HUMANA®

2012

Evidence of Coverage

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HumanaChoice℠

H6609-011 (PPO)

Greater Idaho
Select Counties in Idaho

January 1 - December 31, 2012

Evidence of Coverage:

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of HumanaChoice H6609-011 (PPO)

This booklet gives you the details about your Medicare health care and prescription drug coverage from January 1 - December 31, 2012. It explains how to get the health care and prescription drugs you need covered. This is an important legal document. Please keep it in a safe place.

This plan, HumanaChoice H6609-011 (PPO), is offered by Humana Insurance Company. (When this Evidence of Coverage says "we," "us," or "our," it means Humana Insurance Company. When it says "plan" or "our plan," it means HumanaChoice H6609-011 (PPO).)

Our plan is a health plan with a Medicare contract.

This information is available for free in other languages. Please contact our Customer Care number at 1-800-457-4708 for additional information. (TTY users should call: 711). Hours are from 8 a.m. to 8 p.m. seven days a week. Customer Care also has free language interpreter services available for non-English speakers.

No se cobra por recibir esta información en otros idiomas. Para obtener más información, comuníquese con nuestro departamento de Atención al Cliente llamando al 1-800-457-4708. (Los usuarios de TTY deben llamar al: 711). El horario de atención es de 8 a.m. a 8 p.m., los siete días de la semana. Además, el departamento de Atención al Cliente les proporciona servicios gratuitos de intérpretes de otros idiomas a los afiliados que no hablen inglés.

This information is available in a different format, including Braille, large print, and audio tapes. Please call Customer Care at the number listed above if you need plan information in another format.

Benefits, formulary, pharmacy network, premium, deductible, and/or copayments/coinsurance may change on January 1, 2013.

H6609_AEOC_MAPD_PPO_011_2012 File & Use 09042011

2012 Evidence of Coverage

Table of Contents

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

CHAPTER 1. Getting started as a member

SECTION 7 How other insurance works with our plan

SECTION 1 Introduction

Section 1.1 You are enrolled in HumanaChoice H6609-011 (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, HumanaChoice H6609-011 (PPO).

There are different types of Medicare health plans. HumanaChoice H6609-011 (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.

Section 1.2 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 covered 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, HumanaChoice H6609-011 (PPO), is offered by Humana Insurance Company. (When this Evidence of Coverage says "we," "us," or "our," it means Humana Insurance Company. When it says "plan" or "our plan," it means HumanaChoice H6609-011 (PPO).)

The word "coverage" and "covered services" refer to the medical care and services and the prescription drugs available to you as a member of HumanaChoice H6609-011 (PPO).

Section 1.3 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 is your plan's service area?
- What materials will you get from us?
- What is your plan premium and how can you pay it?
- How do you keep the information in your membership record up to date?

Section 1.4 What if you are new to HumanaChoice H6609-011 (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 Customer Care (contact information is on the back cover of this booklet).

Section 1.5 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 HumanaChoice H6609-011 (PPO) covers your care. Other parts of this contract include your enrollment form, the Prescription Drug Guide (Formulary), and any notices you

receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for months in which you are enrolled in HumanaChoice H6609-011 (PPO) between January 1, 2012 and December 31, 2012.

Medicare must approve our plan each year
Medicare (the Centers for Medicare & Medicaid Services) must approve HumanaChoice H6609-011 (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?

Section 2.1 Your eligibility requirements

You are eligible for membership in our plan as long as:
- You live in our geographic service area (Section 2.3 below describes our service area)
- -- and -- you are entitled to Medicare Part A
- -- and -- you are enrolled in Medicare Part B
- -- and -- you do not have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different plan that was terminated.

Section 2.2 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 physicians' services and other outpatient services) and certain items (such as durable medical equipment and supplies).

Section 2.3 Here is the plan service area for HumanaChoice H6609-011 (PPO)

Although Medicare is a federal program, HumanaChoice H6609-011 (PPO) is available only to individuals who live in our plan service area. To remain a member of our plan, you must keep living in this service area. The service area is described below.

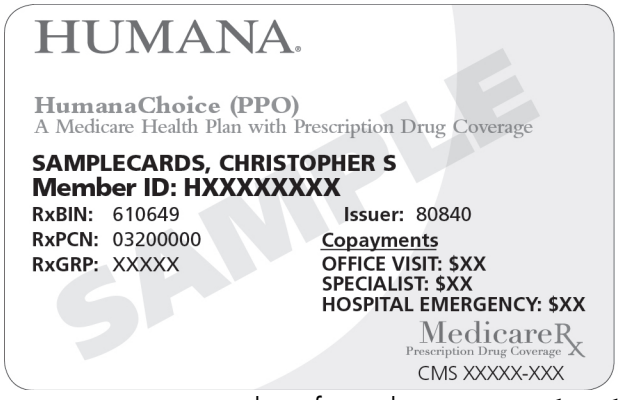
Our service area includes the following county/counties in Idaho: Bannock, Bingham, Bonneville, Jefferson, Kootenai Counties, ID.

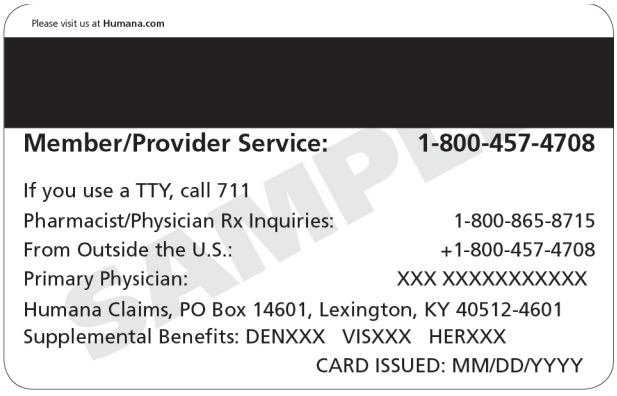
If you plan to move out of the service area, please contact Customer Care. When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

SECTION 3 What other materials will you get from us?

Section 3.1 Your plan membership card - Use it to get all covered care and prescription drugs

While you are a member of our plan, you must use your membership card for our plan whenever you get any services covered by this plan and for prescription drugs you get at network pharmacies. Here's a sample membership card to show you what yours will look like:





As long as you are a member of our plan **you must not use your red, white, and blue Medicare card** to get covered medical services (with the exception of routine clinical research studies and hospice services). Keep your red, white, and blue Medicare card in a safe place in case you need it later.

Here's why this is so important: If you get covered services using your red, white, and blue Medicare card instead of using your HumanaChoice H6609-011 (PPO) membership card while you are a plan member, you may have to pay the full cost yourself.

If your plan membership card is damaged, lost, or stolen, call Customer Care right away and we will send you a new card.

Section 3.2 The Provider Directory: Your guide to all providers and pharmacies 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 network providers and pharmacies.

What are "network providers"?

Network providers are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and 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.

What are "network pharmacies"?

Our Provider 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 Provider 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 Provider Directory, you can get a copy from Customer Care (phone numbers are on the back cover of this booklet). You may ask Customer Care for more information about our network providers, including their qualifications. You can also see the Provider Directory at **Humana.com** or download it from this website. Both Customer Care and the website can give you the most up-to-date information about changes in our network pharmacies.

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

The plan has a Prescription Drug Guide (Formulary). We call it the "Drug Guide" for short. It tells which Part D prescription drugs are covered by HumanaChoice H6609-011 (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 HumanaChoice H6609-011 (PPO) Drug Guide.

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

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

Section 3.4 SmartSummary: Reports with a summary of payments made for your Part D prescription drugs

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

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

SmartSummary is also available upon request. To get a copy, please contact Customer Care.

SECTION 4 Your monthly premium for HumanaChoice H6609-011 (PPO)

Section 4.1 How much is your plan premium?

As a member of our plan, you pay a monthly plan premium. For 2012, the monthly premium for HumanaChoice H6609-011 (PPO) is **$44**. In addition, you must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

In some situations, your plan premium could be less

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

If you are already enrolled and getting help from one of these programs, **the information about premiums in this Evidence of Coverage may not apply to you**. We send you a separate insert called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (LIS Rider), which tells you about your drug coverage. If you do not have this mailing, please call Customer Care and ask for the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (LIS Rider). Phone numbers for Customer Care are on the back cover of this booklet.

In some situations, your plan premium could be more

In some situations, your plan premium could be more than the amount listed above in Section 4.1. These situations are described below.

- If you signed up for extra benefits, also called "optional supplemental benefits", then you pay an additional premium each month for these extra benefits. If you have any questions about your plan premiums, please call Customer Care.
- MyOption[SM] Vision: **$15** additional monthly premium
- MyOption[SM] Plus: **$27** additional monthly premium
- MyOption[SM] Complete: **$28** additional monthly premium
- MyOption[SM] Healthy Back: **$16** additional monthly premium
- MyOption[SM] Platinum Dental: **$29** additional monthly premium
- 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 for your Medicare Part D coverage. If you have to pay an extra amount, the Social Security Administration, 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, you can 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. You may call the Social Security Administration at 1-800-772-1213. TTY users should call 1-800-325-0778.
- 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 have "creditable" prescription drug coverage. ("Creditable" means the drug coverage is at least as good as Medicare's prescription drug coverage.) For these members, the late enrollment penalty is added to the plan's monthly premium. Their premium amount will be the monthly plan premium plus the amount of their late enrollment penalty.
  - 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 10 explains the late enrollment penalty.
  - If you have a late enrollment penalty and do not pay it, you could be disenrolled from the plan.

Many members are required to pay other Medicare premiums

As explained in Section 2 above, in order to be eligible for our plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B. For that reason, 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, in addition to paying the monthly plan premium. You must continue paying your Medicare Part B premium to remain a member of the plan.

- Your copy of Medicare & You 2012 gives information about these premiums in the section called "2012 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 download a copy of Medicare & You 2012 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.

Section 4.2 There are several ways you can pay your plan premium

There are four ways you can pay your plan premium.

Members select a premium payment option choice at the time of enrollment. If you wish to change your premium payment option, you can easily do so by contacting Customer Care, or you can visit our eBilling site at **Humana.com** to set up a payment option for your account.

1. Login to **Humana.com** with your user id and password. If you don't have a user name or password, click on "Register for *My*Humana."
2. Click on the eBilling link under "My Claims & Spending" tab.
3. Once you click on the eBilling link, you'll be able to make a payment. You can also check your account balance and review an invoice summary.

If you decide to change the way you pay your premium, it can take up to three months for your new payment method to take effect. While we are processing your request for a new payment method, you are responsible for making sure that your plan premium is paid on time.

Option 1: You can pay by check

You may decide to pay your monthly plan premium directly to your plan with a check or money order using the coupon book we will provide to you. Checks should not be made out to the plan and sent to the plan. Checks should not be made out to the Centers for Medicare & Medicaid Services or the U.S. Department of Health and Human Services (HHS) and should not be sent to these agencies.

Your premium payment will always be due on the first day of the month.

If you pay by coupon book, you may choose to pay more than one month's premium at a time by sending in as many coupons as you wish to pay. Write your Humana account number on your personal check or money order. Refer to your coupon for your account number. If the payment is for two members, write both Humana account numbers on the check or money order, as well as the amount intended for each to avoid delays in processing. If someone else is paying the monthly premium for you, be sure your name and Humana account number are written on his or her check. Always include the coupon along with your payment. Please call our Customer Care department if you run out of coupons or lose your coupon book, or you can visit our eBilling site at **Humana.com** to set up or change your payment option to Coupon Book.

Option 2: Automatically withdrawn from your checking or savings account, or charged directly to your credit card or debit card

Instead of paying by check, you can have your monthly premium automatically withdrawn from your checking or savings account, or charged directly to your credit card or debit card. Premiums will be automatically withdrawn from your checking

or savings account on the third working day of each month or charged directly to your credit card or debit card monthly. Please call our Customer Care department or visit our eBilling site at **Humana.com** to set up your automatic premium withdrawal or credit or debit card payments.

Options 3 and 4: You can have the plan premium taken out of your monthly Social Security check or Railroad Retiree Board (RRB) benefit

You can have the plan premium taken out of your monthly Social Security or Railroad Retiree Board benefit check. You can contact Customer Care for more information on how to pay your plan premium this way or you can visit our eBilling site at Humana.com to set up your SSA or RRB payment option. We will be happy to help you set this up.

What to do if you are having trouble paying your plan premium

Your plan premium is due in our office by the first day of the month. If we have not received your premium payment by the 15th of the month, we will send you a notice telling you that your plan membership will end if we do not receive your premium within six months.

If you are having trouble paying your premium on time, please contact Customer Care to see if we can direct you to programs that will help with your plan premium. If we end your membership with the plan because you did not pay your premium, and you don't currently have prescription drug coverage then you will not be able to receive Part D coverage until the annual election period. At that time, you may either join a stand-alone prescription drug plan or a health plan that also provides drug coverage. (If you go without "creditable" drug coverage for more than 63 days, you may have to pay a late enrollment penalty when you sign up for a Part D plan.)

If we end your membership because you did not pay your plan premium, you will have coverage under Original Medicare. At the time we end your membership, you may still owe us for premiums you have not paid. We have the right to pursue collection of these premiums. In the future, if you want to enroll again in our plan (or another plan that we offer), you will need to pay the late premiums before you can enroll.

If you think we have wrongfully ended your membership, you have a right to appeal our decision. For information about how to appeal the termination of coverage, 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 4.3 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 September and the change will take effect on January 1.

However, in some cases the part of the premium that you have to pay can change during the year. This happens if you become eligible for the Extra Help program or if you lose your eligibility for the Extra Help program during the year. If a member qualifies for Extra Help with their prescription drug costs, the Extra Help program will pay 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 the Extra Help program in Chapter 2, Section 7.

SECTION 5 Please keep your plan membership record up to date

Section 5.1 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 network 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.

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

If any of this information changes, please let us know by calling Customer Care (phone numbers are on the back cover of this booklet).

Read over the information we send you about any other insurance coverage you have
Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see Section 7 in this chapter.)

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

SECTION 6 We protect the privacy of your personal health information

Section 6.1 We make sure that your health information is protected

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

For more information about how we protect your personal health information, please go to Chapter 8, Section 1.4 of this booklet.

SECTION 7 How other insurance works with our plan

Section 7.1 Which plan pays first when you have other insurance?

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

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

These types of coverage usually pay first for services related to each type:
- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

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

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 cover of this booklet.) 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 HumanaChoice H6609-011 (PPO) contacts

(how to contact us, including how to reach Customer Care at the plan)

How to contact our plan's Customer Care

For assistance with claims, billing, or member card questions, please call or write to HumanaChoice H6609-011 (PPO) Customer Care. We will be happy to help you.

Customer Care	
CALL	1-800-457-4708 Calls to this number are free. (A Customer Care representative will be available to answer your call directly during the annual enrollment period and 60 days after from 8 a.m. until 8 p.m.) However, beginning February 15, 2012, your call may be handled by our automated phone system on Saturdays, Sundays, and some Public Holidays. When leaving a message, simply select the reason for your call from the automated list and a knowledgeable representative will return your call by the end of the next working day. Customer Care also has free language interpreter services available for non-English speakers.
TTY	711 8 a.m. to 8 p.m. seven days a week This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
FAX	1-877-837-7741
WRITE	Humana, P.O. Box 14168, Lexington, KY 40512-4168
WEBSITE	**Humana.com**

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. 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)).

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

Coverage Decisions for Medical Care	
CALL	1-866-737-5113 from 8 a.m. to 5 p.m., after regular weekday business hours call 1-800-457-4708 Calls to this number are free.
TTY	711 8 a.m. to 8 p.m. seven days a week 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

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. 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)).

Appeals for Medical Care	
CALL	1-800-457-4708 8 a.m. to 8 p.m. seven days a week Calls to this number are free.
TTY	711 8 a.m. to 8 p.m. seven days a week This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
FAX	1-800-949-2961 for expedited appeals only.
WRITE	Humana Grievances and Appeals Dept., P.O. Box 14165, Lexington, KY 40512-4165

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.) 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)).

Complaints about Medical Care	
CALL	1-800-457-4708 8 a.m. to 8 p.m. seven days a week Calls to this number are free.
TTY	711 8 a.m. to 8 p.m. seven days a week This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
FAX	1-800-949-2961, for expedited grievances only.
WRITE	Humana Grievances and Appeals Dept., P.O. Box 14165, Lexington, KY 40512-4165

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. 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)).

Coverage Decisions for Part D Prescription Drugs	
CALL	1-800-555-2546, 24 hours a day, seven days a week. Calls to this number are free.
TTY	711 8 a.m. to 8 p.m. seven days a week This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
FAX	1-877-486-2621 for coverage determinations only.
WRITE	Humana Clinical Pharmacy Review, Attn: Medicare Part D Coverage Determinations, P.O. Box 33008, Louisville, KY 40232
WEBSITE	**Humana.com**

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

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your Part D prescription drugs, see Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

Appeals for Part D Prescription Drugs	
CALL	1-800-457-4708 8 a.m. to 8 p.m. seven days a week Calls to this number are free.
TTY	711 8 a.m. to 8 p.m. seven days a week This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
FAX	1-800-949-2961 for expedited appeals only.
WRITE	Humana Grievances and Appeals Dept., P.O. Box 14165, Lexington, KY 40512-4165
WEBSITE	**Humana.com**

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

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your Part D prescription drugs, see Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

Complaints about Part D Prescription Drugs	
CALL	1-800-457-4708 8 a.m. to 8 p.m. seven days a week Calls to this number are free.
TTY	711 8 a.m. to 8 p.m. seven days a week This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
FAX	1-800-949-2961, for expedited grievances only.
WRITE	Humana Grievances and Appeals Dept., P.O. Box 14165, Lexington, KY 40512-4165

Where to send a request asking 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 us to pay our share of a bill you have received for covered 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	1-800-457-4708 8 a.m. to 8 p.m. seven days a week Calls to this number are free.
TTY	711 8 a.m. to 8 p.m. seven days a week This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WRITE	Humana, P.O. Box 14168, Lexington, KY 40512-4168
WEBSITE	**Humana.com**

SECTION 2 Medicare

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

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

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called "CMS"). This agency contracts with Medicare 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. You can also find Medicare contacts in your state by selecting "Help and Support" and then clicking on "Useful 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. 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.

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

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

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 (QIO) for each state.

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

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

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

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

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

Contact information for your state Medicaid Office can be found in "Exhibit A" in the back of this document.

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 income and resources save money each year:

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

To find out more about Medicaid and its programs, contact your state Medicaid office.

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 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 a.m. to 7 p.m., Monday through Friday. TTY users should call 1-800-325-0778; or
- Your State Medicaid Office. (See "Exhibit A" in the back of this document 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 back 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 is available nationwide. Because HumanaChoice H6609-011 (PPO) offers additional gap coverage during the Coverage Gap Stage, your out-of-pocket costs will sometimes be lower than the costs described here. Please go to Chapter 6, Section 6 for more information about your coverage during the Coverage Gap Stage.

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 and vaccine administration fee, if any) 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 SmartSummary will show any discount provided. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the coverage gap.

You also receive some coverage for generic drugs. If you reach the coverage gap, the plan pays **14 percent** of the price for generic drugs and you pay the remaining **86 percent** of the price. The coverage for generic drugs works differently than the **50 percent** discount for brand name drugs. For generic drugs, the amount paid by the plan (**14 percent**) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap. Also, the dispensing fee is included as part of the cost of the drug.

If you have any questions about the availability of discounts for the drugs you are taking or about the Medicare Coverage Gap Discount Program in general, please contact Customer Care (phone numbers are on the back cover of this booklet).

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

If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (other than Extra Help), you still get the **50 percent** discount on covered brand name drugs. The **50 percent** 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 SmartSummary. If the discount doesn't appear on your SmartSummary, you should contact us to make sure that your prescription records are correct and up-to-date. If we don't agree that you are owed a discount, you can appeal. You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP) (telephone numbers are in "Exhibit A" in the back of this 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 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.

