds.

Emergency - A medical emergency is when you believe that you have an injury or illness that requires immediate medical attention to prevent disability or death.

Emergency Care - Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition.

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

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

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

Formulary - A list of covered drugs provided by the plan.

Freestanding Dialysis Center - A freestanding facility that provides dialysis on an outpatient basis. This type of facility does not provide inpatient room and board and is Medicare-certified and licensed by the proper authority.

Freestanding Lab - A freestanding facility that provides laboratory tests on an outpatient basis for the prevention, diagnosis, and treatment of an injury or illness. This type of facility does not provide inpatient room and board and Medicare-certified and licensed by the proper authority.

Freestanding Radiology (Imaging) Center - A freestanding facility that provides one or more of the following services on an outpatient basis for the prevention, diagnosis, and treatment of an injury or illness: X-rays; nuclear medicine; radiation oncology. This type of facility does not provide inpatient room and board and Medicare-certified and licensed by the proper authority.

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

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

Health Maintenance Organization (HMO) - A type of Medicare managed care plan where a group of doctors, hospitals, and other health care providers agree to give health care to Medicare beneficiaries for a set amount of money from Medicare every month. You usually must get your care from the providers in the plan.

Home Health Aide - A home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g. bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Home Health Care - Skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Benefits Chart under the heading "Home health care." If you need home health care services, our plan will cover these services for you provided the Medicare coverage requirements are met. Home health care can include services from a home health aide if the services are part of the home health plan of care for your illness or injury. They aren't covered unless you are also getting a covered skilled service. Home health services don't include the services of housekeepers, food service arrangements, or full-time nursing care at home.

Hospice Care - A special way of caring for people who are terminally ill and providing counseling for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients in the last months of life by giving comfort and relief from pain. The focus is on care, not cure. For more information on hospice care, visit www.medicare.gov and under "Search Tools" choose "Find a Medicare Publication" to view or download the publication "Medicare Hospice Benefits." Or, call 1-800-MEDICARE (1-800-633-4227). TYY users should call 1-877-486-2048.

Hospital Inpatient Stay - A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an "outpatient."

Humana's National Transplant Network (NTN) - A network of Humana-approved facilities all of which are also Medicare-approved facilities.

Immediate Care Facility - A facility established to diagnose and treat an unforeseen injury or illness on an outpatient basis. This facility is staffed by physicians and provides treatment by, or under, the supervision of physicians as well as nursing care. This type of facility does not provide inpatient room and board.

Initial Coverage Limit - The maximum limit of coverage under the Initial Coverage Stage.

Initial Coverage Stage - This is the stage after you have met your deductible (if you have one) and before your total drug expenses have reached \$2,970, including amounts you've paid and what our Plan has paid on your behalf.

Initial Enrollment Period - When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part B. For example, if you're eligible for Part B when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

In-Network Out-of-Pocket Maximum - If applicable for your plan, this is the most you will pay for covered Part A and Part B services received from network providers. After you have reached this limit, you will not have to pay anything when you get covered services from network providers for the rest of the contract year.

Inpatient Care - Health care that you get when you are admitted to a hospital.

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. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions.

List of Covered Drugs (Formulary or "Drug Guide") - A list of prescription drugs covered by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand-name and generic drugs.

Low Income Subsidy - See "Extra Help"

Magnetic Resonance Angiography (MRA) - A noninvasive method and a form of magnetic resonance imaging (MRI) that can measure blood flow through the blood vessels.

Magnetic Resonance Imaging (MRI) - A diagnostic imaging modality method that uses a magnetic field and computerized analysis of induced radio frequency signals to noninvasively image body tissue.

Medicaid (or Medical Assistance) - A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 13 for information about how to contact Medicaid in your state.

Medically Accepted Indication - A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See chapter 5 for more information about a medically accepted indication.

Medically Necessary - Drugs, services, or supplies that are needed for the 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 Organization - Medicare Advantage plans are run by private companies. They give you more options, and sometimes, extra benefits. These plans are still part of the Medicare program and are also called "Part C." They provide all your Part A (Hospital) and Part B (Medical) coverage. Some may also provide Part D (Prescription Drug) coverage.

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 (Hospital) and Part B (Medical) benefits. A MA plan offers a specific set of health benefits at the same premium and level of cost-sharing to all people with Medicare who live in the service area covered by the plan. Medicare Advantage Organizations can offer one or more Medicare Advantage plan in the same service area. A Medicare Advantage plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and are not paid for under Original Medicare. In most cases, Medicare Advantage plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare Health Plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare Allowable Charge - The amount allowed by Medicare for a particular benefit or service.

Medicare Coverage Gap Discount Program - A program that provides discounts on most covered Part D brand-name drugs to Part D enrollees who have reached the Coverage Gap Stage and who are not already receiving "Extra Help." Discounts are based on agreements between the federal government and certain drug manufacturers. For this reason, most, but not all, brand-name drugs are discounted.

Medicare-Covered Services - Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and B.

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

Medicare Limiting Charge - In the Original Medicare plan, the highest amount of money you can be charged for a covered service by doctors and other health care suppliers who do not accept assignment. The limiting charge is 15 percent over Medicare's approved amount. The limiting charge only applies to certain services and does not apply to supplies or equipment.

Medicare Prescription Drug Coverage (Medicare Part D) - Insurance to help pay for outpatient prescription drugs, vaccines, biological, 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 - A group of doctors, hospitals, pharmacies, and other health care experts/professionals contracted with a health plan to take care of its members.

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

Network Provider - "Provider" is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them "**network providers**" when they have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our Plan. Our Plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as "plan providers."

Non-Plan Provider or Non-Plan Facility - A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Non-plan providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to you. As explained in this booklet, most services you get from non-plan providers are not covered by our plan or Original Medicare.

Nuclear Medicine - Radiology in which radioisotopes (compounds containing radioactive forms of atoms) are introduced into the body for the purpose of imaging, evaluating organ function, or localizing disease or tumors.

Observation - A stay in a hospital for less than 24 hours if: (1) You have not been admitted as a registered bed patient; (2) you are physically detained in an emergency room, treatment room, observation room, or other such area; or (3) you are being observed to determine whether an inpatient confinement will be required.

Organization Determination - The Medicare Advantage organization has made an organization determination when it makes a decision about whether items or services are covered or how much you have to pay for covered items or services. The Medicare Advantage organization's network provider or facility has also made an organization determination when it provides you with an item or service, or refers you to an out-of-network provider for an item or service. Organization determinations are called "coverage decisions" in this booklet. Chapter 7 explains how to ask us for a coverage decision.

Original Medicare ("Traditional Medicare" or "Fee-for-service" Medicare) - Original Medicare is offered by the government, and not a private health plan like Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-network Provider or Out-of-network Facility - A provider or facility with which we have not arranged to coordinate or provide covered services to members of our Plan. Out-of-network providers are providers that are not employed, owned, or operated by our Plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

Out-of-network Pharmacy - A pharmacy that doesn't have a contract with our Plan to coordinate or provide covered drugs to members of our Plan. As explained in this Evidence of Coverage, most drugs you get from out-of-network pharmacies are not covered by our Plan unless certain conditions apply.