These programs provide limited income and medically needy seniors and individuals with disabilities financial help for prescription drugs.

Contact information for your State Pharmaceutical Assistance Programs (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 a.m. to 3:30 p.m., 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 not free.
WEBSITE	http://www.rrb.gov

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

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group, call the employer/union benefits administrator or Customer Care if you have any questions. You can ask about your (or your spouse's) employer or retiree health benefits, premiums, or enrollment period.

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

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

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 covered. 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).

Section 1.1 What are "network 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 licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.
- **"Network providers"** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We 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 network 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.

Section 1.2 Basic rules for getting your medical care covered by the plan

As a Medicare health plan, HumanaChoice H6609-011 (PPO) must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

HumanaChoice H6609-011 (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 network 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

Section 2.1 You may choose a Primary Care Physician (PCP) to provide and oversee your medical care

What is a "PCP" and what does the PCP do for you?

When you become a member of our plan, we encourage you to select a network doctor to be your Primary Care Physician (PCP). Your PCP is a doctor trained to give you basic medical care. Your Provider Directory tells you which doctors can act as your PCP.

You can get your routine or basic care from your PCP. Your PCP can also help you get other services covered by your plan.

This includes:
- X-rays
- Laboratory tests
- Therapies
- Care from specialists
- Hospital admissions
- Follow-up care

Your PCP can check or consult with other network providers about your care and how it's going. Since your PCP can provide and coordinate your medical care, you should have all of your medical records sent to your PCP's office. Chapter 8 tells you how we protect the privacy of your medical records and personal health information.

Referrals are not required from your PCP for covered medical services.

How do you choose your PCP?

When you enroll, you'll receive a Provider Directory to help you select a PCP. The name of the PCP you choose will appear on your enrollment form. You can change your PCP any time.

Changing your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP in our plan. Change requests received by the last working day of the month usually will be effective the first day of the following month. To change your PCP, call Customer Care.

Section 2.2 How to get care from specialists and other network providers

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. 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 network 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 for covered services. Some services require prior authorization from network providers, but prior authorization is not required when you get care from out-of-network providers. However, before getting services from out-of-network providers you may want to confirm with us that the services you are getting are covered by us and are medically necessary. See Chapter 4, Section 2.1 for more information about which services require prior authorization.

If an out-of-network provider sends you a bill that you think we should pay, refer to Chapter 7 (Asking the plan to pay its share of a bill you have received for covered services or drugs) for information on how to ask us to pay that bill for you. We will pay your doctor for our share of the bill and will let you know what, if anything, you must pay. You won't have to pay an out-of-network provider any more than what he or she would have gotten if you had been covered with the Original Medicare Plan. It is best to ask an out-of-network provider to bill us first, but if you have already paid for the covered services, we will reimburse you for our share of the cost. (Please note that we cannot pay a provider who has opted out of the Medicare program. Check with your provider before receiving services to confirm that they have not opted out of Medicare.) If we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost.

What if a network provider leaves our plan?

Sometimes a specialist, clinic, hospital or other network 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.

Section 2.3 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. Our plan will cover services from either in-network or out-of-network providers as long as the services are covered benefits and are medically necessary. However, **if you use an out-of-network provider, your share of the costs for your covered services may be higher**. Here are other important things to know about using out-of-network providers:

- You can get your care from an out-of-network provider, however, that provider must be eligible to participate in Medicare. We cannot pay a provider who is not eligible to participate in Medicare. If you receive care from a provider who is not eligible to participate in Medicare you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.
- You don't need to get a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers you may have to ask for a pre-visit coverage decision to confirm that the services you are getting are covered and are medically necessary. (See Chapter 9, Section 4 for information about asking for coverage decisions.) This is important because:
  - Without a pre-visit coverage decision, if we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. See Chapter 9 (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 covered 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, 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

Section 3.1 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, hospital, or urgent care center. Call for an ambulance if you need it. You do not need to get approval from our plan.
- **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. Call the telephone number on the back of your ID 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 or its territories. 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 out-of-network providers, we will try to arrange for network 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 network providers or out-of-network providers. If you get the care from network providers, your share of the costs will usually be lower than if you get the care from out-of-network providers.

Section 3.2 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, but the plan's network of providers is temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have (for example, a flare-up of a chronic skin condition).

What if you are in the plan's service area when you have an urgent need for care?
In most other 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. However, if the circumstances are unusual or extraordinary, and network providers are temporarily unavailable or inaccessible, we will allow you to get covered services from an out-of-network provider at the lower in-network cost-sharing amount.

What if you are outside the plan's service area when you have an urgent need for care?
When you are outside the service area and cannot get care from a network provider, our plan will cover urgently needed care that you get from any provider at the 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?

Section 4.1 You can ask the plan to pay our share of the cost for your covered 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 us to pay our share of a bill you have received for covered medical services or drugs) for information about what to do.

Section 4.2 If services are not covered by our plan, you must pay the full cost

HumanaChoice H6609-011 (PPO) covers all medical services that are medically necessary, are listed in the plan's Medical Benefits Chart (this chart is in Chapter 4 of this booklet), 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 (coverage decisions, appeals, complaints)) 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 number on the back cover of this booklet 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"?

Section 5.1 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 most of the costs 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 us. 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).

Section 5.2 When you participate in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, you are covered for routine items and services you receive as part of the study, including:
- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure if it 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 Chapter 7 for more information about submitting requests for payment.

When you are part of a clinical research study, **neither Medicare nor our plan will 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"

Section 6.1 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. 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.

Section 6.2 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 (Medical Benefits Chart).

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 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 HumanaChoice H6609-011 (PPO), 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 (phone numbers are on the back cover of this booklet) 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 new 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 new 13 consecutive payments. You will have to make 13 new 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

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 HumanaChoice H6609-011 (PPO). Later in this chapter, you can find information about medical services that are not covered. Also, see exclusions and limitations pertaining to certain mandatory supplemental benefits in the chart in this chapter.

Section 1.1 Types of out-of-pocket costs you may 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.

- A **"copayment"** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)
- **"Coinsurance"** is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)

Some people qualify for state Medicaid programs to help them pay their out-of-pocket costs for Medicare. (These "Medicare Savings Programs" include the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualifying Individual (QI), and Qualified Disabled & Working Individuals (QDWI) programs.) If you are enrolled in one of these programs, you may still have to pay a copayment for the service, depending on the rules in your state.

Section 1.2 What is the most you will pay for Medicare Part A and Part B covered medical services?

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

- Your **in-network maximum out-of-pocket amount** is **$3,400**. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from in-network providers. The amounts you pay for copayments and coinsurance for covered services from in-network providers count toward this in-network maximum out-of-pocket amount. (The amounts you pay for plan premiums, Part D prescription drugs, Additional Benefits (found at the end of the Medical Benefits Chart in Section 2.1 of this chapter), and services from out-of-network providers do not count toward your in-network maximum out-of-pocket amount.)

  If you have paid **$3,400** for covered services from in-network providers, you will not have any out-of-pocket costs for the rest of the year when you see our network providers. However, you must to continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

- Your **combined maximum out-of-pocket amount** is **$4,500**. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from both in-network and out-of-network providers. The amounts you pay for copayments and coinsurance for covered services count toward this combined maximum out-of-pocket amount. (The amounts you pay for your plan premiums, Part D prescription drugs, and Additional Benefits (found at the end of the Medical Benefits Chart in Section 2.1 of this chapter) do not count toward your combined maximum out-of-pocket amount.)

  If you have paid **$4,500** for covered services, you will have **100 percent** coverage and will not have any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party.)

Section 1.3 Our plan does not allow providers to "balance bill" you

As a member of HumanaChoice H6609-011 (PPO), an important protection for you is that, after you meet any deductibles, you only have to pay the plan's cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges such as "balance billing." This protection (that you never pay more than the plan 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.

Here is how this protection works.

- If your cost sharing is a copayment (a set amount of dollars, for example, **$15.00**), then you pay only that amount for any services from a network provider. You will generally have higher copays when you obtain care from out-of-network providers.
- If your cost sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
  - If you obtain covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
  - If you obtain covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
  - If you obtain covered services from an out-of-network provider who does not participate with Medicare, then you pay the coinsurance amount multiplied by the Medicare payment rate for non-participating providers.

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

Section 2.1 Your medical benefits and costs as a member of the plan

The Medical Benefits Chart on the following pages lists the services HumanaChoice H6609-011 (PPO) covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare-covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, and equipment) must be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

- 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 HumanaChoice H6609-011 (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 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
    - Cardiac Implants
    - Sleep Studies
- For benefits where your cost-sharing is a coinsurance percentage, the amount you pay depends on what type of provider you receive the services from:
  - If you receive the covered services from a network provider, you will pay the coinsurance percentage multiplied by the total provider rate in the provider's contract,
  - If you receive the covered services from an out-of-network provider who participates with Medicare, you will pay the coinsurance percentage times the Medicare allowable,
  - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you will pay the coinsurance percentage multiplied by the Original Medicare Limiting charge.
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you as long as you get them from a network provider. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.

Medical Benefits Chart

Services that are covered for you	**What you must pay** when you get these services
Inpatient Care	
Inpatient hospital care You are covered for an unlimited number of medically necessary days. Covered services include: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs	**In Network:** • 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.

Services that are covered for you	**What you must pay** when you get these services
• Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services 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 HumanaChoice H6609-011 (PPO) provides transplant services at a distant location (farther away than the normal community patterns of care) and you chose to obtain transplants at this distant location, 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. • If you are in need of a solid organ or bone marrow/stem cell transplant, please contact our Transplant Department at 1-866-421-5663 for important information about your transplant care. • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you to the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare - Ask!" This fact sheet is available on the Web at http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. • Prior authorization is required for in-network inpatient hospital care. • Prior authorization is required for transplant services.	• **$250** copayment per day, days 1 to 5 for inpatient care in an inpatient hospital **Out of Network:** • 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. • **$275** copayment per day, days 1 to 5 for inpatient care in an inpatient hospital
Inpatient mental health care • Covered services include mental health care services that require a hospital stay. • 190-day lifetime limit for inpatient services in a psychiatric hospital. • The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital. The benefit days used under the Original Medicare program will count toward the 190-day lifetime reserve days when enrolling in a Medicare Advantage plan. • Prior authorization is required for in-network inpatient hospital care.	**In Network:** • 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.

Services that are covered for you	**What you must pay** when you get these services
	• **$250** copayment per day, days 1 to 5 for inpatient mental health care in an inpatient hospital • **$250** copayment per day, days 1 to 5 for inpatient mental health care in an inpatient psychiatric facility **Out of Network:** • 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. • **$275** copayment per day, days 1 to 5 for inpatient mental health care in an inpatient hospital • **$275** copayment per day, days 1 to 5 for inpatient mental health care in an inpatient psychiatric facility

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 care," see Chapter 12 of this booklet. Skilled nursing facilities are sometimes called "SNFs.") You are covered for up to 100 medically necessary days per benefit period. Prior hospital stay is not required. Covered services include: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Regular nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood 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. • 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. **In Network:** • Per benefit period, you pay: • **$0** copayment per day, days 1 to 7 for skilled nursing care in a Skilled Nursing Facility • **$50** copayment per day, days 8 to 20 for skilled nursing care in a Skilled Nursing Facility • **$100** copayment per day, days 21 to 100 for skilled nursing care in a Skilled Nursing Facility **Out of Network:** • Per benefit period, you pay: • **30%** coinsurance per admission for skilled nursing care in a Skilled Nursing Facility.

Services that are covered for you	**What you must pay** when you get these services
Inpatient services covered during a non-covered inpatient stay If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF) stay. Covered services include, but are not limited to: • Physician services • Diagnostic Tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings, • Splints, casts, and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses; and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy	**In Network:** • **$0** copayment for physician services in an inpatient hospital. • **$0** copayment for physician services in a Skilled Nursing Facility. **Out of Network:** • **$0** copayment for physician services in an inpatient hospital. • **$0** copayment for physician services in a Skilled Nursing Facility.
Home health agency care Covered services include: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than eight hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies • Prior authorization is required for in-network home health care.	**In Network:** • **$0** copayment for each home health visit. **Out of Network:** • **40%** coinsurance for each home health visit.

Services that are covered for you	**What you must pay** when you get these services
Hospice care You may receive care from any Medicare-certified hospice program. Your hospice doctor can be a network provider or an out-of-network provider. Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal condition. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care You are still a member of our plan. If you need non-hospice care (care that is not related to your terminal condition), you have two options: • You can obtain your non-hospice care from plan providers. In this case, you only pay plan allowed cost sharing • --or-- You can get your care covered by Original Medicare. In this case, you must pay the cost-sharing amounts under Original Medicare, except for emergency or urgently needed care. However, after payment, you can ask us to pay you back for the difference between the cost sharing in our plan and the cost sharing under Original Medicare. **Note:** If you need non-hospice care (care that is not related to your terminal condition), you should contact us to arrange the services. Getting your non-hospice care through our network providers will lower your share of the costs for the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal condition are paid for by Original Medicare, not HumanaChoice H6609-011 (PPO).

Services that are covered for you	**What you must pay** when you get these services
Outpatient Services	
Physician services, including doctor's office visits Covered services include: • Medically-necessary medical or surgical services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment • Telehealth office visits including consultation, diagnosis and treatment by a specialist • Second opinion by another provider prior to surgery • 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)	**In Network:** • **$10** copayment for each visit in a primary care physician's office. – **$125** copayment for advanced imaging services in a primary care physician's office. • **$25** copayment for each visit in a specialist's office. – **$125** copayment for advanced imaging services in a specialist's office. **Out of Network:** • **30%** coinsurance for each visit in a primary care physician's office. • **30%** coinsurance for each visit in a specialist's office. – **20%** coinsurance for radiation therapy in a specialist's office.

Services that are covered for you	**What you must pay** when you get these services
Outpatient hospital services We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include: • Services in an emergency department or outpatient clinic, including same-day surgery • Laboratory tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain screenings and preventive services • Certain drugs and biologicals that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare - Ask!" This fact sheet is available on the Web at http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. • Prior authorization is required for in-network CT scans, MRA, MRI, nuclear stress test, PET scans, PET registry (NOPR), SPECT, and Molecular Diagnostic/Genetic Testing.	**In Network:** • **$50** copayment for services in an outpatient hospital. – **$175** copayment for advanced imaging services in an outpatient hospital. – **$175** copayment for nuclear medicine services in an outpatient hospital. – **20%** coinsurance for radiation therapy in an outpatient hospital. – **$175** copayment for surgery services in an outpatient hospital. • **$65** copayment for emergency services in an emergency room. • **$25** copayment for clinic services. **Out of Network:** • **30%** coinsurance for services in an outpatient hospital. – **20%** coinsurance for radiation therapy in an outpatient hospital. • **$65** copayment for emergency services in an emergency room. • **30%** coinsurance for clinic services.
Chiropractic services Covered services include: • We cover only manual manipulation of the spine to correct subluxation	**In Network:** • **$10** copayment for Medicare covered chiropractic services in a specialist's office. **Out of Network:** • **30%** coinsurance for Medicare covered chiropractic services in a specialist's office.

Services that are covered for you	**What you must pay** when you get these services
Podiatry services Covered services include: • Treatment of injuries and diseases of the feet (such as hammertoe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs	**In Network:** • **$25** copayment for Medicare covered podiatry services in a specialist's office. **Out of Network:** • **30%** coinsurance for Medicare covered podiatry services in a specialist's office.
Outpatient mental health care Covered services include: • 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.	**In Network:** • **$25** copayment for mental health services in a specialist's office. • **$50** copayment for mental health services in an outpatient hospital. **Out of Network:** • **30%** coinsurance for mental health services in a specialist's office. • **30%** coinsurance for mental health services in an outpatient hospital.
Partial hospitalization services "Partial hospitalization" is a structured program of active psychiatric treatment provided in a hospital outpatient setting or by a community mental health center 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.	**In Network:** • **$50** copayment for each partial hospitalization visit. **Out of Network:** • **30%** coinsurance for each partial hospitalization visit.
Outpatient substance abuse services	**In Network:** • **$25** copayment for substance abuse services in a specialist's office. • **$50** copayment for substance abuse services in an outpatient hospital. • **$50** copayment for each partial hospitalization visit. **Out of Network:** • **30%** coinsurance for substance abuse services in a specialist's office. • **30%** coinsurance for substance abuse services in an outpatient hospital.

Services that are covered for you	**What you must pay** when you get these services
	• **30%** coinsurance for each partial hospitalization visit.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you are having surgery in a hospital, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient." • Prior authorization is required for in-network abdominoplasty, blepharoplasty, breast procedures, otoplasty, elective outpatient cardiac catheterizations, penile implant, rhinoplasty, septoplasty, obesity, and oral surgeries.	**In Network:** • **$175** copayment for surgery services in an outpatient hospital. • **$125** copayment for surgery services in an ambulatory surgical center. • **$0** copayment for surgeon services in an outpatient hospital. • **$0** copayment for surgeon services in an ambulatory surgical center. **Out of Network:** • **30%** coinsurance for surgery services in an outpatient hospital. • **30%** coinsurance for surgery services in an ambulatory surgical center. • **30%** coinsurance for surgeon services in an outpatient hospital. • **30%** coinsurance for surgeon services in an ambulatory surgical center.
Ambulance services • 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) or if authorized by the plan. 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.	**In Network:** • **$150** copayment per date of service for ambulance services regardless of the number of trips. **Out of Network:** • **$150** copayment per date of service for ambulance services regardless of the number of trips.

Services that are covered for you	**What you must pay** when you get these services
Emergency care Emergency care is care that is needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, 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. You are covered for emergency care world-wide.	• You do not pay the emergency room visit costshare if you are admitted to the hospital within 24 hours for the same condition. **In Network:** • **$65** copayment for emergency services in an emergency room. **Out of Network:** • **$65** copayment for emergency services in an emergency room. • If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital in order to pay the in-network cost-sharing amount for the part of your stay after you are stabilized. If you stay at the out-of-network hospital, your stay will be covered but you will pay the out-of- network cost-sharing amount for the part of your stay after you are stabilized.
Urgently needed care Urgently needed care is care provided to treat non-emergency, unforeseen medical illness, injury, or condition, that requires immediate medical care, but the plan's network of providers is temporarily unavailable or inaccessible. You are covered for urgently needed care in the United States and its territories.	**In Network:** • **$10** copayment for urgently needed care in a primary care physician's office. • **$25** copayment for urgently needed care in a specialist's office. • **$25** copayment for urgently needed care in an immediate care facility. **Out of Network:** • **30%** coinsurance for urgently needed care in a primary care physician's office. • **30%** coinsurance for urgently needed care in a specialist's office. • **30%** coinsurance for urgently needed care in an immediate care facility.