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

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

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

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

Point-of-Service (POS) Plan - A Medicare managed care plan option that lets you use doctors and hospitals outside the plan for an additional cost.

Positron Emission Tomography (PET) Scan - A medical imaging technique that involves injecting the patient with an isotope and using a PET scanner to detect the radiation emitted.

Preferred Provider Organization Plan - A Preferred Provider Organization plan is an MA plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost-sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network providers and a higher combined limit on your total annual out-of-pocket costs for services from both network and out-of-network providers.

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

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

Primary Care Physician (PCP) - Your primary care physician is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization - Approval in advance to get services or certain drugs that may or may not be on our formulary. Some in-network medical services are covered only if your doctor or other network provider gets "prior authorization" from our Plan. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4. Some drugs are covered only if your doctor or other network provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the formulary.

Quality Improvement Organization (QIO) - Groups of practicing doctors and other health care experts that are paid by the Federal government to check and improve the care given to Medicare patients. See Chapter 13 for information about how to contact the QIO in your state.

Quantity Limits - A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Rehabilitation Services - These services include physical therapy, speech and language therapy, and occupational therapy.

Screening Mammogram - A radiological procedure for early detection of breast cancer, and; includes a physician's interpretation of the results.

Service Area - A geographic area where a health insurance plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you move out of the plan's service area.

Skilled Nursing Facility (SNF) Care - Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

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 the Social Security Administration 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.

Urgently Needed Care - Urgently needed care is care provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed care may be furnished by out-of-network providers when network providers are temporarily unavailable or inaccessible.

Chapter 13. STATE SPECIFIC INFORMATION

ALABAMA

QIO

Alabama Quality Assurance Foundation
Two Perimeter Park South
Suite 200 West
Birmingham, AL 35423
1-800-760-4550 (toll free)
1-205-970-1600 (local)
1-205-970-1616 fax
<http://www.aqaf.com>

SHIP

State Health Insurance Assistance Program (SHIP)
770 Washington Avenue RSA Plaza
Suite 570
Montgomery, AL 36130
1-800-243-5463 (toll free)
1-334-242-5743 (local)
1-334-242-5594 (fax)
<http://www.alabamaageline.gov/>

SMO

Medicaid Agency of Alabama
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

ALASKA**QIO**

Mountain-Pacific Quality Health Foundation
4241 B Street,
Suite 303
Anchorage, AK 99503
1-877-561-3202 (toll free)
907-561-3202 (local)
1-907-561-3204 fax
<http://www.mpqhf.org/>

SHIP

Alaska State Health Insurance Assistance Program (SHIP)
1217 E. 10th Ave
Anchorage, AK 99501
1-800-478-6065 (toll free; in-state calls only)
1-907-269-3680 (local)
1-800-770-8973 (TTY)
<http://www.hss.state.ak.us/dsds/medicare/>

SMO

Alaska Department of Health and Social Services (Medicaid)
350 Main Street, Room 229
P.O. Box 110601
Juneau, AK 99801
1-800-780-9972 (toll free)
<http://www.hss.state.ak.us>

SPAP

Not Applicable

ARIZONA**QIO**

Health Services Advisory Group, Inc.
3133 East Camelback Road
Suite 300
Phoenix, AZ 85016 - 4501
1-800-359-9909 (toll free)
1-602-264-6382 (local)
1-602-241-0757 (fax)
<http://www.hsag.com>

SHIP

Arizona State Health Insurance Assistance Program (SHIP)
1789 West Jefferson St.
(Site Code 950A)
Phoenix, AZ 85007
1-800-432-4040 (SHIP Hotline)
1-602-542-4446 (local)
1-602-542-6575 (fax)
<http://www.azdes.gov/aaa/programs/ship/default.asp>

SMO

Health Care Cost Containment of Arizona (Medicaid)
801 E. Jefferson St.
MD 4100
Phoenix, AZ 85034
1-800-523-0231 (toll free)
1-602-417-7000 (local)
1-602-417-7700 (Spanish)
<http://www.azahcccs.gov>

SPAP

Not Applicable

ARKANSAS**QIO**

Arkansas Foundation for Medical Care
1020 West 4th Street
Suite 300
Little Rock, AR 72201
1-888-987-1200 (toll free)
1-479-649-8501 (local)
1-888-354-9100 (medicare helpline)
<http://www.afmc.org>

SHIP

Senior Health Insurance Information Program (SHIIP)
1200 West Third Street
Little Rock, AR 72201
1-800-224-6330 (toll free)
1-501-371-2782 (local)
1-501-371-2781 (fax)
<http://www.insurance.arkansas.gov/Seniors/divpage.htm>

SMO

Department of Human Services of Arkansas (Medicaid)
Donaghey Plaza
PO Box 1437
Little Rock, AR 72203
1-800-482-5431 (in-state toll free)
1-501-682-8233 (local)
1-800-482-8988 (Spanish- in-state toll free)
<http://www.arkansas.gov/dhs/homepage.html>

SPAP

Not Applicable

CALIFORNIA

QIO

Health Services Advisory Group
700 N. Brand Blvd
Suite 370
Glendale, CA 91203
1-866-800-8749 (medicare helpline)
1-800-881-5980 (TTY)
<http://www.hsag.com>

SHIP

California Health Insurance Counseling & Advocacy Program (HICAP)
1300 National Drive
Suite 200
Sacramento, CA 95834 - 1992
1-800-434-0222 (toll free)
1-916-419-7500 (local)
1-916-928-2267 (fax)
1-800-735-2929 (TTY)
<http://www.aging.ca.gov/HICAP>

SMO

Department of Health Care Services - Medi-Cal (Medicaid)
P.O. Box 13029
Sacramento, CA 95813 - 4029
1-800-541-5555 (toll free)
1-916-636-1980 (local)
<http://www.medi-cal.ca.gov>

SPAP

Not Applicable

COLORADO

QIO

Colorado Foundation for Medical Care
23 Iverness Way East
Suite 100
Englewood, CO 80112 - 5708
1-800-727-7086 (medicare helpline)
1-303-695-3300 (local)
1-303-695-3343 (fax)
<http://www.cfmc.org>

SHIP

Senior Health Insurance Assistance Program (SHIP)
1560 Broadway
Suite 850
Denver, CO 80202
1-800-930-3745 (toll free outside Denver)
1-303-894-7490(consumer information)
1-866-665-9668 (Spanish)
1-303-894-7455 (fax)
1-303-894-7880 (TTY)
www.dora.state.co.us/insurance/senior/senior.htm

SMO

Department of Health Care Policy and Financing of Colorado (Medicaid)
1570 Grant Street
Denver, CO 80203 - 1818
1-800-221-3943 (toll free)
1-303-866-3513 (local)
1-800-659-2656 (TDD)
<http://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)
<http://www.cdph.state.co.us/dc/HIVandSTD/ryanwhite/medicared>

CONNECTICUT
QIO

Qualidigm
1111 Cromwell Avenue
Suite 201
Rocky Hill, CT 06067 - 3454
1-800-553-7590 (medicare helpline)
1-860-632-2008 (local)
1-860-632-5865 (fax)
<http://www.qualidigm.org>