Services that are covered for you	**What you must pay** when you get these services
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs). • Prior authorization is required for in-network physical, occupational, and speech therapies.	**In Network:** • **$25** copayment for services in a specialist's office. • **$50** copayment for services in an outpatient hospital. • **$30** copayment for services in a Comprehensive Outpatient Rehabilitation Facility. **Out of Network:** • **30%** coinsurance for services in a specialist's office. • **30%** coinsurance for services in an outpatient hospital. • **30%** coinsurance for services in a Comprehensive Outpatient Rehabilitation Facility.
Cardiac rehabilitation services Comprehensive programs that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's referral. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intensive that cardiac rehabilitation programs.	**In Network:** • **$25** copayment for cardiac rehabilitation in a specialist's office. • **$30** copayment for cardiac rehabilitation in an outpatient hospital. **Out of Network:** • **30%** coinsurance for cardiac rehabilitation in a specialist's office. • **30%** coinsurance for cardiac rehabilitation in an outpatient hospital.
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating their chronic respiratory disease.	**In Network:** • **$25** copayment for respiratory therapy in a specialist's office. • **$50** copayment for respiratory therapy in an outpatient hospital. • **$30** copayment for respiratory therapy in a Comprehensive Outpatient Rehabilitation Facility. **Out of Network:**

Services that are covered for you	What you must pay when you get these services
	• **30%** coinsurance for respiratory therapy in a specialist's office. • **30%** coinsurance for respiratory therapy in an outpatient hospital. • **30%** coinsurance for respiratory therapy in a Comprehensive Outpatient Rehabilitation Facility.
Durable medical equipment and related supplies (For a definition of "durable medical equipment," see Chapter 12 of this booklet.) Covered items include, but are not limited to: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and 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**.	**In Network:** • **20%** coinsurance for durable medical equipment. **Out of Network:** • **40%** coinsurance for durable medical equipment.
Prosthetic devices and related supplies Devices (other than dental) that replace a body part or function. These include, but are not limited to, colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery - see "Vision Care" later in this section for more detail. • Prior authorization is required for in-network prosthetic devices.	**In Network:** • **20%** coinsurance for prosthetics. **Out of Network:** • **40%** coinsurance for prosthetics.
Diabetes self-management, training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and 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). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions	**In Network:** • **$0** copayment for diabetes self monitoring training in a primary care physician's office. • **$0** copayment for diabetes self monitoring training in a specialist's office. • **$0** copayment for diabetes self monitoring training in an outpatient hospital. • **0%** coinsurance for diabetic monitoring supplies from a preferred durable medical equipment provider • **20%** coinsurance for diabetic monitoring supplies from a

Services that are covered for you	**What you must pay** when you get these services
	non-preferred durable medical equipment provider • **0%** coinsurance for diabetic shoes and inserts. • **10%** coinsurance for a 30-day supply of Accu-Check and Onetouch diabetic monitoring supplies from a network retail pharmacy • **20%** coinsurance for a 30-day supply of all other diabetic monitoring supplies from a network retail pharmacy **Out of Network:** • **30%** coinsurance for diabetes self monitoring training in a primary care physician's office. • **30%** coinsurance for diabetes self monitoring training in a specialist's office. • **30%** coinsurance for diabetes self monitoring training in an outpatient hospital. • **40%** coinsurance for diabetic shoes and inserts. • **40%** coinsurance for diabetic monitoring supplies from a durable medical equipment provider • **40%** coinsurance for a 30-day supply of Accu-Check and Onetouch diabetic monitoring supplies from a non-network retail pharmacy. • **40%** coinsurance for a 30-day supply of all other diabetic monitoring supplies from a non-network retail pharmacy.

Services that are covered for you	**What you must pay** when you get these services
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood. Coverage begins with the first pint of blood that you need. Coverage of storage and administration begins with the first pint of blood that you need. • Wound care • Coumadin services (not including drugs) • Other outpatient diagnostic tests • Prior authorization is required for in-network CT scans, MRA, MRI, nuclear stress test, PET scans, PET registry (NOPR), SPECT, Molecular Diagnostic/Genetic Testing, and radiation therapy.	**In Network:** • **$10** copayment for services in a primary care physician's office. – **$125** copayment for advanced imaging services in a primary care physician's office. • **$25** copayment for services in a specialist's office. – **$125** copayment for advanced imaging services in a specialist's office. • **$50** copayment for services in an outpatient hospital. – **$175** copayment for advanced imaging services in an outpatient hospital. – **$175** copayment for nuclear medicine services in an outpatient hospital. – **20%** coinsurance for radiation therapy in an outpatient hospital. • **$50** copayment for services in a freestanding radiological facility. – **$125** copayment for advanced imaging services in a freestanding radiological facility. – **$125** copayment for nuclear medicine services in a freestanding radiological facility. – **20%** coinsurance for radiation therapy in a freestanding radiological facility. • **$0** copayment for laboratory services in a freestanding laboratory facility. • **20%** coinsurance for medical supplies. **Out of Network:** • **30%** coinsurance for services in a primary care physician's office. • **30%** coinsurance for services in a specialist's office. – **20%** coinsurance for radiation therapy in a specialist's office.

Services that are covered for you	**What you must pay** when you get these services
	• **30%** coinsurance for services in an outpatient hospital. – **20%** coinsurance for radiation therapy in an outpatient hospital. • **30%** coinsurance for services in a freestanding radiological facility. – **20%** coinsurance for radiation therapy in a freestanding radiological facility. • **30%** coinsurance for laboratory services in a freestanding laboratory facility. • **40%** coinsurance for medical supplies.
Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and conditions of the eye. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts • 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. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. You are also covered for mandatory supplemental vision benefits. See the complete mandatory supplemental vision benefit description at the end of this chart for details.Please note that the network physicians for your mandatory supplemental vision benefits may be different than the network physicians for the vision care listed above.	**In Network:** • **$25** copayment for vision services in a specialist's office. • **$0** copayment for eyewear following cataract surgery. **Out of Network:** • **30%** coinsurance for vision services in a specialist's office. • **$0** copayment for eyewear following cataract surgery.
Preventive Services	
For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you as long as you get them from a network provider. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.	
Abdominal aortic aneurysm screening 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.	• If you also are treated or monitored for an existing medical condition during the visit when you receive a preventive service, the cost sharing for

Services that are covered for you	**What you must pay** when you get these services
	the care received for the existing medical condition will also apply. **In Network:** • **$0** copayment for an abdominal aortic aneurysm screening in a specialist's office. • **$0** copayment for an abdominal aortic aneurysm screening in a freestanding radiological facility. • **$0** copayment for an abdominal aortic aneurysm screening in an outpatient hospital. **Out of Network:** • **30%** coinsurance for an abdominal aortic aneurysm screening in a specialist's office. • **30%** coinsurance for an abdominal aortic aneurysm screening in a freestanding radiological facility. • **30%** coinsurance for an abdominal aortic aneurysm screening in an outpatient hospital.
Bone mass measurement 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 of the results.	• If you also are treated or monitored for an existing medical condition during the visit when you receive a preventive service, the cost sharing for the care received for the existing medical condition will also apply. **In Network:** • **$0** copayment for bone mass measurement in a specialist's office. • **$0** copayment for bone mass measurement in a freestanding radiological facility. • **$0** copayment for bone mass measurement in an outpatient hospital. **Out of Network:** • **30%** coinsurance for bone mass measurement in a specialist's office.

Services that are covered for you	**What you must pay** when you get these services
	• **30%** coinsurance for bone mass measurement in a freestanding radiological facility. • **30%** coinsurance for bone mass measurement in an outpatient hospital.
Colorectal cancer screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months • Fecal occult blood test, every 12 months For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy	• If you also are treated or monitored for an existing medical condition during the visit when you receive a preventive service, the cost sharing for the care received for the existing medical condition will also apply. **In Network:** • **$0** copayment for colorectal screening exams in a specialist's office. • **$0** copayment for colorectal screening exams in an ambulatory surgical center. • **$0** copayment for colorectal screening exams in an outpatient hospital. **Out of Network:** • **30%** coinsurance for colorectal screening exams in a specialist's office. • **30%** coinsurance for colorectal screening exams in an ambulatory surgical center. • **30%** coinsurance for colorectal screening exams in an outpatient hospital.
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	• If you also are treated or monitored for an existing medical condition during the visit when you receive a preventive service, the cost sharing for the care received for the existing medical condition will also apply. **In Network:** • **$0** copayment for an HIV screening in a primary care physician's office. • **$0** copayment for an HIV screening in a specialist's office.

Services that are covered for you	**What you must pay** when you get these services
	• **$0** copayment for an HIV screening in an outpatient hospital. • **$0** copayment for an HIV screening in a freestanding laboratory facility. **Out of Network:** • **30%** coinsurance for an HIV screening in a primary care physician's office. • **30%** coinsurance for an HIV screening in a specialist's office. • **30%** coinsurance for an HIV screening in an outpatient hospital. • **30%** coinsurance for an HIV screening in a freestanding laboratory facility.
Immunizations Covered Medicare Part B services include: • 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 and they meet Medicare Part B coverage rules We also cover some vaccines under our outpatient prescription drug benefit.	• If you also are treated or monitored for an existing medical condition during the visit when you receive a preventive service, the cost sharing for the care received for the existing medical condition will also apply. **In Network:** • **$0** copayment for immunizations in a primary care physician's office. • **$0** copayment for immunizations in a specialist's office. **Out of Network:** • **$0** copayment for immunizations in a primary care physician's office. • **$0** copayment for immunizations in a specialist's office.
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months	• If you also are treated or monitored for an existing medical condition during the visit when you receive a preventive service, the cost sharing for the care received for the existing medical condition will also apply. **In Network:** • **$0** copayment for mammography services in a specialist's office.

Services that are covered for you	**What you must pay** when you get these services
	• **$0** copayment for mammography services in a freestanding radiological facility. • **$0** copayment for mammography services in an outpatient hospital. **Out of Network:** • **30%** coinsurance for mammography services in a specialist's office. • **30%** coinsurance for mammography services in a freestanding radiological facility. • **30%** coinsurance for mammography services in an outpatient hospital.
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • 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	• If you also are treated or monitored for an existing medical condition during the visit when you receive a preventive service, the cost sharing for the care received for the existing medical condition will also apply. **In Network:** • **$0** copayment for services in a primary care physician's office. • **$0** copayment for services in a specialist's office. **Out of Network:** • **30%** coinsurance for services in a primary care physician's office. • **30%** coinsurance for services in a specialist's office.
Prostate cancer screening exams For men age 50 and older, covered services include the following - once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	• If you also are treated or monitored for an existing medical condition during the visit when you receive a preventive service, the cost sharing for the care received for the existing medical condition will also apply. **In Network:** • **$0** copayment for prostate cancer screening exam in a primary care physician's office.

Services that are covered for you	**What you must pay** when you get these services
	• **$0** copayment for prostate cancer screening exam in a specialist's office. **Out of Network:** • **30%** coinsurance for prostate cancer screening exam in a primary care physician's office. • **30%** coinsurance for prostate cancer screening exam in a specialist's office.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	• If you also are treated or monitored for an existing medical condition during the visit when you receive a preventive service, the cost sharing for the care received for the existing medical condition will also apply. **In Network:** • **$0** copayment for services in a primary care physician's office. • **$0** copayment for services in a specialist's office. • **$0** copayment for services in a freestanding laboratory facility. • **$0** copayment for services in an outpatient hospital. **Out of Network:** • **30%** coinsurance for services in a primary care physician's office. • **30%** coinsurance for services in a specialist's office. • **30%** coinsurance for services in a freestanding laboratory facility. • **30%** coinsurance for services in an outpatient hospital.

Services that are covered for you	**What you must pay** when you get these services
"Welcome to Medicare" physical exam The plan covers a one-time "Welcome to Medicare" physical exam, which 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. **Important:** You must have the physical exam 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" physical exam. You are also covered for one routine physical per year (in the years following your "Welcome to Medicare" physical exam) by your primary care physician to include: • History and examination to identify risk status and guide interventions; • Counseling on diet, exercise, substance abuse, injury prevention; • Height and weight at intervals according to provider's clinical discretion; • Blood pressure every two years after age 21; • Vision screening at provider's discretion; and • Hearing screening at provider's discretion.	• If you also are treated or monitored for an existing medical condition during the visit when you receive a preventive service, the cost sharing for the care received for the existing medical condition will also apply. **In Network:** • There is no coinsurance, copayment, or deductible for the Welcome to Medicare exam. • **$0** copayment for routine physical exams in a primary care physician's office. **Out of Network:** • **30%** coinsurance for the Welcome to Medicare exam in a primary care physician's office • **30%** coinsurance for routine physical exams in a primary care physician's office.
Annual wellness exam 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. **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.	• If you also are treated or monitored for an existing medical condition during the visit when you receive a preventive service, the cost sharing for the care received for the existing medical condition will also apply. **In Network:** • There is no coinsurance, copayment, or deductible for the annual wellness visit. **Out of Network:** • **30%** coinsurance for the annual wellness exam in a primary care physician's office

Services that are covered for you	**What you must pay** when you get these services
Diabetes screening 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.	• If you also are treated or monitored for an existing medical condition during the visit when you receive a preventive service, the cost sharing for the care received for the existing medical condition will also apply. **In Network:** • **$0** copayment for diabetes screening in a primary care physician's office. • **$0** copayment for diabetes screening in a specialist's office. • **$0** copayment for diabetes screening in a freestanding laboratory facility. • **$0** copayment for diabetes screening in an outpatient hospital. **Out of Network:** • **30%** coinsurance for diabetes screening in a primary care physician's office. • **30%** coinsurance for diabetes screening in a specialist's office. • **30%** coinsurance for diabetes screening in a freestanding laboratory facility. • **30%** coinsurance for diabetes screening in an outpatient hospital.
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a transplant when referred by your doctor. 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 calendar year.	• If you also are treated or monitored for an existing medical condition during the visit when you receive a preventive service, the cost sharing for the care received for the existing medical condition will also apply. **In Network:** • **$0** copayment for nutrition therapy in a primary care physician's office. • **$0** copayment for nutrition therapy in a specialist's office. • **$0** copayment for nutrition therapy in an outpatient hospital. **Out of Network:**

Services that are covered for you	**What you must pay** when you get these services
	• **30%** coinsurance for nutrition therapy in a primary care physician's office. • **30%** coinsurance for nutrition therapy in a specialist's office. • **30%** coinsurance for nutrition therapy in an outpatient hospital.
Smoking and tobacco cessation (counseling to stop smoking) 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.	• If you also are treated or monitored for an existing medical condition during the visit when you receive a preventive service, the cost sharing for the care received for the existing medical condition will also apply. • If you haven't been diagnosed with an illness caused or complicated by tobacco use: **In Network:** – **$0** copayment for smoking cessation services in a primary care physician's office. – **$0** copayment for smoking cessation services in a specialist's office. **Out of Network:** – **30%** coinsurance for smoking cessation services in a primary care physician's office. – **30%** coinsurance for smoking cessation services in a specialist's office. • If you have been diagnosed with an illness caused or complicated by tobacco use, or you take a medicine that is affected by tobacco: **In Network:** – **$0** copayment for smoking cessation services in a primary care physician's office. – **$0** copayment for smoking cessation services in a specialist's office. **Out of Network:**

Services that are covered for you	**What you must pay** when you get these services
	– **30%** coinsurance for smoking cessation services in a primary care physician's office. – **30%** coinsurance for smoking cessation services in a specialist's office.

Services that are covered for you	**What you must pay** when you get these services
Other Services	
Services to treat Kidney disease and conditions Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section below, "Medicare Part B prescription drugs."	**In Network:** • **$0** copayment for kidney disease education services in a primary care physician's office. • **$0** copayment for kidney disease education services in a specialist's office. • **20%** coinsurance for renal dialysis services in a dialysis center. • **20%** coinsurance for renal dialysis services in an outpatient hospital. • **20%** coinsurance for dialysis equipment. • **$0** copayment for each home health visit in a member's home. • For inpatient renal dialysis services, please see "Inpatient hospital care" earlier in this section. **Out of Network:** • **30%** coinsurance for kidney disease education services in a primary care physician's office. • **30%** coinsurance for kidney disease education services in a specialist's office. • **20%** coinsurance for renal dialysis services in a dialysis center. • **20%** coinsurance for renal dialysis services in an outpatient hospital. • **40%** coinsurance for dialysis equipment. • **40%** coinsurance for each home health visit in a member's home. • For inpatient renal dialysis services, please see "Inpatient hospital care" earlier in this section.
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:	**In Network:** • **20%** coinsurance for drugs administered in a physician's office.

Services that are covered for you	**What you must pay** when you get these services
• Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center 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 erythropoisis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Prior authorization may be required for in-network Part B drugs. Contact plans for details. Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is listed in Chapter 6.	• **$50** copayment for drugs administered in an outpatient hospital • **20%** coinsurance for chemotherapy drugs in a physician's office. • **20%** coinsurance for chemotherapy drugs in an outpatient hospital. • **20%** coinsurance for Medicare Part B covered drugs from a network retail pharmacy. **Out of Network:** • **30%** coinsurance for drugs administered in a physician's office. • **30%** coinsurance for drugs administered in an outpatient hospital • **20%** coinsurance for chemotherapy drugs in a physician's office. • **20%** coinsurance for chemotherapy drugs in an outpatient hospital. • **20%** coinsurance for Medicare Part B covered drugs from a non-network retail pharmacy.
Additional Benefits	
Hearing services Basic hearing evaluations performed by your provider are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.	
Vision care You are covered for mandatory supplemental vision benefits.	See the complete mandatory supplemental vision benefit description at the end of this chart for details.

Services that are covered for you	**What you must pay** when you get these services
Health and wellness education programs **Humana Active Outlook®** Learn to live a healthier, more fulfilled life with the award-winning **Humana Active Outlook** Program. No matter what your personal health goals are, this free health and wellness education program can help. • Discover new things in **HAO** Magazine, health tracking materials, and **Live It Up!**, a digest with practical tips for those living with chronic conditions • Learn from custom health and wellness information and interactive tools at **HumanaActiveOutlook.com** • Explore new experiences at **Humana Active Outlook** classes and workshops, health education seminars, and community volunteer fairs • Find support for healthy changes with programs from Humana: – Work toward wellness with Humana personal health coaching – Seek help online or telephonically from specially trained senior consultants – Learn to live better with personalized health support for chronic health conditions	**$0** copayment
Humana Fitness Get fit with Humana Fitness from the SilverSneakers® Fitness Program. With this benefit, you are covered for everything included with a membership* at participating fitness centers across the country. Your benefit also includes: • SilverSneakers classes designed exclusively for older adults to improve your body's strength and flexibility • On-site advisors to act as your contact for information and personalized service • Social activities and health education events • Access to www.silversneakers.com, where you can create exercise and nutrition plans, track fitness progress, find health articles and recipes, and more. • SilverSneakers® Steps personalized home fitness program * Any nonstandard fitness center services that usually have an extra fee are not included in your membership.	**$0** copayment
Well Dine Inpatient Meal Program After your overnight stay in the hospital or nursing facility, you are eligible for meals at no extra cost to you. Ten nutritious, precooked frozen meals will be delivered to your door. To arrange for this service, simply call 1-866-96MEALS (1-866-966-3257) after your discharge. You will be asked for your Humana member ID number and other basic information.	**$0** copayment

Services that are covered for you	**What you must pay** when you get these services
OTC Drugs and Supplies You are eligible for a **$10** monthly benefit to be used toward the purchase of over-the-counter (OTC) health and wellness products available through our mail order service. The order form can be obtained by calling Customer Care.	**$0** copayment
QuitNet Stop smoking with QuitNet Comprehensive. Services include: • Web-based or telephonic coaching • The QuitNet, QuitGuide, and QuitTips e-mail support • Over-the-counter nicotine replacement therapy, including patches, gums, and lozenges You can enroll by phone at 1-888-572-4074 or online at www.quitnet.com/humana.	**$0** copayment
HumanaFirst® 24 Hour Nurse Advice Line If you have questions about symptoms you're experiencing but aren't sure if you need to see your doctor, Humana can help. Call HumanaFirst, our advice line for members, 24 hours a day, seven days a week at 1-800-622-9529 (TTY 711). It's staffed by nurses who can help address your immediate health concerns and answer questions about particular medical conditions.	**$0** copayment

Mandatory supplemental vision benefit 775

Definitions

- **Network optical provider** means an optical provider who has entered into a service agreement with us or has been designated by us to provide vision care services.
- **Non-network optical provider** means an optical provider who has not entered into a service agreement with us nor been designated by us to provide vision care services.
- **Optometrist** means a person in the profession of examining the eyes, measuring vision, and treating certain defects by means of corrective lenses or other methods.
- **Ophthalmologist** means a physician specializing in the anatomy, functions, pathology, and treatment of the eye.

Coverage description

You shall receive a routine exam once every 12 months to be used at a network **EyeMed Vision Care Select network optical provider**.

Benefit	**Your Cost**(1)
• Routine eyeglass exam with dilation and refraction as necessary once every 12 months	**$0** copayment

(1) If you choose to use an out of network provider, you will be responsible for costs above the plan approved amount.

- If out-of-network, member is responsible in submitting an EyeMed Vision Care out-of-network claim form with itemized receipt to EyeMed.

Exclusions and limitations
The following services are not covered:
- Contacts fit and follow up
- Any expenses which are covered by workers' compensation, Medicare or any other government program
- Any expenses which you are not legally required to pay
- Any item not contained in the coverage description

Section 2.2 Extra "optional supplemental" benefit you can buy

Our Plan offers some extra benefits that are not covered by Original Medicare and not included in your benefits package as a plan member. These extra benefits are called "**Optional Supplemental Benefits**." If you want these optional supplemental benefits, you must sign up for them and you may have to pay an additional premium for them. The optional supplemental benefits included in this section are subject to the same appeals process as any other benefits.

The extra premium will be combined with your Medicare Advantage plan premium. If you purchase these optional supplemental benefits, this contract will apply to the extra benefits you purchase. If you have questions about these optional supplemental benefits, please call Customer Care at the phone number on the back of your Humana ID card. That number also appears at the end of this section.

Services that are covered for you	What you must pay
Optional Supplemental Benefits	
Extra benefits you can add to customize your Medicare Advantage plan	
Optional supplemental benefits enrollment	
To get optional supplemental benefits, you must choose the benefits in one of two ways: 1. Enroll in optional supplemental benefits (OSB) when you enroll in your Medicare Advantage plan. In most cases, your optional supplemental benefits will begin the same day that your Medicare Advantage begins. 2. Fill out a separate optional supplemental benefits enrollment application at any time. You can also call 1-800-645-7322 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. Eastern time. If you enroll this way, your optional supplemental benefits will begin on the first day of the month after Humana receives your application. Medicare Advantage plans and optional supplemental benefits must be reapproved by the Centers for Medicare & Medicaid Services (CMS) each year. Any changes to your plan will be reported to you in the Annual Notification of Changes letter sent in the fall. Once your plan is approved, if you don't change your Medicare Advantage plan during the annual election period and you're enrolled in an OSB, then your OSB will be renewed automatically at the beginning of the next year, if the OSB is still available.	

Services that are covered for you	What you must pay

Please note the following benefits are purchased separately and are not included in your Medicare Advantage plan premium. These benefits are offered on an annual basis. Any unused benefits will not roll-over to the next coverage year.

For more information about enrollment in optional supplemental benefits, call Customer Care at the phone number on the back of your Humana ID card. That number also appears at the end of this section.

Optional supplemental benefits provider directory

To find a provider for your optional supplemental benefits (OSB), see your OSB Provider Directory. It will be sent to you within 10 days of enrolling in an OSB.

If you need an OSB Provider Directory or want the name of a provider, please call Customer Care. We are **not** responsible for the availability or ongoing participation of any provider. Always make sure your provider is in the network before you get care.

Optional supplemental benefits voluntary disenrollment

If you want to end your optional supplemental benefits coverage, you need to let us know by writing us a letter. Your letter should:

- Tell us clearly that you want to disenroll from the optional supplemental benefits only - not the Medicare Advantage plan
- Include your name, member ID number, and signature
- Send the letter to the Humana disenrollment office. You can get the address by calling Customer Care at the phone number on the back of your Humana ID card. The number is also at the end of this section.

Optional supplemental benefits involuntary disenrollment

If you don't pay the premiums for your optional supplemental benefits, you will lose these benefits involuntarily. We'll tell you in writing that you have 60-days to pay the optional supplemental benefit premium before your coverage ends. At the end of your grace period, we'll end the benefits if you haven't paid everything you owe.

If you end these benefits, or if you lose them because you did not pay what you owe, you can start these benefits again later in the year. Any claims that were previously processed in the original coverage will count towards your benefit maximum. Your benefits won't start over.

Services that are covered for you	What you must pay
Refund of premium	
If you pay more premiums than you owe, we may return these funds if you ask to end the benefits. If we issue a refund for overpayment, it will be mailed within 45 business days of notification. However, if you have an outstanding balance for your Medicare Advantage (MA) plan premium, we will apply your overpayment of optional supplemental benefit premiums to your outstanding balance for your Medicare Advantage plan.	
MyOption℠ Vision	
This optional supplemental benefit (OSB) provides you with extra benefits. You will need to pay extra monthly premiums for these benefits. These benefits include coverage for a routine eye exam for members who wear eyeglasses, as well as frames, lenses, or contact lenses.	
Premium Information	
Monthly premium	**$15** monthly benefit premium.
Coverage Information	
Vision Benefit through EyeMed • The MyOption Vision optional supplemental benefit includes coverage for a routine eye exam for members who wear eyeglasses and standard lenses as follows:	

Services that are covered for you	What you must pay	
Covered Vision Benefits	**EyeMed Network Vision Provider**	**Non-EyeMed Network Vision Provider**
• Routine exam for member who wear eyeglasses with refraction/dilation as necessary	**$0** copay	All costs over plan approved amount
• Frame, lens, and lens options • Contact lenses (in lieu of frames; includes materials only for conventional or disposable)	**$290** benefit	**$290** (combined in and out-of-network)

Frequency

- Examination - Once every 12 months
- Frame & lenses or Contact lenses - Once every 12 months

Choosing a vision provider

You may choose to get vision care from either an EyeMed vision provider or a non-EyeMed vision provider. Choosing an EyeMed vision provider from the OSB Provider Directory will decrease your costs for vision OSB services.

- To find a provider for your optional supplemental benefits, see your OSB Provider Directory. It will be sent to you within 10 days of enrolling in an OSB.
- If you don't receive an OSB Provider Directory or need help finding an EyeMed provider, please call Customer Care. Always make sure your provider is in the network before you get care. It is your responsibility to make sure the provider you see if a participating provider. We are not responsible for the availability or ongoing participation of any provider.

After you have chosen an EyeMed vision provider, just call the provider's office and make an appointment. Be sure to tell the provider's office that you are a Humana Medicare Advantage member with EyeMed benefits. If you have questions about EyeMed vision providers in your area or any other questions about your vision coverage under MyOption Vision, please call EyeMed at the phone number at the end of this document.

If you choose to get vision care from a non-EyeMed vision provider, you will have to pay the full bill at the time of your appointment. Then you will submit an EyeMed out-of-network claim. You must include an itemized statement of charges to EyeMed Vision Care.

Whether you choose an EyeMed vision provider or a non-EyeMed vision provider, you must pay for any copayment and any costs and fees that exceed your covered vision benefit allowance, and any services or materials that are not covered under MyOption Vision.

Services that are covered for you	What you must pay

How to submit a paper claim

If you receive emergency services or other services from a non-network provider, you'll have to pay the full cost of those services and then submit claims documentation for payment consideration. Within 90 days, call EyeMed Customer Service at the phone number at the end of this document to request a claims form and instructions on submitting your claim.

General provisions

EyeMed is an independent provider. Humana's obligations are limited to payment for services described in this document.

Limitations and exclusions

The MyOption Vision optional supplemental benefit does NOT include coverage for and is not limited to the following:

1. Contact lens fit and follow-up.
2. More than one frame, lens, or lens options benefit transaction per calendar year (optional supplemental benefit has no rollover feature).
3. Any expenses incurred while you qualify for any workers' compensation or occupational disease act or law, whether or not you applied for coverage.
4. Materials or services that are not specifically covered by MyOption Vision.
5. Services that are:
   a. free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
   b. furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
   c. furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
6. Any loss caused or contributed by: War or any act of war, whether declared or not; any act of international armed conflict; or any conflict involving armed forces of any international authority.
7. Any expense arising from the completion of forms.
8. Your failure to keep an appointment.
9. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
10. Prescription drugs or pre-medications, whether dispensed or prescribed.
11. Any service not specifically listed in your optional supplemental benefit.
12. Any service that we determine is not a visual necessity; does not offer a favorable prognosis; does not have uniform professional endorsement; or is deemed to be experimental or investigational in nature.
13. Orthoptic or vision training.
14. Subnormal vision aids and associated testing.
15. Aniseikonic lenses.
16. Any service we consider cosmetic.

Services that are covered for you	What you must pay

Limitations and exclusions

17. Any expense incurred before your effective date or after the date your coverage under this optional supplemental benefit terminates.
18. Services provided by someone who ordinarily lives in your home or who is a family member.
19. Charges exceeding the allowance for the service.
20. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
21. Plano lenses.
22. Medical or surgical treatment of eye, eyes, or supporting structures.
23. Replacement of lenses or frames furnished under this optional supplemental benefit which are lost or broken, unless otherwise available under the optional supplemental benefit.
24. Any examination or material required by an employer as a condition of employment or safety eyewear.
25. Non-prescription sunglasses.
26. Two pair of glasses in lieu of bifocals.
27. Services or materials provided by any other group benefit plans providing vision care.
28. Certain name brands when manufacturer imposes no discount.
29. Corrective vision treatment of an experimental nature.
30. Solutions and/or cleaning products for glasses or contact lenses.
31. Pathological treatment.
32. Non-prescription items.
33. Costs associated with securing materials.
34. Pre- and post-operative services.
35. Orthokeratology.
36. Routine maintenance of materials.
37. Refitting or change in lens design after initial fitting.
38. Artistically painted lenses.
39. Standard and premium progressive lenses.

Questions?

To request an optional supplemental benefit application, call Humana Customer Care at 1-800-457-4708

For TTY, call 711 Monday - Friday, 8 a.m. - 8 p.m.

For information on vision benefits, call EyeMed Customer Service 1-888-289-0595 Monday - Saturday, 8 a.m. - 11 p.m. Eastern time Sunday, 11 a.m. - 8 p.m. Eastern time

For TTY, call 711

Visit **Humana.com**

Services that are covered for you	What you must pay
MyOption℠ Plus	
This optional supplemental benefit provides you with extra benefits. You will need to pay extra monthly premiums for these benefits. These benefits include both dental and vision. This document will explain all the details of your dental benefits, and then it will cover your vision benefits.	
Premium Information	
Monthly premium	**$27** monthly benefit premium.
Coverage Information	
General Information • Individual Annual Deductible - annual deductible does not apply to preventive and diagnostic services • Maximum plan benefit - combined for both in-network and out-of-network services - of **$1,000** per person per calendar year on dental coverage	**$50** annual deductible on dental coverage.
Dental benefit	
With this optional supplemental benefit, you're covered for certain diagnostic and preventive services - including bitewing X-rays, routine cleanings, and checkups - when you see a network dentist. You can choose a non-network dentist for covered dental services. When you receive your covered dental services from a non-network dentist, the optional supplemental benefit pays a reduced amount based on the negotiated in-network fee schedule in that area. You will need to pay all fees above this amount.	

Services that are covered for you	What you must pay	
Covered Dental Services - Total Annual Benefit (Medicare Advantage Plan and OSB)	**Network Dentist***	**Non-Network Dentist****
Preventive and Diagnostic Dental Services • Oral Examinations - up to two per calendar year • Bitewing X-rays - one series of films per calendar year • Dental Prophylaxis (Cleanings) - up to two per calendar year	**0%**	**30%**
Basic Dental Services (Minor Restorative) • Amalgam Restorations (Fillings) and Composite Resin Restorations (Fillings, Covered on front teeth only) - Up to two from this group per calendar year • Extractions - up to two per calendar year • Crown or Bridge Re-cement - one per calendar year • Emergency Treatment for Pain - up to two per calendar year	**50%**	**55%**

*Network dentists have agreed to provide services at contracted fees (the in-network fee schedules, or INFS). If you visit a participating network dentist, you won't receive a bill for charges more than their share of the negotiated fee schedule. You will still be charged a copayment.

**Non-network dentists have not agreed to provide services at contracted fees. If you see an out-of-network dentist, your copayment may be higher. You will need to pay more because out-of-network dentists charge higher fees than network dentists. Your benefit covers the same amount for network dentists and non-network dentists. If you choose a non-network dentist, you have to pay for the higher fees. Members are fully responsible for the difference between the average INFS and the dentists' charged fees when visiting an out-of-network dentist.

General benefit payments

The optional supplemental benefit helps you pay for covered dental services, as shown in the Coverage Information section. Covered dental services are subject to the conditions, limitations, exclusions, and maximums of this optional supplemental benefit.

After you receive a dental service, we will check to see if it is a covered dental service. If we determine it is a covered dental service, we will pay benefits as follows:

1. We'll determine the total covered expense.
2. We'll review the covered expense against any maximum benefits that may apply.
3. We'll check to see if you have met your deductible. If you haven't, we'll subtract any amount needed to meet the deductible.
4. We'll pay the remaining eligible covered expense to you or your dentist, based on your coinsurance for that covered service.

Services that are covered for you	What you must pay

Alternate services

If there are two or more services that can fix a dental condition, Humana will decide how to pay your benefits using the covered expenses for the least expensive covered service that produces a professionally satisfactory result, as determined by us. We will pay up to the reimbursement limit for the least expensive covered service and subject to any deductible, coinsurance, and maximum benefit. You must pay the excess amount.

If you or your dentist choose a treatment that costs more than the one we recommend, Humana's payment will be based on the cost of the less expensive treatment. You will be responsible for the rest of the bill.

Pretreatment plan

We suggest that if dental care you need is expected to exceed **$300**, you or your dentist send a dental treatment plan for us to review before your treatment. The dental treatment plan should include:

1. A list of services you will receive. Your dentist should use the American Dental Association nomenclature and codes; Your dentist's written description of the proposed treatment;
2. Supporting pretreatment X-rays showing your dental needs;
3. Itemized cost of the proposed treatment; and
4. Any other appropriate diagnostic materials that we may request.

An estimate for services is not a guarantee of what we will pay. It tells you and your dentist in advance about the benefits payable for the covered expenses in the treatment plan. We will notify you and your dentist of the benefits payable based on the submitted treatment plan.

An estimate for services is not necessary for emergency care.

Process and timing

An estimate for services is valid for 90 days after the date we notify you and your dentist of the benefits payable for the proposed treatment plan. This is subject to your eligibility of coverage. If treatment won't begin for more than 90 days after the date we notify you and your dentist, we recommend that you submit a new treatment plan.

Services that are covered for you	What you must pay

General provisions

Dentists are independent providers. Humana's obligations are limited to payment for services described in this document.

Dental records. We have access to dental and treatment records of members. We use this information for determination of benefits, processing claims, utilization review, quality assurance, financial audit, or for any other purpose reasonably related to covered dental services. Each member should fill out and send us such additional consents, releases, and other documents we may ask for in order to determine or provide benefits. If we don't get all of the information we need from you and your dentist, we can decide not to pay benefits for your treatment.

Dental Limitations and Exclusions

This MyOption Plus optional supplemental benefit does NOT include coverage for and is not limited to the following:

1. Any expenses incurred while you qualify for any workers' compensation or occupational disease act or law, whether or not you applied for coverage.
2. Services that are:
   a. Free or that you wouldn't be required to pay for if you didn't have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law
   b. Furnished by, or payable under, any plan or law through any government or any political subdivision - this does not include Medicare or Medicaid
   c. Or furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by: war or any act of war, whether declared or not; any act of international armed conflict; or any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment with the dentist.
6. Any service we consider cosmetic dentistry unless it is necessary as a result of an accidental injury sustained while you're covered under this policy. We consider the following cosmetic dentistry procedures:
   a. Facings on crowns or pontics - the portion of a fixed bridge between the abutments - posterior to the second bicuspid
   b. Any service to correct congenital malformation
   c. Any service performed primarily to improve appearance; or characterization and personalization of prosthetic devices
7. Charges for: any type of implant and all related services, including crowns or the prosthetic device attached to it; precision or semi-precision attachments; overdentures and any endodontic treatment associated with overdentures; other customized attachments.
8. Any service related to:

Services that are covered for you	What you must pay
Dental Limitations and Exclusions	

a. Altering vertical dimension of teeth
b. Restoration or maintenance of occlusion
c. Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth
d. Replacing tooth structures lost as a result of abrasion, attrition, erosion, or abfraction
e. Bite registration or bite analysis

9. Infection control, including but not limited to sterilization techniques.
10. Fees for treatment performed by someone other than a dentist except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards.
11. Any hospital, surgical, or treatment facility, or for services of an anesthesiologist or anesthetist.
12. Prescription drugs or pre-medications, whether dispensed or prescribed.
13. Any service not specifically listed in the Coverage Information.
14. Any service that we determine: Is not a dental necessity; does not offer a favorable prognosis; does not have uniform professional endorsement; or is deemed to be experimental or investigational in nature.
15. Orthodontic services.
16. Any expense incurred before your effective date or after the date your coverage under this optional supplemental benefit terminates.
17. Services provided by someone who ordinarily lives in your home or who is a family member.
18. Charges exceeding the reimbursement limit for the service.
19. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, temporary dental services, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate service. These services are considered an integral part of the entire dental service.
21. Repair and replacement of orthodontic appliances.
22. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder, or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
23. Extractions, except for extractions of erupted tooth or exposed root (includes routine removal of tooth structure, minor smoothing of socket bone, and closure, as necessary), or surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone of section of tooth.

Services that are covered for you	What you must pay
Excess coverage	
We will not pay benefits for any accidental injury if other insurance will provide payments or expense coverage, regardless of whether the other coverage is described as primary, excess, or contingent. If your claim against another insurer is denied or partially paid, we will process your claim according to the terms and conditions of this certificate. If we make a payment, you agree to assign to us any right you have against the other insurer for dental expenses we pay. Payments made by the other insurer will be credited toward any applicable coinsurance or calendar year deductibles. It's your responsibility to understand your dental coverage, including its limitations and exclusions. To be covered, all dental services must be received from a licensed dentist who deems the service necessary and must be approved by the plan. Remember, the greatest savings on covered services are through OSB network dentists. The dentist you choose may ask you to sign an informed consent document detailing the risks, covered dental services, and options to all recommended treatments. You should always ask the dentist for a treatment plan detailing the services to be performed and the associated costs prior to having work performed.	
Coverage Information	
Vision Benefit through EyeMed • The MyOption Plus optional supplemental benefit includes coverage for a routine eye exam for members who wear eyeglasses, standard lenses, and frames as follows:	

Services that are covered for you	What you must pay	
Covered Vision Benefits	**EyeMed Network Vision Provider**	**Non-EyeMed Network Vision Provider**
• Routine exam for member who wear eyeglasses with refraction/dilation as necessary	**$0** copay	All costs over plan approved amount
• Frame, lens, and lens options • Contact lenses (in lieu of frames; includes materials only for conventional or disposable)	**$290** benefit	**$290** (combined in and out-of-network)

Frequency

- Examination - Once every 12 months
- Frame & lenses or Contact lenses - Once every 12 months

Choosing a vision provider

You may choose to get vision care from either an EyeMed vision provider or a non-EyeMed vision provider. Choosing an EyeMed vision provider from the OSB Provider Directory will decrease your costs for vision OSB services.

- To find a provider for your optional supplemental benefits, see your OSB Provider Directory. It will be sent to you within 10 days of enrolling in an OSB.
- If you don't receive an OSB Provider Directory or need help finding an EyeMed provider, please call Customer Care. Always make sure your provider is in the network before you get care. It is your responsibility to make sure the provider you see if a participating provider. We are not responsible for the availability or ongoing participation of any provider.