SHIP

CHOICES
25 Sigourney Street
10th Floor
Hartford, CT 06106
1-800-994-9422 (toll free)
1-860-424-5274 (local)
<http://www.ct.gov/agingservices>

SMO

Department of Social Services of Connecticut (Medicaid)
25 Sigourney Street
Hartford, CT 06106 - 5033
1-800-842-1508 (toll free; in-state calls only)
1-860-424-4908 (local)
1-800-842-4524 (TTY)
<http://www.ct.gov/dss/site/default.asp>

SPAP

Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled Program
(ConnPACE)
P.O. Box 5011
Hartford, CT 06102
1-800-423-5026 (toll free)
1-860-269-2029 (local)
<http://www.connpace.com>

DELAWARE

QIO

Quality Insights of Delaware
Baynard Building, Suite 100
3411 Silverside Road
Wilmington, DE 19810 - 4812
1-866-475-9669 (toll free)
1-302-478-3600 (local)
1-302-478-3873 (fax)
<http://www.qide.org/de/>

SHIP

ELDERinfo
841 Silver Lake Blvd.
Dover, DE 19904
1-800-336-9500 (toll free: in-state calls only)
1-302-674-7364 (local)
<http://delawareinsurance.gov/departments/elder/eldindex.shtml>

SMO

Delaware Health and Social Services (Medicaid)
Main Administration Building
1901 N. DuPont Highway
New Castle, DE 19720
1-800-372-2022 (toll free)
1-302-255-9500 (local)
1-302-391-3505 or 1-302-424-7141 (TDD)
<http://dhss.delaware.gov/dsaapd/>

SPAP

Delaware Prescription Assistance Program
P.O. Box 950
New Castle, DE 19720 - 0950
1-800-996-9969 (option 2, then option1)
<http://dhss.delaware.gov/dhss/dmma/dpap.html>

DISTRICT OF COLUMBIA

QIO

Delmarva Foundation of the District of Columbia
6940 Columbia Gateway Dr
Suite 420
Columbia, MD 21046-2788
1-800-645-0011 (toll free)
1-202-293-9650 (local)
<http://www.dcqio.org/>

SHIP

Health Insurance Counseling Project (HICP)
2136 Pennsylvania Ave. NW
Washington, DC 20052
1-202-739-0668 (local)
1-202-293-4043 (fax)
1-202-973-1079 (TTY)
<http://www.law.gwu.edu/Academics/EL/clinics/insurance/Pages/About.aspx>

SMO

DC Health Family (Medicaid)
899 North Capitol Street, NE
Washington, DC 20002
1-800-620-7802 (toll free)
1-202-639-4030 (local)
<http://dchealth.dc.gov/doh/site/default.asp>

SPAP

Not Applicable

FLORIDA

QIO

FMQAI
5201 West Kennedy Blvd
Suite 900
Tampa, FL 33609 - 1822
1-800-844-0795 (medicare beneficiary)
1-813-354-9111 (local)
<http://www.fmqai.com>

SHIP

SHINE
4040 Esplanade Way
Suite 270
Tallahassee, FL 32399 - 7000
1-800-963-5337 (toll free; in-state/out-of-state)
1-800-955-8770 (TDD)
1-850-414-2150 (fax)
<http://www.floridaSHINE.org>

SMO

Agency for Health Care Administration of Florida (Medicaid)
2727 Mahan Drive
Tallahassee, FL 32308
1-866-762-2237 (toll free)
1-850-487-1111 (local)
<http://ahca.myflorida.com/>

SPAP

Not Applicable

GEORGIA

QIO

Georgia Medical Care Foundation
1455 Lincoln Parkway
Suite 800
Atlanta, GA 30346
1-800-982-0411 (toll free)
1-678-527-3000 (local)
1-678-527-3025 (fax)
<http://www.gmcf.org>

SHIP

GeorgiaCares
2 Peachtree Street NW
33rd Floor
Atlanta, GA 30303-3142
1-866-552-4464 (toll free)
1-404-657-5258 (local)
1-404-657-5285 (fax)
<http://www.aging.dhr.georgia.gov/portal/site>

SMO

Georgia Department of Community Health (Medicaid)
2 Peachtree Street NW
Atlanta, GA 30303
1-800-869-1150 (toll free)
1-404-651-9982 (local)
<http://dch.georgia.gov>

SPAP

Not Applicable

HAWAII

QIO

Mountain-Pacific Quality Health Foundation
1360 S. Beretania
Suite 501
Honolulu, HI 96814
1-800-524-6550 (toll free)
1-808-545-2550 (local)
1-800-440-6030 fax
<http://www.mpqhf.org>

SHIP

Sage PLUS
250 South Hotel Street
Room 406
Honolulu, HI 96813-2831
1-888-875-9229 (toll free)
1-808-586-7299 (local)
1-866-810-4379 (TTY)
<http://hawaiiiship.org>

SMO

Department of Human Services, Med-Quest Division (Medicaid)
601 Kamokila Blvd, Room 415
Kapolei, HI 96707 - 2021
1-800-316-8005 (toll free)
1-808-524-3370 (Oahu)
1-808-603-1201 (TTY)
<http://www.med-quest.us>

SPAP

Not Applicable

IDAHO

QIO

QualisHealth
720 Park Blvd.
Suite 120
Boise, ID 83712
1-800-488-1118 (toll free)
1-208-343-4617 (local)
1-208-343-4705 fax
<http://www.qualishealthmedicare.org>

SHIP

Senior Health Insurance Benefit Advisors (SHIBA)
700 West State Street
Boise, ID 83720 0043
1-800-247-4422 (toll free; in-state calls only)
1-208-334-4352 (local)
<http://www.doi.idaho.gov/shiba/shwelcome.aspx>

SMO

Idaho Department of Health and Welfare (Medicaid)
P.O. Box 83720
Boise, ID 83720 - 0036
1-800-926-2588 (toll free)
1-208-334-6700 (local)
<http://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)
<http://healthandwelfare.idaho.gov/Medical/PrescriptionDrugs/tabid/119/Default.aspx>

ILLINOIS

QIO

IFMC-IL Illinois Foundation for Quality Health Care
711 Jorie Blvd
Suite #301
Oak Brook, IL 60523 - 4425
1-800-647-8089 (toll free)
1-630-928-5800 (local)
<http://www.ifmc-il.org>

SHIP

Senior Health Insurance Program (SHIP)
320 West Washington Street
Springfield, IL 62767 - 0001
1-800-548-9034 (toll free; in-state calls only)
1-217-785-9021 (local)
1-217-524-4872 (TTY)
<http://insurance.illinois.gov/ship>

SMO

Illinois Department of Healthcare and Family Services (Medicaid)
1375 East Woodfield Rd
Suite 600
Schaumburg, IL 60173 - 5418
1-877-912-1999 (toll free)
1-866-565-8577 (TTY)
<http://www.illinoishealthconnect.com>

SPAP

Illinois Cares RX Plus
Illinois Department on Aging
P.O. Box 19003
Springfield, IL 62794
1-800-252-8966 (Senior help line)
1-800-226-0768 (Health Benefits Hotline)
1-866-675-8440 (TTY)
www.illinoiscaresrx.com

INDIANA

QIO

Health Care Excel, Inc.
2629 Waterfront Parkway East Drive
Suite 150
Indianapolis, IN 46214
1-800-288-1499 (toll free)
1-812-235-4991 (fax)
<http://www.hce.org>

SHIP

State Health Insurance Assistance Program (SHIP)
714 West 53rd Street
Anderson, IN 46013
1-800-452-4800 (toll free)
1-765-608-2318 (local)
1-866-846-0139 (TTY)
<http://www.in.gov/idoi/2495.htm>

SMO

Family and Social Services Administration of Indiana (Medicaid)
402 West Washington Street
P.O. Box 7083
Indianapolis, IN 46207 - 7083
1-800-403-0864 (toll free)
1-317-233-4454 (local)
<http://www.in.gov/fssa>

SPAP

Hoosier RX
P.O. Box 6224
Indianapolis, IN 46206
1-866-267-4679 (toll free)
1-317-234-1381 (local)
<http://www.in.gov/fssa/elderly/hoosierRX/>

IOWA

QIO

Telligen Healthcare Intelligence
1776 West Lakes Parkway
West Des Moines, IA 50266
1-800-383-2856 (toll free)
1-515-223-2900 (local)
1-515-222-2407 fax
<http://www.telligen.org/>

SHIP

Senior Health Insurance Information Program (SHIIP)
330 Maple St.
Des Moines, IA 50319 - 0065
1-800-351-4664 (toll free)
1-800-735-2942 (TTY)
<http://www.shiip.state.ia.us>

SMO

Department of Human Services of Iowa (Medicaid)
Hoover State Office Building
1305 E. Walnut Street
Des Moines, IA 50319
1-800-338-8366 (toll free)
1-515-256-4606 (local)
<http://www.dhs.state.ia.us>

SPAP

Not Applicable

KANSAS

QIO

Kansas Foundation for Medical Care, Inc.
2947 S.W. Wanamaker Drive
Topeka, KS 66614 - 4193
1-800-432-0770 (toll free)
1-785-273-2552 (local)
<http://www.kfmc.org>

SHIP

Senior Health Insurance Counseling for Kansas (SHICK)
New England Building,
503 S. Kansas Avenue
Topeka, KS 66603
1-800-860-5260 (toll free)
1-316-337-7386 (local)
http://www.agingkansas.org/SHICK/shick_index.html

SMO

Department of Social and Rehabilitation Services of Kansas (Medicaid)
915 SW Harrison St
Topeka, KS 66612
1-800-766-9012 (toll free)
1-785-296-3981 (local)
1-785-296-1491 (TTY)
<http://www.srs.ks.gov/Pages/Default.aspx>

SPAP

Not Applicable

KENTUCKY

QIO

Health Care Excel
1941 Bishop Lane
Suite 400
Louisville, KY 40218
1-800-288-1499 (toll free)
1-812-235-4991 (fax)
<http://www.hce.org>

SHIP

State Health Insurance Assistance Program (SHIP)
275 East Main Street
Frankfort, KY 40621
1-877-293-7447 (toll free)
1-502-564-6930 (local)
<http://www.chfs.ky.gov/dail/ship.htm>

SMO

Cabinet for Health Services of Kentucky (Medicaid)
275 East Main Street
Frankfort, KY 40621
1-800-635-2570 (toll free)
1-502-564-4321 (local)
1-800-627-4702 (TTY)
<http://chfs.ky.gov>

SPAP

Not Applicable

LOUISIANA

QIO

eQHealth Solutions, Inc, (Formerly Louisiana Health Care Review)
8591 United Plaza Boulevard
Suite 270
Baton Rouge, LA 70809
1-800-433-4958 (toll free)
1-225-926-6353 (local)
1-225-923-0957 (fax)
<http://www.eqhs.org/>

SHIP

Senior Health Insurance Information Program (SHIIP)
P.O. Box 94214
Baton Rouge, LA 70802
1-800-259-5300 (toll free)
1-225-342-5301 (local)
<http://www.ldi.state.la.us/Health/SHIIP/index.html>

SMO

Louisiana Department of Health and Hospital (Medicaid)
628 N. 4th St.
Baton Rouge, LA 70802
1-888-342-6207 (toll free)
1-225-342-9500 (local)
1-877-252-2447 (Spanish)
<http://new.dhh.louisiana.gov/index.cfm/subhome/1>

SPAP

Not Applicable

MAINE

QIO

Northeast Health Care Quality Foundation
15 Old Rollinsford Road
Suite 302
Dover, NH 03820
1-800-772-0151 (toll free)
1-603-749-1641 (local)
1-603-749-1195 (fax)
<http://www.nhcqf.org>

SHIP

Maine State Health Insurance Assistance Program (SHIP)
11 State House Station
32 Blossom Lane
Augusta, ME 04333
1-877-353-3771 (toll free; in-state calls only)
1-207-287-9200 (local)
1-800-606-0215 (TTY)
<http://www.maine.gov/dhhs/oes/community/ship.shtml>

SMO

Maine Department of Health and Human Services (Medicaid)
11 State House Station
Augusta, ME 04333 - 0011
1-800-977-6740 (toll free)
1-207-287-9202 (main number)
1-800-606-0215 (TTY)
<http://www.maine.gov/dhhs/oms>

SPAP

Maine Low Cost Drugs for the Elderly or Disabled Program
Office of MaineCare Services
442 Civic Center Drive
Augusta, ME 04333
1-866-796-2463
http://www.maine.gov/dhhs/beas/resource/lc_drugs.htm

MARYLAND

QIO

Delmarva Foundation for Medical Care, Inc.
6940 Columbia Gateway Drive Suite 420
Columbia, MD 21046-2788
1-800-492-5811 (toll free)
<http://www.mdqio.org>

SHIP

Senior Health Insurance Assistance Program (SHIP)
301 West Preston Street
Room 1007
Baltimore, MD 21201
1-800-243-3425 (toll free)
1-410-767-1100 (local)
1-410-767-1083 (TTY)
<http://www.aging.maryland.gov/>

SMO

Department of Health and Mental Hygiene (Medicaid)
201 West Preston St.
5th Floor
Baltimore, MD 21201 - 2301
1-800-492-5231 (toll free)
1-410-767-5800 (local)
<http://www.dhmf.state.md.us>

SPAP

Maryland Senior Prescription Drug Assistance Program - Maryland SPDAP c/o Pool
Administrators
628 Hebron Avenue
Suite 212
Glastonbury, CT 06033
1-800-551-5995 (toll free)
1-800-877-5156 (TTY)
www.marylandspdap.com

MASSACHUSETTS

QIO

MassPRO
245 Winter Street
Waltham, MA 02451 - 1231
1-800-252-5533 (toll free)
1-781-890-0011 (local)
1-781-487-0083 (fax)
1-781-419-2502 (TTY)
<http://www.masspro.org>

SHIP

Serving Health Information Needs of Elders (SHINE)
1 Ashburton Place
5th Floor
Boston, MA 02108
1-800-243-4636 (toll free)
1-617-727-7750 (local)
1-800-872-0166 (TTY)
www.mass.gov/elders