After you have chosen an EyeMed vision provider, just call the provider's office and make an appointment. Be sure to tell the provider's office that you are a Humana Medicare Advantage member with EyeMed benefits. If you have questions about EyeMed vision providers in your area or any other questions about your vision coverage under MyOption Plus, please call EyeMed at the phone number at the end of this document.

If you choose to get vision care from a non-EyeMed vision provider, you will have to pay the full bill at the time of your appointment. Then you will submit an EyeMed out-of-network claim. You must include an itemized statement of charges to EyeMed Vision Care.

Whether you choose an EyeMed vision provider or a non-EyeMed vision provider, you must pay for any copayment and any costs and fees that exceed your covered vision benefit allowance, and any services or materials that are not covered under MyOption Plus.

Services that are covered for you	What you must pay

How to submit a paper claim

If you receive emergency services or other services from a non-network provider, you'll have to pay the full cost of those services and then submit claims documentation for payment consideration. Within 90 days, call EyeMed Customer Service at the phone number at the end of this document to request a claims form and instructions on submitting your claim.

General provisions

EyeMed is an independent provider. Humana's obligations are limited to payment for services described in this document.

Vision Limitations and Exclusions

The MyOption Plus optional supplemental benefit does NOT include coverage for and is not limited to the following:

1. Contact lens fit and follow-up.
2. More than one frame, lens, or lens options benefit transaction per calendar year (optional supplemental benefit has no rollover feature).
3. Any expenses incurred while you qualify for any workers' compensation or occupational disease act or law, whether or not you applied for coverage.
4. Materials or services that are not specifically covered by MyOption Vision.
5. Services that are:
   a. free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
   b. furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
   c. furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
6. Any loss caused or contributed by: War or any act of war, whether declared or not; any act of international armed conflict; or any conflict involving armed forces of any international authority.
7. Any expense arising from the completion of forms.
8. Your failure to keep an appointment.
9. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
10. Prescription drugs or pre-medications, whether dispensed or prescribed.
11. Any service not specifically listed in your optional supplemental benefit.
12. Any service that we determine is not a visual necessity; does not offer a favorable prognosis; does not have uniform professional endorsement; or is deemed to be experimental or investigational in nature.
13. Orthoptic or vision training.
14. Subnormal vision aids and associated testing.
15. Aniseikonic lenses.
16. Any service we consider cosmetic.

Services that are covered for you	What you must pay
Vision Limitations and Exclusions	
17. Any expense incurred before your effective date or after the date your coverage under this optional supplemental benefit terminates. 18. Services provided by someone who ordinarily lives in your home or who is a family member. 19. Charges exceeding the allowance for the service. 20. Treatment resulting from any intentionally self-inflicted injury or bodily illness. 21. Plano lenses. 22. Medical or surgical treatment of eye, eyes, or supporting structures. 23. Replacement of lenses or frames furnished under this optional supplemental benefit which are lost or broken, unless otherwise available under the optional supplemental benefit. 24. Any examination or material required by an employer as a condition of employment or safety eyewear. 25. Non-prescription sunglasses. 26. Two pair of glasses in lieu of bifocals. 27. Services or materials provided by any other group benefit plans providing vision care. 28. Certain name brands when manufacturer imposes no discount. 29. Corrective vision treatment of an experimental nature. 30. Solutions and/or cleaning products for glasses or contact lenses. 31. Pathological treatment. 32. Non-prescription items. 33. Costs associated with securing materials. 34. Pre- and post-operative services. 35. Orthokeratology. 36. Routine maintenance of materials. 37. Refitting or change in lens design after initial fitting. 38. Artistically painted lenses. 39. Standard and premium progressive lenses.	

Services that are covered for you	What you must pay

Questions?

To request an optional supplemental benefit application, call Humana Customer Care at 1-800-457-4708

For TTY, call 711 Monday - Friday, 8 a.m. - 8 p.m.

For information on **DENTAL** benefits, call HumanaDental Customer Service at 1-800-669-6614

For TTY, call 1-800-325-2025 Monday - Friday, 7 a.m. - 8 p.m. Central time

For information on **VISION** benefits, call EyeMed Customer Service at 1-888-289-0595 Monday - Saturday, 8 a.m. - 11 p.m. Eastern time Sunday, 11 a.m. - 8 p.m. Eastern time

For TTY, call 711

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MyOption℠ Complete

This optional supplemental benefit provides you with extra benefits. You will need to pay extra monthly premiums for these benefits. These benefits include coverage for many preventive, basic, and major dental services, routine eye exam for members who wear eyeglasses, as well as frames, lenses, or contact lenses and hearing aids.

Premium Information

Monthly premium	**$28** monthly benefit premium.

Coverage Information

General Information

- Dental maximum plan benefit - combined for both in-network and out-of-network services - of **$1,500** per person per calendar year
- Hearing maximum plan benefit - combined for both in-network and out-of-network services - of **$1,000** per person per calendar year

Dental benefit

With this optional supplemental benefit, you're covered for certain diagnostic and preventive services - including bitewing X-rays, routine cleanings, and checkups - when you see a network dentist. You can to see a non-network dentist for covered dental services. When you receive your covered dental services from a non-network dentist, the optional supplemental benefit pays a reduced amount based on the negotiated in-network fee schedule in that area. You will need to pay all fees above this amount.

Services that are covered for you	What you must pay	
Covered Dental Services - Total Annual Benefit (Medicare Advantage Plan and OSB)	**Network Dentist***	**Non-Network Dentist****
Preventive and Diagnostic Dental Services • Oral Examinations - two procedure codes from this group per calendar year • Bitewing X-rays - one procedure code from this group per calendar year • Dental Prophylaxis (Cleanings) - up to two per calendar year • Oral Cancer Screening - one per calendar year • Emergency Exam - two per calendar year	**0%**	**50%**
Basic Dental Services (Minor Restorative) • Amalgam Restorations (Fillings) and Composite Resin Restorations (Fillings, Covered on front teeth only) - one procedure code from this group per calendar year	**0%**	**50%**
• Extractions - two procedure codes from this group per calendar year • Re-cement of Crown or Bridge - one procedure from this group per calendar year • Emergency Treatment for Pain - up to two per calendar year	**50%**	**55%**
Major Dental Services (Endodontics, Periodontics, and Oral Surgery) • Periodontal Scaling and Root Planning - one procedure per quadrant every three years • Anesthesia - nitrous oxide as needed with covered codes	**70%**	**75%**
*Network dentists have agreed to provide services at contracted fees (the in-network fee schedules, or INFS). If you visit a participating network dentist, you won't receive a bill for charges more than their share of the negotiated fee schedule. You will still be charged a copayment. **Non-network dentists have not agreed to provide services at contracted fees. If you see an out-of-network dentist, your copayment may be higher. You will need to pay more because out-of-network dentists charge higher fees than network dentists. Your benefit covers the same amount for network dentists and non-network dentists. If you choose a non-network dentist, you have to pay for the higher fees. Members are fully responsible for the difference between the average INFS and the dentists' charged fees when visiting an out-of-network dentist.		

Services that are covered for you	What you must pay

General benefit payments

The optional supplemental benefit helps you pay for covered dental services, as shown in the Coverage Information section. Covered dental services are subject to the conditions, limitations, exclusions, and maximums of this optional supplemental benefit.

After you receive a dental service, we will check to see if it is a covered dental service. If we determine it is a covered dental service, we will pay benefits as follows:

1. We'll determine the total covered expense.
2. We'll review the covered expense against any maximum benefits that may apply.
3. We'll check to see if you have met your deductible. If you haven't, we'll subtract any amount needed to meet the deductible.
4. We'll pay the remaining eligible covered expense to you or your dentist, based on your coinsurance for that covered service.

Alternate services

If there are two or more services that can fix a dental condition, Humana will decide how to pay your benefits using the covered expenses for the least expensive covered service that produces a professionally satisfactory result, as determined by us. We will pay up to the reimbursement limit for the least expensive covered service and subject to any deductible, coinsurance, and maximum benefit. You must pay the excess amount.

If you or your dentist choose a treatment that costs more than the one we recommend, Humana's payment will be based on the cost of the less expensive treatment. You will be responsible for the rest of the bill.

Pretreatment plan

We suggest that if dental care you need is expected to exceed **$300**, you or your dentist send a dental treatment plan for us to review before your treatment. The dental treatment plan should include:

1. A list of services you will receive. Your dentist should use the American Dental Association nomenclature and codes; Your dentist's written description of the proposed treatment;
2. Supporting pretreatment X-rays showing your dental needs;
3. Itemized cost of the proposed treatment; and
4. Any other appropriate diagnostic materials that we may request.

An estimate for services is not a guarantee of what we will pay. It tells you and your dentist in advance about the benefits payable for the covered expenses in the treatment plan. We will notify you and your dentist of the benefits payable based on the submitted treatment plan.

An estimate for services is not necessary for emergency care.

Services that are covered for you	What you must pay

Process and timing

An estimate for services is valid for 90 days after the date we notify you and your dentist of the benefits payable for the proposed treatment plan. This is subject to your eligibility of coverage. If treatment won't begin for more than 90 days after the date we notify you and your dentist, we recommend that you submit a new treatment plan.

General provisions

Dentists, EyeMed and TruHearing are independent providers. Humana's obligations are limited to payment for services described in this document.

Dental records. We have access to dental and treatment records of members. We use this information for determination of benefits, processing claims, utilization review, quality assurance, financial audit, or for any other purpose reasonably related to covered dental services. Each member should fill out and send us such additional consents, releases, and other documents we may ask for in order to determine or provide benefits. If we don't get all of the information we need from you and your dentist, we can decide not to pay benefits for your treatment.

Excess coverage

We will not pay benefits for any accidental injury if other insurance will provide payments or expense coverage, regardless of whether the other coverage is described as primary, excess, or contingent. If your claim against another insurer is denied or partially paid, we will process your claim according to the terms and conditions of this certificate. If we make a payment, you agree to assign to us any right you have against the other insurer for dental expenses we pay. Payments made by the other insurer will be credited toward any applicable coinsurance or calendar year deductibles.

It's your responsibility to understand your dental coverage, including its limitations and exclusions. To be covered, all dental services must be received from a licensed dentist who deems the service necessary and must be approved by the plan. Remember, the greatest savings on covered services are through OSB network dentists. The dentist you choose may ask you to sign an informed consent document detailing the risks, covered dental services, and options to all recommended treatments. You should always ask the dentist for a treatment plan detailing the services to be performed and the associated costs prior to having work performed.

Services that are covered for you	What you must pay
Vision benefit	
Vision Benefit through EyeMed The MyOption Complete optional supplemental benefit includes coverage for a routine eye exam for members who wear eyeglasses and standard lenses as follows:	

Services that are covered for you	What you must pay	
Vision Benefits	**EyeMed Network Vision Provider**	**Non-EyeMed Network Vision Provider**
• Routine exam for members who wear eyeglasses with refraction/dilation as necessary- once every 12 months	**$0** copay	All costs over plan approved amount
• Frames and lens options • Contact lenses (in lieu of frames; includes material only for conventional or disposable) - once every 12 months	**$150** benefit	**$150** (combined in and out-of-network)
• Laser vision correction	**15%** off retail price or **5%** off promo price	N/A

Choosing a vision provider

You may choose to get vision care from either an EyeMed vision provider or a non-EyeMed vision provider. Choosing an EyeMed vision provider from the OSB Provider Directory will decrease your costs for vision OSB services.

- To find a provider for your optional supplemental benefits, see your OSB Provider Directory. It will be sent to you within 10 days of enrolling in an OSB.
- If you don't receive an OSB Provider Directory or need help finding an EyeMed provider, please call Customer Care. Always make sure your provider is in the network before you get care. It is your responsibility to make sure the provider you see if a participating provider. We are not responsible for the availability or ongoing participation of any provider.

After you have chosen an EyeMed vision provider, just call the provider's office and make an appointment. Be sure to tell the provider's office that you are a Humana Medicare Advantage member with EyeMed benefits. If you have questions about EyeMed vision providers in your area or any other questions about your vision coverage under MyOption Complete, please call EyeMed at the phone number at the end of this document.

If you choose to get vision care from a non-EyeMed vision provider, you will have to pay the full bill at the time of your appointment. Then you will submit an EyeMed out-of-network claim. You must include an itemized statement of charges to EyeMed Vision Care.

Whether you choose an EyeMed vision provider or a non-EyeMed vision provider, you must pay for any copayment and any costs and fees that exceed your covered vision benefit allowance, and any services or materials that are not covered under MyOption Complete.

Services that are covered for you	What you must pay
Hearing benefit	
With the MyOption Complete optional supplemental benefit, you're covered for a routine hearing exam and hearing aids as follows:	
Hearing Benefits	
• Routine hearing exam - once every 12 months • **$1,000** allowance for hearing aids - one time allowance per calendar year (one or both ears) • Hearing aid fitting evaluation - authorization rules may apply	**0%**
Choosing a hearing provider	
You may choose to receive covered hearing benefits from a TruHearing hearing provider, a HearUSA hearing provider, or a non-participating hearing provider. To find a TruHearing or HearUSA hearing provider and to schedule your appointment, you can call one of our hearing partners: TruHearing: **1-888-403-3937** (TTY: **1-800-975-2674**), Monday through Friday, 7 a.m. to 7 p.m. Mountain time. HearUSA: **1-800-442-8231** (TTY: **711**), Monday through Friday, 8 a.m. to 8:30 p.m. Eastern time. If you have questions about your hearing coverage or billing under MyOption Complete, please call Customer Care at the phone number on the back of your Humana ID card and at the end of this document. If you choose to get your hearing care from a non-participating hearing provider, you will have to pay the full bill at the time of your appointment. Then you will submit an out-of-network claim form to Humana. You must include an itemized statement of charges with your claim form. If you need a claim form, call Customer Care at the phone number on the back of your Humana ID card and at the end of this document. Whether you choose a participating hearing provider or a non-participating hearing provider, you must pay any copayment and any costs that are not covered under MyOption Complete.	
Limitations and exclusions	
This MyOption Complete optional supplemental benefit does NOT include coverage for and is not limited to the following: <u>Dental benefit limitations and exclusions:</u> 1. Any expenses incurred while you qualify for any workers' compensation or occupational disease act or law, whether or not you applied for coverage. 2. Services that are:	

Services that are covered for you	What you must pay
Limitations and exclusions	

a. Free or that you wouldn't be required to pay for if you didn't have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law
b. Furnished by, or payable under, any plan or law through any government or any political subdivision - this does not include Medicare or Medicaid
c. Or furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.

3. Any loss caused or contributed by: war or any act of war, whether declared or not; any act of international armed conflict; or any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment with the dentist.
6. Any service we consider cosmetic dentistry unless it is necessary as a result of an accidental injury sustained while you're covered under this policy. We consider the following cosmetic dentistry procedures:
   a. Facings on crowns or pontics - the portion of a fixed bridge between the abutments - posterior to the second bicuspid
   b. Any service to correct congenital malformation
   c. Any service performed primarily to improve appearance; or characterization and personalization of prosthetic devices
7. Charges for: any type of implant and all related services, including crowns or the prosthetic device attached to it; precision or semi-precision attachments; overdentures and any endodontic treatment associated with overdentures; other customized attachments.
8. Any service related to:
   a. Altering vertical dimension of teeth
   b. Restoration or maintenance of occlusion
   c. Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth
   d. Replacing tooth structures lost as a result of abrasion, attrition, erosion, or abfraction
   e. Bite registration or bite analysis
9. Infection control, including but not limited to sterilization techniques.
10. Fees for treatment performed by someone other than a dentist except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards.
11. Any hospital, surgical, or treatment facility, or for services of an anesthesiologist or anesthetist.
12. Prescription drugs or pre-medications, whether dispensed or prescribed.
13. Any service not specifically listed in the Coverage Information.

Services that are covered for you	What you must pay
Limitations and exclusions	

14. Any service that we determine: Is not a dental necessity; does not offer a favorable prognosis; does not have uniform professional endorsement; or is deemed to be experimental or investigational in nature.
15. Orthodontic services.
16. Any expense incurred before your effective date or after the date your coverage under this optional supplemental benefit terminates.
17. Services provided by someone who ordinarily lives in your home or who is a family member.
18. Charges exceeding the reimbursement limit for the service.
19. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, temporary dental services, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate service. These services are considered an integral part of the entire dental service.
21. Repair and replacement of orthodontic appliances.
22. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder, or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches.
23. Extractions, except for extractions of erupted tooth or exposed root (includes routine removal of tooth structure, minor smoothing of socket bone, and closure, as necessary), or surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone of section of tooth.

<u>Vision benefit limitations and exclusions</u>

1. Contact lens fit and follow-up.
2. More than one frame, lens, or lens options benefit transaction per calendar year (optional supplemental benefit has no rollover feature).
3. Any expenses incurred while you qualify for any workers' compensation or occupational disease act or law, whether or not you applied for coverage.
4. Materials or services that are not specifically covered by MyOption Vision.
5. Services that are:
   a. Free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
   b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid);
   c. Or furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.

Services that are covered for you	What you must pay
Limitations and exclusions	

6. Any loss caused or contributed by: War or any act of war, whether declared or not; any act of international armed conflict; or any conflict involving armed forces of any international authority.
7. Any expense arising from the completion of forms.
8. Your failure to keep an appointment.
9. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
10. Prescription drugs or pre-medications, whether dispensed or prescribed.
11. Any service not specifically listed in your optional supplemental benefit.
12. Any service that we determine is not a visual necessity; does not offer a favorable prognosis; does not have uniform professional endorsement; or is deemed to be experimental or investigational in nature.
13. Orthoptic or vision training.
14. Subnormal vision aids and associated testing.
15. Aniseikonic lenses.
16. Any service we consider cosmetic.
17. Any expense incurred before your effective date or after the date your coverage under this optional supplemental benefit terminates.
18. Services provided by someone who ordinarily lives in your home or who is a family member.
19. Charges exceeding the allowance for the service.
20. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
21. Plano lenses.
22. Medical or surgical treatment of eye, eyes, or supporting structures.
23. Replacement of lenses or frames furnished under this optional supplemental benefit which are lost or broken, unless otherwise available under the optional supplemental benefit.
24. Any examination or material required by an employer as a condition of employment or safety eyewear.
25. Non-prescription sunglasses.
26. Two pair of glasses in lieu of bifocals.
27. Services or materials provided by any other group benefit plans providing vision care.
28. Certain name brands when manufacturer imposes no discount.
29. Corrective vision treatment of an experimental nature.
30. Solutions and/or cleaning products for glasses or contact lenses.
31. Pathological treatment.
32. Non-prescription items.
33. Costs associated with securing materials.
34. Pre- and post-operative services.
35. Orthokeratology.
36. Routine maintenance of materials.
37. Refitting or change in lens design after initial fitting.
38. Artistically painted lenses.

Services that are covered for you	What you must pay

Limitations and exclusions

39. Standard and premium progressive lenses.

Hearing benefit limitations and exclusions

1. Services that are:
   a. Free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
   b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid);
   c. Or furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
2. Any loss caused or contributed by: War or any act of war, whether declared or not; any act of international armed conflict; or any conflict involving armed forces of any international authority.
3. Any expense arising from the completion of forms.
4. Your failure to keep an appointment.
5. Any hospital, surgical, or treatment facility, or for services of an anesthesiologist or anesthetist.
6. Prescription drugs or pre-medications, whether dispensed or prescribed.
7. Any service not specifically listed in your optional supplemental benefit.
8. Any service that we determine is not a visual necessity; does not offer a favorable prognosis; does not have uniform professional endorsement; or is deemed to be experimental or investigational in nature.

Questions?

For more information about MyOption Complete or to request an optional supplemental benefit application, call Humana Customer Care at 1-800-457-4708

For TTY, call 711 Monday - Friday, 8 a.m. - 8 p.m.