SMO

Office of Health and Human Services of Massachusetts (Medicaid)
One Ashburton Place
5th Floor
Boston, MA 02108
1-800-841-2900 (toll free)
1-800-497-4648 (TTY)
<http://www.mass.gov/eohhs/gov/departments/masshealth/>

SPAP

Massachusetts Prescription Advantage
P.O. Box 15153
Worcester, MA 01615
1-800-243-4636, ext 2 (toll free)
1-800-872-0166 (TTY)
<http://www.mass.gov/elders/healthcare/prescription-advantage/>

MICHIGAN

QIO

MPRO
22670 Haggerty Road
Suite 100
Farmington Hills, MI 48335 - 2611
1-800-365-5899 (toll free)
1-248-465-7300 (local)
1-248-465-7428 (fax)
<http://www.mpro.org>

SHIP

MMAP Inc
6105 West St. Joseph
Suite 204
Lansing, MI 48917 - 4850
1-800-803-7174 (toll free)
www.mmapinc.org

SMO

Michigan Department Community Health (Medicaid)
Capitol View Building
201 Townsend Street
Lansing, MI 48913
1-800-642-3195 (toll free)
1-517-373-3740 (local)
1-800-649-3777 (TTY)
<http://www.michigan.gov/mdch>

SPAP

Not Applicable

MINNESOTA

QIO

Stratis Health
2901 Metro Drive
Suite 400
Bloomington, MN 55425 - 1525
1-800-444-3423 (toll free)
1-952-854-3306 (local)
1-877-627-3848 (Spanish)
1-952-853-8503 (fax)
1-800-627-3529 (TTY)
<http://www.stratishealth.org/index.html>

SHIP

Minnesota State Health Insurance Assistance Program/Senior LinkAge Line
P.O. box 64976
St. Paul, MN 55164 - 0976
1-800-333-2433 (toll-free)
1-800-627-3529 (TTY)
http://www.mnaging.org/advisor/SLL_SHIP.htm

SMO

Department of Human Services of Minnesota - MinnesotaCare (Medicaid)
P.O. Box 64838
St. Paul, MN 55164 - 0838
1-800-657-3672 (toll free)
1-651-431-2801 (local)
<http://www.dhs.state.mn.us>

SPAP

Not Applicable

MISSISSIPPI

QIO

Information and Quality Healthcare
385B Highland Colony Parkway
Suite 504
Ridgeland, MS 39157
1-800-844-0600 (toll free)
1-601-957-1575 (local)
<http://www.iqh.org>

SHIP

MS State Health Insurance Assistance Program (SHIP)
750 North State Street
Jackson, MS 39202
1-800-948-3090 (toll free)
1-601-359-4929 (local)
http://www.mdhs.state.ms.us/aas_ship.html

SMO

Office of the Governor of Mississippi (Medicaid)
Sillers Building, 550 High Street
Suite 1000
Jackson, MS 39201 - 1399
1-800-421-2408 (toll free)
1-601-359-6050 (local)
<http://www.medicaid.ms.gov>

SPAP

Not Applicable

MISSOURI

QIO

Primaris
200 North Keene Street
Suite 101
Columbia, MO 65201
1-800-735-6776 (toll free)
1-573-817-8300 (local)
<http://www.primaris.org>

SHIP

CLAIM
P.O. Box 690, Truman Bldg
Jefferson City, MO 65102
1-800-390-3330 (toll free)
1-573-817-8320 (local)
www.missouriclaim.org

SMO

Department of Social Services of Missouri - MO HealthNet Division (Medicaid)
615 Howerton Court
P.O. Box 6500
Jefferson City, MO 65102 - 6500
1-800-392-2161 (toll free)
1-573-751-3425 (local)
<http://www.dss.mo.gov/mhd>

SPAP

Missouri RX Plan
P.O. Box 6500
Jefferson City, MO 65102
1-800-375-1406 (toll free)
www.morx.mo.gov

MONTANA

QIO

Mountain-Pacific Quality Health Foundation
3404 Cooney Drive
Helena, MT 59602
1-800-497-8232 (toll free)
1-406-443-4020 (local)
1-406-513-1920 (fax)
<http://www.mpqhf.org>

SHIP

Montana State Health Insurance Assistance Program (SHIP)
P.O. Box 4210
Helena, MT 59604
1-800-551-3191 (toll free; in-state calls only)
<http://www.dphhs.mt.gov/sltc/services/aging/SHIP/ship.shtml>

SMO

Montana Department of Public Health and Human Services Division of Child and Adult Health Resources (Medicaid)
1400 Broadway
Cogswell Building
Helena, MT 59620
1-800-362-8312 (toll free)
1-406-444-4540 (local)
711 (TTY)
<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)
711 (TTY)
<http://www.dphhs.mt.gov/prescriptiondrug/bigsky.shtml>

NEBRASKA

QIO

Cimro of Nebraska
1230 O Street
Suite 120
Lincoln, NE 68508
1-800-458-4262 (toll free)
1-402-476-1399 (local)
1-402-476-1335 (fax)
<http://www.cimronebraska.org/default.aspx>

SHIP

Nebraska Senior Health Insurance Information Program (SHIIP)
941 O Street
Suite 400
Lincoln, NE 68508 - 3690
1-800-234-7119 (toll free)
1-402-471-2201 (local)
1-800-833-7352 (TDD)
<http://www.doi.ne.gov/shiip>

SMO

Nebraska Department of Health and Human Services System (Medicaid)
P.O. Box 95026
Lincoln, NE 68509 - 5026
1-800-430-3244 (toll free)
1-402-471-3121 (local)
<http://www.hhs.state.ne.us>

SPAP

Not Applicable

NEVADA

QIO

Health Insight
6830 W. Oquendo Road
Suite 102
Las Vegas, NV 89118
1-800-748-6773 (toll free)
1-702-385-9933 (local)
1-800-741-7532 (fax)
<http://www.healthinsight.org>

SHIP

State Health Insurance Assistance Program (SHIP)
3416 Goni Road
Bldg. D, #132
Carson City, NV 89706
1-800-307-4444 (toll free)
1-702-486-3478 (local)
www.nvaging.net/ship/ship_main.htm

SMO

Nevada Department of Human Resources, Aging Division (Medicaid)
4126 Technology Way
Room 100
Carson City, NV 89706 - 2009
1-800-992-0900 (toll free)
1-775-684-7200 (local)
<https://dhcfr.nv.gov/index.htm>

SPAP

Nevada Senior Rx
Nevada Senior Rx Dept of Humana Resources
3416 Goni Road, Suite B-113
Carson City, NV 89706
1-866-303-6323 (toll free)
1-775-687-4210 (local)
<http://dhhs.nv.gov/SeniorRx.htm>

SPAP

Nevada Disability Rx Program
Department of Health and Human Services
3416 Goni Road, Suite B-113
Carson City, NV 89706
1-866-303-6323 (toll free)
1-775-687-4210 (local)
<http://dhhs.nv.gov/disabilityRx.htm>

NEW HAMPSHIRE

QIO

Northeast Health Care Quality Foundation
15 Old Rollinsford Road
Suite 302
Dover, NH 03820
1-800-772-0151 (toll free)
1-603-749-1641 (local)
1-603-749-1195 (fax)
<http://www.nhcqf.org>

SHIP

NH SHIP - ServiceLink Resource Center
67 Water Street, Suite 105
Laconia, NH 03246
1-866-634-9412 (toll free)
<http://www.nh.gov/servicelink>

SMO

New Hampshire Department of Health and Human Services (Medicaid)
129 Pleasant Street
Concord, NH 03301
1-800-852-3345 (toll free)
1-603-271-4344 (local)
1-800-735-2964 (TDD)
<http://www.dhhs.state.nh.us>

SPAP

Not Applicable

NEW JERSEY

QIO

Healthcare Quality Strategies
557 Cranbury Road
Suite 21
East Brunswick, NJ 08816
1-800-624-4557 (toll free)
1-732-238-5570 (local)
<http://www.hqsi.org>

SHIP

State Health Insurance Assistance Program (SHIP)
Division of Aging and Community Services
P.O. Box 360
Trenton, NJ 08625 - 0360
1-800-792-8820 (toll free; in-state calls only)
1-877-222-3737 (toll free)
www.state.nj.us/health/senior/ship.shtml

SMO

Department of Human Services of New Jersey (Medicaid)
P.O. Box 712
Trenton, NJ 08625 - 0712
1-800-356-1561 (toll free)
1-800-356-1561 (Spanish)
<http://www.state.nj.us/humanservices/dmahs/home/index.html>

SPAP

New Jersey Senior Gold Prescription Discount Program
New Jersey Department of Health and Senior Services
P.O. Box 715
Trenton, NJ 08625
1-800-792-9745 (toll free)
<http://www.state.nj.us/health/seniorbenefits/seniorgold.shtml>

SPAP

New Jersey Pharmaceutical Assistance to the Aged and Disabled Program (PAAD)
PAAD-HAAAD
P.O. Box 360
Trenton, NJ 08625
1-800-792-9745 (toll free)
<http://www.state.nj.us/health/seniorbenefits/paad.shtml>

NEW MEXICO**QIO**

Health Insight New Mexico
5801 Osuna Road NE
Suite 200
Albuquerque, NM 87109
1-800-663-6351 (toll free)
1-505-998-9898 (local)
1-505-998-9899 (fax)
<http://www.nmmra.org>

SHIP

Benefits Counseling Program
2550 Cerrillos Road
Santa Fe, NM 87505
1-800-432-2080 (toll free; in state calls only)
1-505-476-4846 (local)
www.nmaging.state.nm.us

SMO

Department of Human Services of New Mexico (Medicaid)
Medical Assistance Division
P.O. Box 2348
Santa Fe, NM 87504 - 2348
1-888-997-2583 (toll free)
1-505-827-3100 (local Sante Fe)
1-800-432-6217 (Spanish)
<http://www.hsd.state.nm.us/mad>

SPAP

Not Applicable

NEW YORK

QIO

Island Peer Review Organization - IPRO
1979 Marcus Avenue
Lake Success, NY 11042 - 1002
1-800-331-7767 (toll free)
1-516-326-7767 (local)
1-516-326-6182 (TTY)
1-516-328-2310 (fax)
<http://www.ipro.org>

SHIP

Health Insurance Information Counseling and Assistance Program (HIICAP)
2 Empire State Plaza, Agency Bldg #2
Albany, NY 12223 - 1251
1-800-701-0501 (toll free)
1-800-342-9871 (toll free)
www.aging.ny.gov

SMO

New York State Department of Health (Medicaid)
Corning Tower Building
Empire State Plaza
Albany, NY 12223
1-800-541-2831 (toll free)
<http://www.health.state.ny.us>

SPAP

New York State Elderly Pharmaceutical Insurance Coverage (EPIC)
P.O. Box 15018
Albany, NY 12212 - 5018
1-800-332-3742 (toll free)
1-800-290-9138 (TTY)
http://www.health.ny.gov/health_care/epic/

NORTH CAROLINA

QIO

The Carolinas Center for Medical Excellence
100 Regency Forest Drive
Suite 200
Cary, NC 27518 - 8598
1-800-682-2650 (toll free)
1-919-461-5500 (local)
1-800-735-2962 (TTY)
1-919-461-5700 (fax)
<http://www.thecarolinascenter.org>

SHIP

Seniors' Health Insurance Information Program (SHIIP)
430 N. Salisbury Street
Raleigh, NC 27603
1-800-443-9354 (toll free)
1-919-807-6900 (local)
1-919-715-0319 (TTY)
<http://www.ncdoi.com/shiip/default.asp>

SMO

North Carolina Department of Health and Human Services (Medicaid)
2501 Mail Service Center
Raleigh, NC 27699 - 2501
1-919-855-4400 (local)
1-800-622-7030 (toll free)
1-877-733-4851 (TTY)
<http://www.ncdhhs.gov/dma/medicaid/medicare.htm>

SPAP

North Carolina HIV SPAP
1902 Mail Service Center
Raleigh, NC 27699
1-877-466-2232 (toll free)
1-919-733-7301 (local)
<http://epi.publichealth.nc.gov/cd/hiv/adap.html>

NORTH DAKOTA

QIO

North Dakota Health Care Review Inc
3520 North Broadway
Minot, ND 58703
1-888-472-2902 (toll free)
1-701-852-4231 (local)
<http://www.ndhcri.org>

SHIP

State Health Insurance Counseling (SHIC)
600 East Boulevard
State Capitol Floor 5
Bismarck, ND 58505 - 0320
1-800-247-0560 (toll free)
1-701-328-2440 (local)
1-800-366-6888 (TTY)
<http://www.nd.gov/ndins/consumer/shic/>

SMO

Department of Human Services of North Dakota - Medical Services (Medicaid)
600 East Blvd. Ave
Dept 325
Bismarck, ND 58505 - 0250
1-800-472-2622 (toll free)
1-701-328-2310 (local)
1-800-366-6888 (TTY)
<http://www.nd.gov/dhs>

SPAP

Not Applicable

OHIO

QIO

Ohio KePRO, Inc.
Rock Run Center, Suite 100
5700 Lombardo Center Drive
Seven Hills, OH 44131
1-800-589-7337 (toll free)
1-216-447-9604 (local)
1-216-447-7925 (fax)
<http://www.ohiokepro.com>

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)
1-614-644-3458 (local)
1-614-644-3745 (TTY)
<http://www.insurance.ohio.gov/Pages/default.aspx>

SMO

Department of Job and Family Services of Ohio - Ohio Health Plans (Medicaid)
30 E. Broad Street 32nd Floor
Columbus, OH 43215
1-800-324-8680 (toll free)
1-614-644-0140 (local)
<http://jfs.ohio.gov/ohp>

SPAP

Not Applicable

OKLAHOMA

QIO

Oklahoma Foundation for Medical Quality, Inc.
14000 Quail Springs Parkway
Suite 400
Oklahoma City, OK 73134 - 2600
1-800-522-3414 (toll free)
1-405-840-2891 (local)
<http://www.ofmq.com>