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MyOption℠ Healthy Back

This optional supplemental benefit provides you with extra benefits. You will need to pay extra monthly premiums for these benefits. These benefits include a maximum of **$500** allowance annually for chiropractic services. You will pay a **$10** copayment for each in network visit.

Premium Information

Monthly premium	**$16** monthly benefit premium.

Services that are covered for you	What you must pay
Coverage Information	
General Information • Maximum plan benefit for combined in and out-of-network services of **$500** per person per calendar year	
Chiropractic benefit	
With this optional supplemental benefit, you're covered for chiropractic adjustments. You are also covered for chiropractic treatment for the aggravation or exacerbation of an illness or injury. You may choose to see a non-network chiropractor for covered services. In that case, the optional supplemental benefit pays a reduced amount based on the negotiated in-network fee schedule in that area, and you pay all fees in excess of this amount. Chiropractic services covered by this OSB may require a referral from your physician if your Medicare Advantage plan requires a referral for these services. **Please note:** You pay your Medicare Advantage plan's copayment per visit for manual manipulation of the spine to correct subluxation (the Medicare-covered service) when provided by chiropractors or other qualified professionals under your medical plan benefits.	

Services that are covered for you	What you must pay	
Covered Chiropractic Services - Total Annual Benefit (Medicare Advantage Plan and OSB)	**In-Network***	**Non-Network****
Chiropractic benefit: • **$500** annual allowance for routine Chiropractic services - Annual Maximum allowance is combined for in- and out-of-network services	**$10** copayment	**50%**
Note: Excludes services for nutrition, hygiene, and/or sanitation needs. Network chiropractors have agreed to provide services at contracted fees (the in-network fee schedules, or INFS). If you visit a network chiropractor, the member will not receive a bill for more than their share of the negotiated fee schedule (coinsurance payment still applies). Non-network chiropractors have not agreed to provide services at contracted fees. If a member sees a non-network chiropractor, the coinsurance level will apply to the average negotiated in-network fee schedule (INFS) in your area. Members are fully responsible for the difference between the average INFS and the chiropractors' charged fees when visiting an out-of-network provider. Chiropractic benefits that are included are manipulations, examinations, radiology, modalities and therapeutic procedures. Some benefits may be limited by medical necessity of services.		
General benefit payments		
The optional supplemental benefit pays toward covered chiropractic services, as shown in the Coverage Information section. Covered chiropractic services are subject to the conditions, limitations, exclusions, and maximums of this optional supplemental benefit. After you receive a chiropractic service, we will determine if it qualifies as a covered chiropractic service. If we determine it is a covered chiropractic service, we will pay benefits as follows: 1. We will determine the total covered expense. 2. We will review the covered expense against any maximum benefits that may apply. 3. We will pay the remaining eligible covered expense to you or your chiropractor, based on your coinsurance for that covered service.		
General provisions		
Chiropractors are independent providers. Humana's obligations are limited to payment for healthcare services described in this document.		

Services that are covered for you	What you must pay

Excess coverage

We will not pay benefits for any accidental injury if other insurance will provide payments or expense coverage, regardless of whether the other coverage is described as primary, excess, or contingent. If your claim against another insurer is denied or partially paid, we will process your claim according to the terms and conditions of this certificate. If we make a payment, you agree to assign to us any right you have against the other insurer for chiropractic expenses we pay. Payments made by the other insurer will be credited toward any applicable coinsurance or calendar year deductibles.

It's your responsibility to understand your chiropractic coverage, including its limitations and exclusions. To be covered, all chiropractic services must be received from a licensed chiropractor who deems the service necessary and must be approved by the plan. Remember, the greatest savings on covered services are through OSB network (Healthways WholeHealth Networks or Humana) chiropractors. The chiropractor you choose may ask you to sign an informed consent document detailing the risks, covered services, and alternatives to all recommended treatments. You may also be required to obtain a referral for services.

General provisions

Chiropractors are independent providers. Humana's obligations are limited to payment for services described in this document.

Limitations and Exclusions

This MyOption Healthy Back optional supplemental benefit does NOT include coverage for and is not limited to the following:

1. Any expenses incurred while you qualify for any workers' compensation or occupational disease act or law, whether or not you applied for coverage.
2. Services that are:
   a. Free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law
   b. Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid)
   c. Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury
3. Any loss caused or contributed by: War or any act of war, whether declared or not; any act of international armed conflict; or any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment with the chiropractor.
6. Infection control, including but not limited to sterilization techniques.

Services that are covered for you	What you must pay

Limitations and Exclusions

7. Any hospital, surgical, or treatment facility, or for services of an anesthesiologist or anesthetist.
8. Prescription drugs or pre-medications, whether dispensed or prescribed.
9. Any service not specifically listed in the Coverage Information.
10. Any expense incurred before your effective date or after the date your coverage under this optional supplemental benefit terminates.
11. Services provided by someone who ordinarily lives in your home or who is a family member.
12. Charges exceeding the reimbursement limit for the service.
13. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
14. Hypnotherapy, behavior training, sleep therapy, and weight programs.
15. Services for nutrition, hygiene, and/or sanitation needs.

Questions?

For more information about MyOption Healthy Back or to request an optional supplemental benefit application, call Humana Customer Care at 1-800-457-4708

For TTY, call 711 Monday - Friday, 8 a.m. - 8 p.m.

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MyOption[SM] Platinum Dental

This optional supplemental benefit provides you with extra benefits. You will need to pay extra monthly premiums for these benefits. These benefits include coverage for many preventive, basic, and major dental services.

Premium Information

Monthly premium	**$29** monthly benefit premium.

Coverage Information

General Information

- Maximum plan benefit (combined for both in-network and out-of-network services) of **$2,000** per person per calendar year

Services that are covered for you	What you must pay
Dental benefit	
With this optional supplemental benefit, you're covered for certain diagnostic and preventive services - including bitewing X-rays, routine cleanings, and checkups - when you see a network dentist. You can see a non-network dentist for covered dental services. When you receive your covered dental services from a non-network dentist, the optional supplemental benefit pays a reduced amount based on the negotiated in-network fee schedule in that area. You will need to pay all fees above this amount.	

Services that are covered for you	What you must pay	
Covered Dental Services - Total Annual Benefit (Medicare Advantage Plan and OSB)	**Network Dentist***	**Non-Network Dentist****
Preventive and Diagnostic Dental Services • Oral Examinations - up to two per calendar year • Bitewing X-rays - one procedure from this group per calendar year • Dental Prophylaxis (Cleanings) - up to two per calendar year • Oral cancer screening- up to one per calendar year • Emergency Exam - two per calendar year	**0%**	**50%**
Basic Dental Services (Minor Restorative) • Amalgam Restorations (Fillings) and Composite Resin Restorations - two procedure codes from this group per mouth per calendar year	**0%**	**50%**
• Extractions - two procedure codes from this group per calendar year • Crown or Bridge Re-cement - one procedure from this group per calendar year • Emergency Treatment for Pain - up to two per calendar year	**50%**	**55%**
Major Dental Services (Endodontics, Periodontics, and Oral Surgery) • Root Canal Treatment - one per calendar year • Crowns - one procedure from this group per calendar year • Periodontal Scaling and Root Planning - one procedure per quadrant every three years • Periodontal Maintenance following periodontal therapy - two per calendar year • Partial Dentures - one procedure from this group per mouth per calendar year • Denture Adjustments (Not covered if within 6 months of initial placement) - one procedure from this group per mouth per calendar year • Denture Reline (Not allowed on spare dentures) - one procedure from this group per mouth per calendar year • Complete Dentures (Including routine post-delivery care) - one upper and/or one lower complete denture every 5 years • Restoration Implant Services (Implant or Abutment Supported) - one procedure from this group per mouth per calendar year	**70%**	**75%**
*Network dentists have agreed to provide services at contracted fees (the in-network fee schedules, or INFS). If you visit a participating network dentist, you won't receive a bill for charges more than their share of the negotiated fee schedule. You will still be charged a copayment. **Non-network dentists have not agreed to provide services at contracted fees. If you see an out-of-network dentist, your copayment may be higher. You will need to pay more because out-of-network dentists charge higher fees than network dentists. Your benefit covers the same amount for network dentists and non-network dentists. If you choose a non-network dentist, you have to		

Services that are covered for you	What you must pay

pay for the higher fees. Members are fully responsible for the difference between the average INFS and the dentists' charged fees when visiting an out-of-network dentist.

General benefit payments

The optional supplemental benefit helps you pay for covered dental services, as shown in the Coverage Information section. Covered dental services are subject to the conditions, limitations, exclusions, and maximums of this optional supplemental benefit.

After you receive a dental service, we will check to see if it is a covered dental service. If we determine it is a covered dental service, we will pay benefits as follows:

1. We'll determine the total covered expense.
2. We'll review the covered expense against any maximum benefits that may apply.
3. We'll check to see if you have met your deductible. If you haven't, we'll subtract any amount needed to meet the deductible.
4. We'll pay the remaining eligible covered expense to you or your dentist, based on your coinsurance for that covered service.

Alternate services

If there are two or more services that can fix a dental condition, Humana will decide how to pay your benefits using the covered expenses for the least expensive covered service that produces a professionally satisfactory result, as determined by us. We will pay up to the reimbursement limit for the least expensive covered service and subject to any deductible, coinsurance, and maximum benefit. You must pay the excess amount.

If you or your dentist choose a treatment that costs more than the one we recommend, Humana's payment will be based on the cost of the less expensive treatment. You will be responsible for the rest of the bill.

Services that are covered for you	What you must pay

Pretreatment plan

We suggest that if dental care you need is expected to exceed **$300**, you or your dentist send a dental treatment plan for us to review before your treatment. The dental treatment plan should include:

1. A list of services you will receive. Your dentist should use the American Dental Association nomenclature and codes; Your dentist's written description of the proposed treatment;
2. Supporting pretreatment X-rays showing your dental needs;
3. Itemized cost of the proposed treatment; and
4. Any other appropriate diagnostic materials that we may request.

An estimate for services is not a guarantee of what we will pay. It tells you and your dentist in advance about the benefits payable for the covered expenses in the treatment plan. We will notify you and your dentist of the benefits payable based on the submitted treatment plan.

An estimate for services is not necessary for emergency care.

Process and timing

An estimate for services is valid for 90 days after the date we notify you and your dentist of the benefits payable for the proposed treatment plan. This is subject to your eligibility of coverage. If treatment won't begin for more than 90 days after the date we notify you and your dentist, we recommend that you submit a new treatment plan.

General provisions

Dentists are independent providers. Humana's obligations are limited to payment for services described in this document.

Dental records. We have access to dental and treatment records of members. We use this information for determination of benefits, processing claims, utilization review, quality assurance, financial audit, or for any other purpose reasonably related to covered dental services. Each member should fill out and send to us such additional consents, releases, and other documents we may ask for in order to determine or provide benefits. If we don't get all of the information we need from you and your dentist, we can decide not to pay benefits for your treatment.

Limitations and exclusions

This MyOption Platinum Dental optional supplemental benefit does NOT include coverage for and is not limited to the following:

1. Any expenses incurred while you qualify for any workers' compensation or occupational disease act or law, whether or not you applied for coverage.
2. Services that are:

Services that are covered for you	What you must pay
Limitations and exclusions	

a. Free or that you wouldn't be required to pay for if you didn't have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law
b. Furnished by, or payable under, any plan or law through any government or any political subdivision - this does not include Medicare or Medicaid
c. Or furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.

3. Any loss caused or contributed by: war or any act of war, whether declared or not; any act of international armed conflict; or any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment with the dentist.
6. Any service we consider cosmetic dentistry unless it is necessary as a result of an accidental injury sustained while you're covered under this policy. We consider the following cosmetic dentistry procedures:
   a. Facings on crowns or pontics - the portion of a fixed bridge between the abutments - posterior to the second bicuspid
   b. Any service to correct congenital malformation
   c. Any service performed primarily to improve appearance; or characterization and personalization of prosthetic devices
7. Charges for: any type of implant and all related services, including crowns or the prosthetic device attached to it; precision or semi-precision attachments; overdentures and any endodontic treatment associated with overdentures; other customized attachments.
8. Any service related to:
   a. Altering vertical dimension of teeth
   b. Restoration or maintenance of occlusion
   c. Splinting teeth, including multiple abutments, or any service to stabilize periodontally weakened teeth
   d. Replacing tooth structures lost as a result of abrasion, attrition, erosion, or abfraction
   e. Bite registration or bite analysis
9. Infection control, including but not limited to sterilization techniques.
10. Fees for treatment performed by someone other than a dentist except for scaling and teeth cleaning, and the topical application of fluoride that can be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards.
11. Any hospital, surgical, or treatment facility, or for services of an anesthesiologist or anesthetist.
12. Prescription drugs or pre-medications, whether dispensed or prescribed.
13. Any service not specifically listed in the Coverage Information.

Services that are covered for you	What you must pay
Limitations and exclusions	
14. Any service that we determine: Is not a dental necessity; does not offer a favorable prognosis; does not have uniform professional endorsement; or is deemed to be experimental or investigational in nature. 15. Orthodontic services. 16. Any expense incurred before your effective date or after the date your coverage under this optional supplemental benefit terminates. 17. Services provided by someone who ordinarily lives in your home or who is a family member. 18. Charges exceeding the reimbursement limit for the service. 19. Treatment resulting from any intentionally self-inflicted injury or bodily illness. 20. Local anesthetics, irrigation, nitrous oxide, bases, pulp caps, temporary dental services, study models, treatment plans, occlusal adjustments, or tissue preparation associated with the impression or placement of a restoration when charged as a separate service. These services are considered an integral part of the entire dental service. 21. Repair and replacement of orthodontic appliances. 22. Any surgical or nonsurgical treatment for any jaw joint problems, including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder, or other conditions of the joint linking the jaw bone and skull; or treatment of the facial muscles used in expression and chewing functions, for symptoms including, but not limited to, headaches. 23. Extractions, except for extractions of erupted tooth or exposed root (includes routine removal of tooth structure, minor smoothing of socket bone, and closure, as necessary), or surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone of section of tooth.	

Services that are covered for you	What you must pay
Excess coverage	
We will not pay benefits for any accidental injury if other insurance will provide payments or expense coverage, regardless of whether the other coverage is described as primary, excess, or contingent. If your claim against another insurer is denied or partially paid, we will process your claim according to the terms and conditions of this certificate. If we make a payment, you agree to assign to us any right you have against the other insurer for dental expenses we pay. Payments made by the other insurer will be credited toward any applicable coinsurance or calendar year deductibles. It's your responsibility to understand your dental coverage, including its limitations and exclusions. To be covered, all dental services must be received from a licensed dentist who deems the service necessary and must be approved by the plan. Remember, the greatest savings on covered services are through OSB network dentists. The dentist you choose may ask you to sign an informed consent document detailing the risks, covered dental services, and options to all recommended treatments. You should always ask the dentist for a treatment plan detailing the services to be performed and the associated costs prior to having work performed.	
Questions?	
For more information about MyOption Platinum Dental or to request an optional supplemental benefit application, call Humana Customer Care at 1-800-457-4708 For TTY, call 711 Monday - Friday, 8 a.m. - 8 p.m. Visit **Humana.com**	

Section 2.3 Getting care using our plan's optional visitor/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.

You have access to providers in the HumanaChoice 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 Care. We'll tell you whether you're in one of our other HumanaChoice 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.

If you are in another HumanaChoice service area and are using your U.S. Travel Benefit, you can be outside your service area for up to 12 months.

SECTION 3 What benefits are not covered by the plan?

Section 3.1 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 excluded 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 Chapter 9, Section 5.3 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 covered services.
- Experimental medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under a Medicare-approved clinical research study. (See Chapter 3, Section 5 for more information on clinical research studies.) Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.
- 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.
- 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, unless 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, fillings, or dentures. However, non-routine dental care required to treat illness or injury may be covered as inpatient or outpatient care.
- Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.
- Routine foot care, except for the limited coverage provided according to Medicare guidelines.
- 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.
- Hearing aids and routine hearing examinations.
- Eyeglasses, Radial keratotomy, LASIK surgery, vision therapy, and other low vision aids and services. However, eyeglasses are covered for people after cataract surgery.

- 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.

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

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

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

Are you currently getting help to pay for your drugs?
If you are in a program that helps pay for your drugs, **some information in this Evidence of Coverage about the costs for Part D prescription drugs may not apply to you**. We send you a separate mailing containing the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (LIS Rider), which tells you about your drug coverage. If you do not have this mailing, please call Customer Care and ask for the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (LIS Rider). Phone numbers for Customer Care are on the back cover of this booklet.

SECTION 1 Introduction

Section 1.1 This chapter describes your coverage for Part D drugs

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

In addition to your coverage for Part D drugs, HumanaChoice H6609-011 (PPO) 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. **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).

Section 1.2 Basic rules for the plan's Part D drug coverage

The plan will generally cover your drugs as long as you follow these basic rules:
- You must have a provider (a doctor or other prescriber) write your prescription.
- You must use a network pharmacy to fill your prescription. (See Section 2, Fill your prescriptions at a network pharmacy or through the plan's mail-order service.)
- Your drug must be in the plan's Prescription Drug Guide (Formulary) (we call it the "Drug Guide" for short). (See Section 3, Your drugs need to be in the plan's Drug Guide.)
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 4 for more information about a medically accepted indication.)

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

Section 2.1 To have your prescription covered, use a network pharmacy

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

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

Section 2.2 Finding network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your Provider Directory, visit our website (**Humana.com**), or call Customer Care (phone numbers are on the back cover of this booklet). Choose whatever is easiest for you.

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

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

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can get help from Customer Care (phone numbers are on the back cover of this booklet) or use the Provider Directory. You can also find information on our website at **Humana.com**.

What if you need a specialized pharmacy?

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care 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.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To locate a specialized pharmacy, look in your Provider Directory or call Customer Care.

Section 2.3 Using the plan's mail-order services

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

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

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

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

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 mail-order, in case your order is delayed.**

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

When you get a long-term supply of drugs, your cost sharing may be lower. The plan offers two ways to get a long-term supply of "mail-order" drugs in 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.)

1. **Some retail pharmacies** in our network allow you to get a long-term supply of mail-order drugs. Some of these retail pharmacies may agree to accept the mail-order cost-sharing amount for a long-term supply of mail-order drugs. Other retail pharmacies may not agree to accept the mail-order cost-sharing amounts for a long-term supply of mail-order drugs. In this case you will be responsible for the difference in price. Your Provider Directory tells you which pharmacies in our network can give you a long-term supply of mail-order drugs. You can also call Customer Care for more information.
2. For certain kinds of drugs, you can use the plan's network **mail-order services**. The drugs available through our plan's mail-order service are marked as **"mail-order" drugs** in our plan's Drug Guide. Our plan's mail-order service requires you to order at least a 30-day supply of the drug and no more than a 90-day supply. See Section 2.3 for more information about using our mail-order services.

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

Your prescription may be covered in certain situations

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. 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 2.1 explains how to ask the plan to pay you back.)
- **If you need coverage while you are traveling away from the plan's service area**
  - If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. You may be able to order your prescription drugs ahead of time through our 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 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 2.1 explains how to ask the plan to pay you back.)

– **Please recognize, however, that multiple non-emergency occurrences of out-of-network pharmacy claims will result in claim denials. In addition, we cannot pay for any stolen medications or prescriptions that are filled by pharmacies outside the United States and territories, even for a medical emergency.**

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 Customer Care** 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 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 2.1 explains how to ask the plan to pay you back.)

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

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

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

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

The drugs in the Drug Guide are only those covered under Medicare Part D (earlier in this chapter, Section 1.1 explains about Part D drugs).

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

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- -- or -- supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor.)