SHIP

Senior Health Insurance Counseling Program (SHIP)
Five Corporate Plaza, 3625 NW 56th
Suite 100
Oklahoma City, OK 73112 - 4511
1-800-763-2828 (toll free)
1-405-521-6628 (local)
<http://www.ok.gov/oid/>

SMO

Health Care Authority of Oklahoma (Medicaid)
2401 N.W. 23rd St.
Suite 1A
Oklahoma City, OK 73107
1-800-522-0310 (toll free)
1-405-522-7171 (local)
1-405-522-7179 (TTY)
<http://okhca.org>

SPAP

Not Applicable

OREGON

QIO

Acumentra Health
2020 SW Fourth Ave.
Suite 520
Portland, OR 97201
1-800-344-4354 (toll free)
1-503-279-0100 (local)
1-503-382-3983 (fax)
<http://www.acumentra.org>

SHIP

Senior Health Insurance Benefits Assistance (SHIBA)
350 Winter St NE, P.O. Box 14480
Suite 330
Salem, OR 97309 - 0405
1-800-722-4134 (toll free)
1-503-947-7979 (local)
1-503-947-7092 fax
1-800-735-2900 (TTY)
<http://www.oregon.gov/DCBS/SHIBA>

SMO

Oregon Department of Human Services (Medicaid)
500 Summer Street, NE
Salem, OR 97301
1-800-527-5772 (toll free)
1-503-945-5772 (local)
1-503-945-5896 (TTY)
<http://www.oregon.gov/DHS>

SPAP

Not Applicable

PENNSYLVANIA

QIO

Quality Insights of Pennsylvania
2601 Market Place Street
Suite 320
Harrisburg, PA 17110
1-877-346-6180 (toll free)
1-717-671-5425 (local)
<http://www.qipa.org/pa>

SHIP

APPRISE
642 N. Broad Street
Philadelphia, PA 19130 - 3049
1-800-783-7067 (toll free)
1-215-765-9000 (local)
1-215-765-9066 (fax)
http://www.pccares.org/pca_ss_APPRISE.aspx

SMO

Department of Public Welfare of Pennsylvania (Medicaid)
Health and Welfare Building
Rm. 515, P.O. Box 2675
Harrisburg, PA 17105 - 2675
1-800-692-7462 (toll free)
<http://www.dpw.state.pa.us/>

SPAP

Pharmaceutical Assistance Contract for the Elderly (PACE)
1st. Health Services, 4000 Crums Mill Road
Suite 301
Harrisburg, PA 17112
1-800-225-7223 (toll free)
1-717-651-3600 (local)
http://www.aging.state.pa.us/portal/server.pt/community/pace_pacenet/17944

PUERTO RICO

QIO

QI PRO, Inc.
Carretera 165 Km 1.2 Torre 1
City View Plaza, Suite 412
Guaynabo, PR 00968
1-877-566-0566 (toll free)
1-787-641-1240 (local)
1-877-881-8812 (TTY)
<http://www.qipro.org>

SHIP

State Health Insurance Assistance Program (SHIP)
P.O. Box 19179
San Juan, PR 00919 - 1179
1-877-725-4300 (toll free)
1-787-721-6121 (local)
<http://www.ogave.gobierno.pr/>

SMO

Medicaid Office of Puerto Rico and Virgin Island
GPO Box 70184
San Juan, PR 00936
1-787-765-1230 (local)
<http://www.oppi.gobierno.pr>

SPAP

Not Applicable

RHODE ISLAND

QIO

Healthcentric Advisors
235 Promenade Street
Suite 500, Box 18
Providence, RI 02908
1-800-662-5028 (toll free)
1-401-528-3200 (local)
1-401-528-3210 (fax)
<http://www.healthcentricadvisors.org/>

SHIP

Senior Health Insurance Program (SHIP)
Hazard Building 74 West Road
Cranston, RI 02920
1-401-462-4444 (local)
1-401-462-0740 (TTY)
<http://www.dea.ri.gov/insurance>

SMO

Department of Human Services of Rhode Island (Medicaid)
Louis Pasteur Building #74
600 New London Avenue
Cranston, RI 02920
1-401-462-5300 (local)
1-800-745-5555 (TTY)
<http://www.dhs.ri.gov>

SPAP

Rhode Island Pharmaceutical Assistance for the Elderly (RIPAE)
Attention RIPAE<p>Hazard Building, Second Floor
74 West Road
Cranston, RI 02920
1-401-462-3000 (local)
1-401-462-0740 (local)
1-401-462-0740 (TTY)
http://www.dea.state.ri.us/programs/prescription_assist.php

SOUTH CAROLINA

QIO

The Carolinas Center for Medical Excellence
246 Stoneridge Drive
Suite 200
Columbia, SC 29210
1-800-922-3089 (toll free)
1-803-212-7500 (local)
1-800-735-8583 (TTY)
1-803-212-7600 (fax)
<http://www.thecarolinascenter.org>

SHIP

(I-CARE) Insurance Counseling Assistance and Referrals for Elders Program
1301 Gervais Street
Suite 350
Columbia, SC 29201
1-800-868-9095 (toll free)
1-803-734-9900 (local)
<http://www.aging.sc.gov/Seniors/ICARE.htm>

SMO

South Carolina Department of Health & Human Services (Medicaid)
P.O. Box 8206
Columbia, SC 29202
1-888-549-0820 (toll free)
1-803-898-2500 (local)
<http://www2.scdhhs.gov/>

SPAP

Not Applicable

SOUTH DAKOTA

QIO

South Dakota Foundation for Medical Care, Inc.
2600 West 49th Street
Suite 300
Sioux Falls, SD 57105
1-800-658-2285 (toll free)
1-605-336-3505 (local)
1-605-373-0580 (fax)
<http://www.sdfmc.org>

SHIP

Senior Health Information and Insurance Education (SHIINE)
700 Governors Drive
Pierre, SD 57501 - 2291
1-800-536-8197 (toll free)
1-605-333-3314 (local)
711 (TTY - in-state only)
www.shiine.net

SMO

Department of Social Services of South Dakota (Medicaid)
700 Governors Drive
Pierre, SD 57501
1-800-597-1603 (toll free)
1-605-773-3495 (local)
1-800-305-9673 (Spanish)
<http://dss.sd.gov>

SPAP

Not Applicable

TENNESSEE

QIO

Qsource
3340 Players Club Pkwy
Memphis, TN 38125
1-800-489-4633 (toll free)
1-901-761-3786 (fax)
<http://www.qsource.org>

SHIP

TN SHIP
Andrew Jackson Building, 500 Deaderick St.
Suite 825
Nashville, TN 37243 - 0860
1-877-801-0044 (toll free)
1-615-741-2056 (local)
1-615-532-3893 (TTY)
<http://www.state.tn.us/comaging/ship.htm>

SMO

Bureau of TennCare (Medicaid)
310 Great Circle Road
Nashville, TN 37243
1-866-311-4287 (toll free)
1-877-779-3103 (TTY)
<http://www.state.tn.us/tenncare>