The Drug Guide includes both brand-name and generic drugs

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

What is not in the Drug Guide?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more information about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug in the Drug Guide.

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

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

- **Cost-Sharing Tier 1 - Preferred Generic:** Drugs that have the same active ingredients as brand drugs and are prescribed for the same reasons. The Food and Drug Administration (FDA) requires generic drugs to have the same quality, strength, purity, and stability as brand drugs. Your cost for generic drugs is usually lower than your cost for brand drugs.
- **Cost-Sharing Tier 2 - Preferred Brand:** Brand prescription drugs that Humana offers at a lower cost to you than non-preferred brand drugs.
- **Cost-Sharing Tier 3 - Non-Preferred Brand:** Brand prescription drugs that Humana offers at a higher cost to you than preferred brands.
- **Cost-Sharing Tier 4 - Specialty:** Some injectables and other high-cost drugs.

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

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).

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

You have three ways to find out:

1. Check the most recent Drug Guide we sent you in the mail. Please note: The Drug Guide we send 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.
2. Visit the plan's website (**Humana.com**). The Drug Guide on the website is always the most current.
3. Call Customer Care to find out if a particular drug is in the plan's Drug Guide or to ask for a copy of the list. Phone numbers for Customer Care are on the back cover of this booklet.

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

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

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

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If you want us to waive the restriction for you, you will need to use the formal appeals process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 6.2 for information about asking for exceptions.)

Section 4.2 What kinds of restrictions?

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

Restricting brand-name drugs when a generic version is available

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

Getting plan approval in advance

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

Trying a different drug first

This requirement encourages you to try less costly but 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.

Section 4.3 Do any of these restrictions apply to your drugs?

The plan's Drug Guide includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug Guide. For the most up-to-date information, call Customer Care (phone numbers are on the back cover of this booklet) or check our website **Humana.com**.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If there is a restriction on the drug you want to take, you should contact Customer Care to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the formal appeals process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 6.2 for information about asking for exceptions.)

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

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

Suppose there is a prescription drug you are currently taking, or one that you and your provider 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. In some cases, you may want us to waive the restriction for you. For example, you might want us to cover a certain drug for you without having to try other drugs first. Or you may want us to cover more of a drug (number of pills, etc.) than we normally will cover.
- **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. Your options depend on what type of problem you have:

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

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

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

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

You may be able to get a temporary supply

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

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

1. **The change to your drug coverage must be one of the following types of changes:**
   - The drug you have been taking is **no longer in the plan's Drug Guide**.
   - -- or -- the drug you have been taking is **now restricted in some way** (Section 4 in this chapter tells about restrictions).
2. **You must be in one of the situations described below:**
   - **For those members who were in the plan last year and aren't in a long-term care facility:** We will cover a temporary supply of your current drug therapy **one time only during the first 90 days of the calendar year**. This temporary supply will be for a maximum of 30 days, or less if your prescription is written for fewer days.
   - **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 members who are new to the plan and reside 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 34 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 34 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 members who have been in the plan for more than 90 days and reside in a long-term care facility and need a supply right away:** We will cover one 34-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 with changes in treatment setting:** 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 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 34-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 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 2012 plan year. In 2012, 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 2012, 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 Jan. 1, 2012, 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 34-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 34-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 34-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 polices 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 (phone numbers are on the back cover of this booklet).

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

You can change to another drug
Start by talking with your provider. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call Customer Care to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

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

If you are a current member and a drug you are taking will be removed from the formulary or restricted in some way for next year, we will allow you to request a formulary exception in advance for next year. We will tell you about any change in the coverage for your drug for 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 provider want to ask for an exception, Chapter 9, Section 6.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

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

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

You can change to another drug
If your drug is in a cost-sharing tier you think is too high, start by talking with your provider. Perhaps there is a different drug in a lower cost-sharing tier that might work just as well for you. You can call Customer Care to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

You can ask for an exception
For drugs in Cost-Sharing Tier 3 - Non-Preferred Brand Drugs, you and your provider can ask the plan to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule.

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

Drugs in some of our cost-sharing tiers are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in Cost-Sharing Tier 4 - Specialty drugs, Cost-Sharing Tier 2 - Preferred Brand drugs or Cost-Sharing Tier 1 - Preferred Generic drugs.

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

Section 6.1 The Drug Guide can change during the year

Most of the changes in drug coverage happen at the beginning of each year (January 1). 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 any changes we make to the plan's Drug Guide.

Section 6.2 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 provider 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 January 1 of the next year if you stay in the plan:
- If we move your drug into a higher cost-sharing tier.
- If we put a new restriction on your use of the drug.
- If we remove your drug from the Drug Guide, but not because of a sudden recall or because a new generic drug has replaced it.

If any of these changes happen 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 January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restriction to your use of the drug. However, on January 1 of the next year, the changes will affect you.

In some cases, you will be affected by the coverage change before January 1:
- 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 provider to switch to the generic or to a different drug that we cover.
  - Or you and your provider 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 (coverage decisions, appeals, complaints)).
- 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 provider 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 <u>not</u> covered by the plan?

Section 7.1 Types of drugs we do not cover

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

If you get drugs that are excluded, you must pay for them yourself. We won't pay for the drugs that are listed in this section (except for certain excluded drugs covered under our enhanced drug coverage). The only exception: If the requested drug is found upon appeal to be a drug that is not excluded under Part D and we should have paid for or covered it because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to Chapter 9, Section 6.5 in this booklet.)

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:
- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- Our plan usually cannot cover off-label use. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
  - Generally, coverage for "off-label use" is allowed only when the use is supported by certain 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:
- Non-prescription drugs (also called over-the-counter drugs)

- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra, and Caverject
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Barbiturates and Benzodiazepines

If **you receive Extra Help paying for your drugs**, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

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

Section 8.1 Show your membership card

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

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

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

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up**. (You can then **ask us to reimburse you** for our share. See Chapter 7, Section 2.1 for information about how to ask the plan for reimbursement.)

SECTION 9 Part D drug coverage in special situations

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

If you are admitted to a hospital or to a skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, the plan will cover your 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 when you can leave our plan and join a different Medicare plan.)

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

Usually, a long-term care facility (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 Provider 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 in 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 a 34-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 in our Drug Guide, or if the plan has any restriction on the drug's coverage, we will cover one 34-day supply, or less if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells what to do.

Section 9.3 What if you're also getting drug coverage from an employer or retiree group plan?

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

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

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

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

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

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

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

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

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

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

Section 10.2 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 you from the program. If you have any questions about these programs, please contact Customer Care (phone numbers are on the back cover of this booklet).

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

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

Are you currently getting help to pay for your drugs?
If you are in a program that helps pay for your drugs, **some information in this Evidence of Coverage about the costs for Part D prescription drugs may not apply to you**. We send you a separate mailing containing the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (LIS Rider), which tells you about your drug coverage. If you do not have this mailing, please call Customer Care and ask for the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (LIS Rider). Phone numbers for Customer Care are on the back cover of this booklet.

SECTION 1 Introduction

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

This chapter focuses on what you pay for your Part D prescription drugs. To keep things simple, we use "drug" in this chapter to mean a Part D prescription drug. As explained in Chapter 5, not all drugs are Part D drugs - some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law.

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

- **The plan's Prescription Drug Guide (Formulary).** To keep things simple, we call this the "Drug Guide."
  - This Drug Guide tells which drugs are covered for you.
  - It also tells which of the four "cost-sharing tiers" the drug is in and whether there are any restrictions on your coverage for the drug.
  - If you need a copy of the Drug Guide, call Customer Care (phone numbers are on the back cover of this booklet). 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. 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

Section 2.1 What are the drug payment stages for HumanaChoice H6609-011 (PPO) members?

As shown in the table below, there are "drug payment stages" for your prescription drug coverage under HumanaChoice H6609-011 (PPO). How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled. Keep in mind you are always responsible for the plan's monthly premium regardless of the drug payment stage.

Stage 1	Stage 2	Stage 3	Stage 4
Yearly Deductible Stage Because there is no deductible for the plan, this payment stage does not apply to you.	**Initial Coverage Stage** You begin in this stage when you fill your first prescription of the year. During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost**. You stay in this stage until your year-to-date "**total drug costs**" (your payments plus any Part D plan's payments) total **$2,930** (Details are in Section 5 of this chapter.)	**Coverage Gap Stage** During this stage, the plan provides coverage for select Home Infusion drugs. For all other drugs, you pay **50%** of the price (plus the dispensing fee) for brand name drugs and will generally pay no more than **86%** of the price for generic drugs. You stay in this stage until your year-to-date "**out-of-pocket costs**" (your payments) reach a total of **$4,700**. This amount and rules for counting costs toward this amount have been set by Medicare. (Details are in Section 6 of this chapter)	**Catastrophic Coverage Stage** During this stage, **the plan will pay most of the cost** of your drugs for the rest of the calendar year (through December 31, 2012). (Details are in Section 7 of this chapter.)

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

Section 3.1 We send you a monthly 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 through the plan during the previous month. 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 drugs costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called "year-to-date" information. It shows you the total drug costs and total payments for your drugs since the year began.

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

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

- **Show your membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 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 a State Pharmaceutical Assistance Program, 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 if you have any questions, please call Customer Care (phone numbers are on the back cover of this booklet). Be sure to keep these reports. They are an important record of your drug expenses.

SECTION 4 There is no deductible for HumanaChoice H6609-011 (PPO)

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

There is no deductible for HumanaChoice H6609-011 (PPO). You begin in the Initial Coverage Stage when you fill your first prescription of the year. See Section 5 for information about your coverage in the Initial Coverage Stage.

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

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

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

The plan has four cost-sharing tiers

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

- **Cost-Sharing Tier 1 - Preferred Generic:** Drugs that have the same active ingredients as brand drugs and are prescribed for the same reasons. The Food and Drug Administration (FDA) requires generic drugs to have the same quality, strength, purity, and stability as brand drugs. Your cost for generic drugs is usually lower than your cost for brand drugs.
- **Cost-Sharing Tier 2 - Preferred Brand:** Brand prescription drugs that Humana offers at a lower cost to you than non-preferred brand drugs.
- **Cost-Sharing Tier 3 - Non-Preferred Brand:** Brand prescription drugs that Humana offers at a higher cost to you than preferred brands.
- **Cost-Sharing Tier 4 - Specialty:** Some injectables and other high-cost drugs.

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

Your pharmacy choices

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

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

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

Preferred pharmacies are pharmacies in our network where members have lower cost sharing for covered drugs than at non-preferred pharmacies. However, you will usually have lower prices at 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.

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

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

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

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

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

- We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5 for information about when we will cover a prescription filled at an out-of-network pharmacy.

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

	Retail Pharmacy	Preferred Mail Order Pharmacy	Non-Preferred Mail Order Pharmacy	LTC Pharmacy	OON Pharmacy*
Cost-Sharing Tier 1 Preferred Generic	**$6**	**$0**	**$6**	**$6**	**$6**
Cost-Sharing Tier 2 Preferred Brand	**$39**	**$39**	**$39**	**$39**	**$39**
Cost-Sharing Tier 3 Non-Preferred Brand	**$80**	**$80**	**$80**	**$80**	**$80**
Cost-Sharing Tier 4 Specialty	**33%**	**33%**	**33%**	**33%**	**33%**

* You pay the in network cost share plus the difference between the in network cost and the out of network cost for covered prescription drugs received from a non network pharmacy.

Section 5.3 A table that shows your costs for a long-term (up to a 90-day) supply of a drug

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

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

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

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

	Retail Pharmacy	Preferred Mail Order Pharmacy	Non-Preferred Mail Order Pharmacy
Cost-Sharing Tier 1 Preferred Generic	**$18**	**$0**	**$18**
Cost-Sharing Tier 2 Preferred Brand	**$117**	**$107**	**$117**

	Retail Pharmacy	Preferred Mail Order Pharmacy	Non-Preferred Mail Order Pharmacy
Cost-Sharing Tier 3 Non-Preferred Brand	**$240**	**$230**	**$240**

Cost-Sharing Tier 4 drugs are limited to a 30 day supply

Section 5.4 You stay in the Initial Coverage Stage until your total drug costs for the year reach $2,930

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled and refilled reaches the **$2,930 limit for the Initial Coverage Stage**.

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

- **What you have paid** for all the covered drugs you have received since you started with your first drug purchase of the year. (See Section 6.2 for more information about how Medicare calculates your out-of-pocket costs.) This includes:
  – The total you paid as your share of the cost for your drugs during the Initial Coverage Stage.
- **What the plan has paid** as its share of the cost for your drugs during the Initial Coverage Stage. (If you were enrolled in a different Part D plan at any time during 2012, the amount that plan paid during the Initial Coverage Stage also counts toward your total drug costs.)

We also provide some over-the-counter medications exclusively for your use. These over-the-counter drugs are provided at no cost to you. To find out which drugs our plan covers, refer to your Drug Guide.

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 **$2,930** limit in a year.

We will let you know if you reach this **$2,930** amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage.

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

Section 6.1 You stay in the Coverage Gap Stage until your out-of-pocket costs reach $4,700

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

For drugs we do not provide coverage for in the Coverage Gap, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. You pay **50%** of the negotiated price (excluding the dispensing fee and vaccine administration fee, if any) for brand name drugs. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the coverage gap.

You also receive some coverage for generic drugs that we do not cover in the Coverage Gap. You pay no more **86%** of the cost for generic drugs and the plan pays the rest. For generic drugs, the amount paid by the plan (**14%**) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap.

For drugs we do not cover in the Coverage Gap, you continue paying the discounted price for brand name drugs and no more than **86%** of the costs of generic drugs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. In 2012, that amount is **$4,700**.

The table below shows what you pay when you get a one-month 30-day supply (or less) of a drug.

	Retail Pharmacy	Preferred Mail Order Pharmacy	Non-Preferred Mail Order Pharmacy	LTC Pharmacy	OON Pharmacy*
Cost-Sharing Tier 1					
Home Infusion Drugs	**$6**	**$0**	**$6**	**$6**	**$6**
All Other Drugs	**100%**	**100%**	**100%**	**100%**	**100%**
Cost-Sharing Tier 2					
Home Infusion Drugs	**$39**	**$39**	**$39**	**$39**	**$39**
All Other Drugs	**100%**	**100%**	**100%**	**100%**	**100%**
Cost-Sharing Tier 3					
Home Infusion Drugs	**$80**	**$80**	**$80**	**$80**	**$80**
All Other Drugs	**100%**	**100%**	**100%**	**100%**	**100%**
Cost-Sharing Tier 4					
Home Infusion Drugs	**33%**	**33%**	**33%**	**33%**	**33%**
All Other Drugs	**100%**	**100%**	**100%**	**100%**	**100%**

* You pay the in network cost share plus the difference between the in network cost and the out of network cost for covered prescription drugs received from a non network pharmacy.

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

	Retail Pharmacy	Preferred Mail Order Pharmacy	Non-Preferred Mail Order Pharmacy
Cost-Sharing Tier 1			
Home Infusion Drugs	**$18**	**$0**	**$18**
All Other Drugs	**100%**	**100%**	**100%**

	Retail Pharmacy	Preferred Mail Order Pharmacy	Non-Preferred Mail Order Pharmacy
Cost-Sharing Tier 2			
Home Infusion Drugs	**$117**	**$107**	**$117**
All Other Drugs	**100%**	**100%**	**100%**
Cost-Sharing Tier 3			
Home Infusion Drugs	**$240**	**$230**	**$240**
All Other Drugs	**100%**	**100%**	**100%**

Cost-Sharing Tier 4 drugs are limited to a 30 day supply

Medicare has rules about what counts and what does not count as your out-of-pocket costs. When you reach an out-of-pocket limit of **$4,700**, you leave the Coverage Gap Stage and move on to the Catastrophic Coverage Stage.

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

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

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

When you add up your out-of-pocket costs, **you can include** the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 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.
  - The Coverage Gap Stage.
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

It matters who pays:

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are also included if they are made on your behalf by **certain other individuals or organizations**. This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, by a State Pharmaceutical Assistance Program that is qualified by Medicare, or by the Indian Health Service. Payments made by Medicare's "Extra Help" are also included.
- Some of the payments made by the Medicare Coverage Gap Discount Program are included. The amount the manufacturer pays for your brand name drugs is included. But the amount the plan pays for your generic drugs is not included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of **$4,700** in out-of-pocket costs within the calendar year, you will move from the Coverage Gap Stage to the Catastrophic Coverage Stage.

These payments are **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.
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments made by the plan for your generic drugs while in the Coverage Gap.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Administration.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan. Call Customer Care to let us know (phone numbers are on the back cover of this booklet).

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

- **We will help you.** The SmartSummary report we send to you includes the current amount of your out-of-pocket costs (Section 3 in this chapter tells about this report). When you reach a total of **$4,700** in out-of-pocket costs for the year, this report will tell you that you have left the Coverage Gap Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

SECTION 7 During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs

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

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the **$4,700** 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.

- **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 percent** of the cost of the drug
  - - or - **$2.60** copayment for a generic drug or a drug that is treated like a generic. Or a **$6.50** copayment for all other drugs.
- **Our plan pays the rest** of the cost.

SECTION 8 Additional benefits information

Section 8.1 Our plan does not offer additional benefits

There are no additional prescription drug benefits available with this plan.

SECTION 9 What you pay for vaccinations covered by Part D depends on how and where you get them

Section 9.1 Our plan has separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccination shot

Our plan provides coverage of a number of Part D vaccines. We also cover vaccines that are considered medical benefits. You can find out about coverage of these vaccines by going to the Medical Benefits Chart in Chapter 4, Section 2.1.

There are two parts to our coverage of Part D 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 Part D vaccination?
What you pay for a Part D vaccination depends on three things:
1. **The type of vaccine** (what you are being vaccinated for).
   - Some vaccines are considered 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 (Formulary).
2. **Where you get the vaccine medication.**
3. **Who gives you the vaccination shot.**

What you pay at the time you get the Part D vaccination can vary depending on the circumstances. For example:
- Sometimes when you get your 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 Part D vaccination shot. Remember you are responsible for all of the costs associated with vaccines (including their administration) during the Coverage Gap Stage of your benefit.

Situation 1: You buy the Part D vaccine at the pharmacy and you get your 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 pay nothing to the pharmacy for the vaccine itself.
- Our plan will pay for the cost of giving you the vaccination shot.

Situation 2: You get the Part D vaccination at your doctor's office.
- When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 7 of this booklet (Asking us to pay a bill you have received for covered 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 get Extra Help, we will reimburse you for this difference.)

Situation 3: You buy the Part D vaccine at your pharmacy, and then take it to your doctor's office where they give you the 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 for administering the vaccine less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help, we will reimburse you for this difference.)

Section 9.2 You may want to call us at Customer Care before you get a vaccination

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call us first at Customer Care whenever you are planning to get a vaccination (phone numbers are on the back cover of this booklet).
- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
- We can tell you how to keep your own cost down by using providers and pharmacies in our network.
- If you are not able to use a network provider and pharmacy, we can tell you what you need to do to get payment from us for our share of the cost.

SECTION 10 Do you have to pay the Part D "late enrollment penalty"?

Section 10.1 What is the Part D "late enrollment penalty"?

Note: If you receive "Extra Help" from Medicare to pay for your prescription drugs, the late enrollment penalty rules do not apply to you. You will not pay a late enrollment penalty, even if you go without "creditable" prescription drug coverage.

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 have creditable prescription drug coverage. ("Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) The amount of the penalty depends on how long you waited to enroll in a creditable prescription drug coverage plan any time after the end of your initial enrollment period or how many full calendar months you went without creditable prescription 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 HumanaChoice H6609-011 (PPO), we let you know the amount of the penalty.

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

Section 10.2 How much is the Part D late enrollment penalty?