SPAP

Not Applicable

TEXAS

QIO

TMF Health Quality Institute
BridgePoint I Suite 300
5918 West Courtyard Drive
Austin, TX 78730 - 5036
1-800-725-9216 (toll free)
1-512-329-6610 (local)
1-512-327-7159 (fax)
<http://www.tmf.org/>

SHIP

Health Information Counseling and Advocacy Program (HICAP)
701 West 51st Street
Austin, TX 78751
1-800-252-9240 (toll free)
<http://www.dads.state.tx.us>

SMO

Health and Human Services Commission of Texas (Medicaid)
Brown-Heatly Building, 4900 N. Lamar Blvd
Austin, TX 78751 - 2316
1-877-541-7905 (toll free)
1-512-424-6500 (local)
1-512-424-6597 (TTY)
<http://www.hhsc.state.tx.us>

SPAP

Texas Kidney Health Care Program (KHC)
Department of State Health Services, MC 1938
P.O. Box 149347
Austin, TX 78714
1-800-222-3986 (toll free)
1-512-776-7150 (local)
<http://www.dshs.state.tx.us/kidney/default.shtm>

UTAH**QIO**

HealthInsight
756 East Winchester Street
Suite 200
Salt Lake City, UT 84107
1-800-748-6773 (toll free)
1-800-741-7532 (fax)
1-801-892-0155 (local)
<http://www.healthinsight.org>

SHIP

Senior Health Insurance Information Program (SHIP)
195 North 1950 West
Salt Lake City, UT 84116
1-877-424-4640 (toll free)
1-801-538-3910 (local)
http://www.hsdaas.utah.gov/insurance_programs.htm

SMO

Utah Department of Health (Medicaid)
Cannon Health Building
288 North 1460 West
Salt Lake City, UT 84116
1-800-662-9651 (toll free)
1-801-538-6155 (local)
1-800-662-9651 (Spanish)
<http://health.utah.gov/medicaid/>

SPAP

Not Applicable

VERMONT

QIO

Northeast Health Care Quality Foundation
15 Old Rollinsford Road
Suite 302
Dover, NH 03820
1-800-772-0151 (toll free)
1-603-749-1641 (local)
1-603-749-1195 (fax)
<http://www.nhcqf.org>

SHIP

State Health Insurance Assistance Program (SHIP)
481 Summer Street, Suite 101
St. Johnsbury, VT 05819
1-800-642-5119 (toll free)
1-802-748-5182 (local)
www.medicarehelpvt.net

SMO

Agency of Human Services of Vermont (Medicaid)
103 South Main Street
Waterbury, VT 05671 - 0204
1-800-250-8427 (toll free)
1-802-879-5900 (local)
<http://humanservices.vermont.gov>

SPAP

Vermont V-Pharm
312 Hurricane Lane
Suite 201
Williston, VT 05495
1-800-250-8427 (toll free)
<http://www.greenmountaincare.org/vermont-health-insurance-plans/prescription-assistance>

VIRGINIA

QIO

Virginia Health Quality Center
9830 Mayland Drive
Suite J
Richmond, VA 23233
1-866-263-8402 (toll free)
1-804-289-5320 (local)
1-804-289-5324 (fax)
<http://www.vhqc.org>

SHIP

Virginia Insurance Counseling and Assistance Program (VICAP)
1610 Forest Avenue
Suite 100
Richmond, VA 23229 - 5009
1-800-552-3402 (toll free)
1-804-662-9333 (local)
711 (TTY)
www.vda.virginia.gov

SMO

Department of Medical Assistance Services (Medicaid)
600 East Broad Street
Richmond, VA 23219
1-804-786-7933 (local)
1-800-343-0634 (TDD)
<http://www.dmas.virginia.gov>

SPAP

Virginia HIV SPAP
P. O. Box 5930
Midlothian, VA 23112
1-800-366-7741 (toll free)
<http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/spap.htm>

WASHINGTON

QIO

QualisHealth
P.O. Box 33400
Seattle, WA 98133 - 0400
1-800-949-7536 (toll free)
1-206-364-9700 (local)
1-206-368-2419 (fax)
<http://www.qualishealthmedicare.org>

SHIP

Statewide Health Insurance Benefits Advisors (SHIBA) Helpline
Office of Insurance Commissioner, P.O. Box 40256
Olympia, WA 98504 - 0256
1-800-562-6900 (toll free)
1-360-586-0241 (TTY)
<http://www.insurance.wa.gov/shiba/index.shtml>

SMO

Department of Social and Health Services of Washington (Medicaid)
DSHS Constituent Services
P.O. Box 45130
Olympia, WA 98504 - 5130
1-800-562-3022 (toll free)
<http://www.adsa.dshs.wa.gov>

SPAP

Washington State Health Insurance Pool
P.O. Box 1090
Great Bend, KS 67530
1-800-877-5187 (toll free)
<https://www.wship.org/Default.asp>

WEST VIRGINIA

QIO

WVMI West Virginia Medical Institute
3001 Chesterfield Avenue
Charleston, WV 25311
1-800-642-8686 (toll free)
1-304-346-9864 (local)
<http://www.qiww.org/Home.aspx>

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)
www.wvship.org

SMO

West Virginia Department of Health & Human Resources (Medicaid)
State Capitol Complex, Building 3, Room 206
Charleston, WV 25305
1-800-642-8589 (toll free)
1-304-558-1700 (local)
<http://www.dhhr.wv.gov/bms/Pages/default.aspx>

SPAP

Not Applicable

WISCONSIN

QIO

MetaStar, Inc.
2909 Landmark Place
Madison, WI 53713
1-800-362-2320 (toll free)
1-608-274-1940 (local)
1-608-274-5008 (fax)
<http://www.metastar.com/web>

SHIP

Wisconsin SHIP (SHIP)
1 West Wilson Street
Madison, WI 53703
1-800-242-1060 (toll free)
1-608-267-3201 (local)
1-888-701-1255 (Spanish)
1-888-701-1251 (TTY)
<http://www.dhs.wisconsin.gov/aging/EBS/ship.htm>

SMO

Wisconsin Department of Health (Medicaid)
1 West Wilson Street
Madison, WI 53703
1-800-362-3002 (toll free)
1-608-221-5720 (local)
711 (TTY)
<http://www.dhs.wisconsin.gov/medicaid/index.htm>

SPAP

Wisconsin SeniorCare
P.O. Box 6710
Madison, WI 53716
1-800-657-2038 (toll free)
<http://www.dhs.wisconsin.gov/seniorcare/>

WYOMING**QIO**

Mountain-Pacific Quality Health Foundation
145 S Durbin, Suite 105
Casper, WY 82601
1-877-810-6248 (toll free)
1-307-472-0507 (local)
1-307-472-1791 (fax)
<http://www.mpqhf.org>

SHIP

Wyoming State Health Insurance Information Program (WSHIIP)
P.O. Box BD
Riverton, WY 82501
1-800-856-4398 (toll free)
1-307-856-6880
www.wyomingseniors.com

SMO

Wyoming Department of Health (Medicaid)
401 Hathaway Building
Cheyenne, WY 82002
1-866-571-0944 (toll free)
1-307-777-7656 (local)
<http://health.wyo.gov>

SPAP

Not Applicable