Medicare determines the amount of the penalty. Here is how it works:
- First count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months in which you did not have creditable prescription drug coverage, if the break

in coverage was 63 days or more. The penalty is **1 percent** for every month that you didn't have creditable coverage. For example, if you go 14 months without coverage, the penalty will be **14 percent**.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2011, this average premium amount was **$31.94**. This amount may change for 2012.
- To get your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here it would be **14 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 aging into Medicare.

Section 10.3 In some situations, you can enroll late and not have to pay the penalty

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

You will not have to pay a premium penalty for late enrollment if you are in any of these situations:
- If you already have prescription drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Medicare calls this "**creditable drug coverage**." Please note:
  - Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.
    > Please note: If you receive a "certificate of creditable coverage" when your health coverage ends, it may not mean your prescription drug coverage was creditable. The notice must state that you had "creditable" prescription drug coverage that expected to pay as much as Medicare's standard prescription drug plan pays.
  - The following are not creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.
  - For additional information about creditable coverage, please look in your Medicare & You 2012 Handbook or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
- If you were without creditable coverage, but you were without it for less than 63 days in a row.
- If you are receiving "Extra Help" from Medicare.

Section 10.4 What can you do if you disagree about your late enrollment penalty?

If you disagree about your late enrollment penalty, you or your representative can ask for a review of the decision about your late enrollment penalty. Generally, you must request this review **within 60 days** from the date on the letter you receive stating you have to pay a late enrollment penalty. Call Customer Care at the number on the back cover of this booklet to find out more about how to do this.

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

SECTION 11 Do you have to pay an extra Part D amount because of your income?

Section 11.1 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 for your Medicare Part D coverage.

If you have to pay an extra amount, the Social Security Administration, 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.

Section 11.2 How much is the extra Part D amount?

If your modified adjusted gross income 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**	**$48.10**
Greater than **$214,000**	Greater than **$129,000**	Greater than **$428,000**	**$66.40**

Section 11.3 What can you do if you disagree about paying an extra Part D amount?

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

CHAPTER 7. Asking us to pay our share of a bill you have received for covered medical services or drugs

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

Section 1.1 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 receive 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 network 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 for 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 network provider sends you a bill you think you should not pay**
   Network 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.
   - Whenever you get a bill from a network 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 network 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. **If you are retroactively enrolled in our plan**
   Sometimes a person's enrollment in the plan is retroactive. (Retroactive means that the first day of their enrollment has already past. The enrollment date may even have occurred last year.)

   If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered services or drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork for us to handle the reimbursement.
   - Please call Customer Care for additional information about how to ask us to pay you back and deadlines for making your request.
4. **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, Sec. 2.5 to learn more.)

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

5. 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.

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

You may pay the full cost of the prescription because you find 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

Section 2.1 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 Customer Care if you have any questions. If you don't know what you should have paid, 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

Section 3.1 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 make a coverage decision.

- 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 covered. Chapter 5 explains the rules you need to follow for getting your Part D prescription drugs covered.)
- 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.

Section 3.2 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 formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 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 5.3 in Chapter 9.
- If you want to make an appeal about getting paid back for a drug, go to Section 6.5 of Chapter 9.

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

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

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

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

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

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

- For example, a pharmacy might offer a special price on the drug. Or you may have a discount card that is outside our benefit that offers a lower price.
- Unless special conditions apply, you must use a network pharmacy in these situations and your drug must be in our Drug Guide.
- 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 Coverage Gap Stage, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

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

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

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

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

CHAPTER 8. Your rights and responsibilities

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

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

To get information from us in a way that works for you, please call Customer Care (phone numbers are on the back cover of this booklet).

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 alternative formats if you need it. If you are eligible for Medicare because of a 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 a 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.

Para obtener información de una forma que se ajuste a sus necesidades, llame al departamento de Atención al Cliente (los números de teléfono están en la contraportada de este manual).

Nuestro plan cuenta con personal y servicios gratuitos de intérpretes de otros idiomas disponibles para responder preguntas de afiliados que no hablan inglés. También podemos darle información en Braille, en letra grande o en otros formatos alternativos en caso de ser necesario. Si usted es elegible para Medicare por una discapacidad, se nos exige darle información sobre los beneficios del plan que sea accesible y apropiada para usted.

Si se le dificulta obtener información de nuestro plan debido a problemas relacionados con el idioma o una discapacidad, llame a Medicare al 1-800-MEDICARE (1-800-633-4227), 24 horas del día, 7 días de la semana, y dígales que quiere presentar una queja. Los usuarios de TTY deben llamar al 1-877-486-2048.

Section 1.2 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 Customer Care (phone numbers are on the back cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Customer Care can help.

Section 1.3 We must ensure that you get timely access to your covered services and drugs

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

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, Section 10 of this booklet tells what you can do. (If we have denied coverage for your medical care or drugs and you don't agree with our decision, Chapter 9, Section 4 tells what you can do.)

Section 1.4 We must protect the privacy of your personal health information

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

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

How do we protect the privacy of your health information?

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

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

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

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

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

Notice of Privacy Practices for your personal health information

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

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

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 healthcare provider or health plan that relates to your physical or mental health or condition, providing healthcare to you, or the payment for such healthcare. We protect this information in all formats including electronic, written, and oral information.

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 healthcare provider so you can receive medical care
- For payment activities, including claims payment for covered services provided to you by healthcare providers and for health plan premium payments
- For healthcare 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 healthcare professionals, and determining premiums
- For performing underwriting activities. However, we will not use any results of genetic testing.
- 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.
- Adverse Underwriting Decision - You have the right to be provided a reason for denial or adverse underwriting decision if Humana declines your application for insurance. (This right applies only to our Massachusetts residents in accordance with state regulations.)
- 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** 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 a 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 Health Plan, Inc.
Cariten Insurance Company
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, Inc.
Emphesys Insurance Company
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 Wisconsin Health Organization Insurance Corporation
Managed Care Indemnity, Inc.
Preferred Health Partnership of Tennessee, Inc.
The Dental Concern, Inc.
The Dental Concern, Ltd.

Section 1.5 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 1.1, 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 alternative formats.)

If you want any of the following kinds of information, please call Customer Care (phone numbers are on the back cover of this booklet):

- **Information about our plan.** This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **Information about our network 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 Customer Care (phone numbers are on the back cover of this booklet) 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 (Formulary), tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.

  - If you have questions about the rules or restrictions, please call Customer Care (phone numbers are on the back cover of this booklet).
- **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 provider 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. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 9 of this booklet. It gives you the details about 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.

We have 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 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.

Section 1.6 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 one of these situations. 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.

Contact information for the state agency that handles advance directives can be found in "Exhibit A" in the back of this document.

Section 1.7 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 Customer Care (phone numbers are on the back cover of this booklet).

Section 1.8 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 Customer Care** (phone numbers are on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 1.9 How to get more information about your rights

There are several places where you can get more information about your rights:
- You can **call Customer Care** (phone numbers are on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare**.
  - You can visit the Medicare website to read or download the publication "Your Medicare Rights & Protections." (The publication is available at: http://www.medicare.gov/Publications/Pubs/pdf/10112.pdf.)
  - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Care (phone numbers are on the back cover of this booklet). We're here to help.
- **Get familiar with your covered services or drugs and the rules you must follow to get these covered services or drugs.** Use this Evidence of Coverage 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 in addition to our plan, you are required to tell us.** Please call Customer Care 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 or drugs 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. (For more information about coordination of benefits, go to Chapter 1, Section 7.)
- **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:
  - You must pay your plan premiums to continue being a member of our plan.
  - In order to be eligible for our plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B. For that reason, some plan members must pay a premium for Medicare Part A and most plan members must pay a premium for Medicare Part B to remain a member of the plan.
  - For most 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 disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see Chapter 9 of this booklet for information about how to make an appeal.
  - If you are required to pay a late enrollment penalty, you must pay the penalty to remain a member of the plan.
- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call Customer Care (phone numbers are on the back cover of this booklet).
  - **If you move outside of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, 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 Customer Care 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 Customer Care are on the back cover of this booklet.
  - 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)

MAKING COMPLAINTS

SECTION 10 How to make a complaint about quality of care, waiting times, customer service, or other concerns

BACKGROUND

SECTION 1 Introduction

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

This chapter explains two types of processes for handling problems and concerns:
- For some types of problems, you need to use the **process for coverage decisions and 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.

Section 1.2 What about the legal terms?

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

To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says "making a complaint" rather than "filing a grievance," "coverage decision" rather than "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

Section 2.1 Where to get more information and personalized assistance

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

Get help from an independent government organization
We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a

problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

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

You can also get help and information from Medicare
For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

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

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

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

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

To figure out which part of this chapter will help with your specific problem or concern, **START HERE**	
Is your problem or concern about your benefits or coverage? (This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)	
Yes. My problem is about benefits or coverage. Go on to the next section of this chapter, **Section 4, "A guide to the basics of coverage decisions and making appeals."**	**No.** My problem is not about benefits or coverage. Skip ahead to **Section 10** at the end of this chapter: **"How to make a complaint about quality of care, waiting times, customer service or other concerns."**

COVERAGE DECISIONS AND APPEALS

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

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

The process for coverage decisions and 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. For example, your plan network doctor makes a (favorable) coverage decision for you whenever

you receive medical care from him or her or if your network doctor refers you to a medical specialist. You can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, 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. In some cases we might decide a 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 review the coverage decision we have made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review we give you our decision.

If we say no to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to us. (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.

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

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

- You **can call us at Customer Care** (phone numbers are on the back cover of this booklet).
- 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).
- **Your doctor or other provider can make a request for you.** Your doctor or other provider can request a coverage decision or a Level 1 Appeal on your behalf. To request any appeal after Level 1, your doctor or other provider must be appointed as your representative.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
  - There may be someone who is already legally authorized to act as your representative under state law.
  - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Customer Care and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf). The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.3 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: "Your medical care: How to ask for a coverage decision or make an appeal"
- **Section 6** of this chapter: "Your Part D prescription drugs: How to ask for a coverage decision or make an appeal"
- **Section 7** of this chapter: "How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon"
- **Section 8** of this chapter: "How to ask us to keep covering certain medical services if you think your coverage is ending too soon" (Applies to these services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which section you should be using, please call Customer Care (phone numbers are on the back cover of this booklet). You can also get help or information from government organizations such as your State Health Insurance Assistance Program ("Exhibit A" at the end 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.

Section 5.1 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 benefits are 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 us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon.
- Chapter 9, 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.

- 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?	
If you are in this situation:	**This is what you can do:**
Do you want to find out whether we will cover the medical care or services you want?	You can ask us to make a coverage decision for you. Go to the next section of this chapter, **Section 5.2**.
Have we already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for?	You can make an **appeal**. (This means you are asking us to reconsider.) Skip ahead to **Section 5.3** of this chapter.
Do you want to ask us to pay you back for medical care or services you have already received and paid for?	You can send us the bill. Skip ahead to **Section 5.5** of this chapter.

Section 5.2 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**."

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 determination**."

How to request coverage for the medical care you want
- Start by calling, writing, or faxing our plan to make your request for us to provide coverage for the medical care you want. You, 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 us 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 that may benefit you is missing, 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, we 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: We consider your request for medical care coverage and 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 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. (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 5.3 below 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 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. (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 5.3 below 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 we say 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 an appeal, it means you are going on to Level 1 of the appeals process (see Section 5.3 below).

Section 5.3 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 us about a medical care coverage decision is called a plan "**reconsideration**."

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

What to do

- **To start your appeal, you, your doctor, or your representative, must contact us.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 and look for the section called, How to contact us when you are making an appeal about your medical care.
- **If you are asking for a standard appeal, 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 us 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.
- **If you are asking for a fast appeal, make your appeal in writing or call us** at the phone number shown in Chapter 2, Section 1 (How to contact us when you are making an appeal about your medical care).
- **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 regarding your medical decision and add more information to support your appeal.**
  - 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**."

- If you are appealing a decision we 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: We consider 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 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 calendar days**. If we decide to take extra days to make the decision, we will tell you in writing.
  - 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 automatically 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 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 automatically 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 automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

Step 3: If we say no to part or all of your appeal, your case will automatically be sent on to the next level of the appeals process.

To make sure we were following all the rules 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.

Section 5.4 Step-by-step: How to make a Level 2 Appeal

If we say 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 we made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

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

Step 1: The Independent Review Organization reviews your appeal.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to 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 you a fee for copying and sending this information to you.
- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization will take a careful look at all of the information 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, you will automatically receive a fast appeal at Level 2. 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 calendar days**.

If you had a "standard" appeal at Level 1, you will also have a **"standard" appeal** at Level 2

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. 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 calendar 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 calendar days after we receive the decision from the review organization.
- **If this organization says no to part or all of your appeal,** it means they agree with us that your request (or part of 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 written 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.

Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?

If you want to ask us for payment for medical care, start by reading Chapter 7 of this booklet: Asking us to pay our share of a bill you have received for covered 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 us

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 4.1 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 within 60 calendar days after we receive your request. 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 part 5.3 of this section. 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.

Section 6.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many 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 Prescription 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 3 for more information about a medically accepted indication.)

- **This section is about your Part D drugs only.** To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time.
- For details about what we mean by Part D drugs, the Prescription Drug Guide (Formulary), rules and restrictions on coverage, and cost information, see Chapter 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 determination.**"

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

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

  - Please note: If your pharmacy tells you that your prescription cannot be filled as written, 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 the chart below to help you determine which part has information for your situation:

Which of these situations are you in?			
Do you need a drug that isn't in our Drug Guide or need us to waive a rule or restriction on a drug we cover?	Do you want us to cover a drug in our Drug Guide and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?	Do you want to ask us to pay you back for a drug you have already received and paid for?	Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?
You can ask us to make an exception. (This is a type of coverage decision.) Start with **Section 6.2** of this chapter.	You can ask us for a coverage decision. Skip ahead to **Section 6.4** of this chapter.	You can ask us to pay you back. (This is a type of coverage decision.) Skip ahead to **Section 6.4** of this chapter.	You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to **Section 6.5** of this chapter.

Section 6.2 What is an exception?

If a drug is not covered in the way you would like it to be covered, you can ask us to make an "exception." An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

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

1. **Covering a Part D drug for you that is not in our plan's Prescription Drug Guide (Formulary).** (We call it the "Drug Guide" for short.)

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

- If we agree to make an exception and cover a drug that is not in the Drug Guide, you will need to pay the cost-sharing amount that applies to Cost-Sharing Tier 3 - Non-Preferred Brand Drugs. You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.
- You cannot ask for coverage of any "excluded drugs" or other non-Part D drugs which Medicare does not cover. (For more information about excluded drugs, see Chapter 5.)

2. **Removing a restriction on our coverage for a covered drug.** There are extra rules or restrictions that apply to certain drugs in our Prescription Drug Guide (Formulary) (for more information, go to Chapter 5 and look for Section 4).

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

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

3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug in our Drug Guide is in one of four cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

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

- If your drug is in Cost-Sharing Tier 3 - Non-Preferred Brand Drugs you can ask us to cover it at the cost-sharing amount that applies to drugs in Tier 2 - Preferred Brand Drugs. 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 Tier 4 - Specialty Drugs.

Section 6.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons 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.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. Section 6.5 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.

Section 6.4 Step-by-step: How to ask for a coverage decision, including an exception

Step 1: You ask us to make a coverage decision about the drug(s) or payment you need. If your health requires a quick response, you must ask us to make a **"fast 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 calling, 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 us when you are asking for a coverage decision about your Part D prescription drugs. Or if you are asking us to pay you back for a drug, go to the section called, Where to send a request that asks us to pay for our share of the cost for 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 us to pay you back for a drug,** start by reading Chapter 7 of this booklet: Asking us to pay our share of a bill you have received for covered 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 us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See Sections 6.2 and 6.3 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 "**expedited coverage determination**."

- When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard 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 have 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), we 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: We consider your request and we give you our answer.

Deadlines for a "**fast**" coverage decision

- If we are using the fast deadlines, we must give you our answer **within 24 hours**.
  - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent 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 30 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no.

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

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

Section 6.5 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan)

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

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

What to do

- **To start your appeal, you, your doctor or your respresentative must contact us.**
  - For details on how to reach us by phone, fax, or mail for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called, How to contact us when you are making an appeal about your Part D prescription drugs.
- **If you are asking for a standard appeal, make your appeal by submitting a written request.**
- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown in Chapter 2, Section 1** (How to contact 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. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.**
  - You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
  - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

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

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

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements and procedures for getting a "fast appeal" are the same as those for getting a "fast decision"in Section 6.4 of this chapter.

Step 2: We consider 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 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 after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how 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 you believe your health requires it, you should ask for a "fast" appeal.
  - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we 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 we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal.
- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

Section 6.6 Step-by-step: How to make a Level 2 Appeal

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

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

Step 1: To make a Level 2 Appeal, you must contact the Independent Review Organization and ask for a review of your case.

- If we say no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.
- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file.** We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the Independent Review Organization additional information to support your appeal.

Step 2: The Independent Review Organization does a review of your appeal and gives you an answer.

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

Deadlines for **"fast" appeal** at Level 2

- If your health requires it, ask the Independent Review Organization for a "fast appeal."
- If the review organization agrees to give you a "fast appeal," the review organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.
- **If the Independent Review Organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

Deadlines for **"standard" appeal** at Level 2

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal.
- **If 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 our 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.

Section 7.1 During your inpatient 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 (for example, a caseworker or nurse) must 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. 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 we will cover your hospital care for a longer time. (Section 7.2 below tells how you can request an immediate review.)

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 two 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 or 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 also see it online at http://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp.

Section 7.2 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 (phone numbers are on the back cover of this booklet). 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**."

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 About Your Rights) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4 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 7.4.

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**."

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 we have given to them.
- By noon of the day after the reviewers informed our plan of your appeal, 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 or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you can see a sample notice online at http://www.cms.hhs.gov/BNI/.

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, **we 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 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 the review organization says no to your appeal and 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.

Section 7.3 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 calendar days** after the day when the Quality Improvement Organization said no to your Level 1 Appeal. You can ask for this review only if you 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 calendar days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

- **We 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. **We 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 on 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.

Section 7.4 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 7.2, 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 us, 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 appeal**".

Step 1: Contact us 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 us 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: We do a "fast" review of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take 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: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If we say 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 we say 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 we say 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 following all the rules when we said no to your fast appeal, **we are 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 we say 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 we 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**."

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 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 we 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 us that your planned hospital discharge date was medically appropriate.
  - 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 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

Section 8.1 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 we decide 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, we will stop paying our 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 for an appeal.

Section 8.2 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 letter or 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 you 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 request a change to our coverage decision about when to stop your care. (Section 8.3 below tells how you can request a fast-track appeal.)

Legal Terms	The written notice is called the "**Notice of Medicare Non-Coverage**." To get a sample copy, call Customer Care or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or see a copy online at http://www.cms.hhs.gov/BNI/.

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 us that it's time to stop getting the care.

Section 8.3 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 (phone numbers are on the back cover of this booklet). 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 "Exhibit A" in the back of this booklet.

What should you ask for?

- Ask this organization to do an independent review of whether it is medically appropriate for us 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 us instead. For details about this other way to make your appeal, see Section 8.5.

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.

- By the end of the day the reviewers informed us of your appeal, and you will also get a written notice from us that gives our reasons for ending our coverage for your services.

Legal Terms This notice is called the "**Detailed Explanation of Non-Coverage**."

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 **we 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**. We 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.

Section 8.4 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?

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We 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 we made to your Level 1 Appeal and will not change it.
- 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 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 8.5 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 8.3, 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 us, 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 appeal**".

Step 1: Contact us and ask for a "fast review."

- For details on how to contact us go to Chapter 2, Section 1 and look for the section called, How to contact us 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: We do a "fast" review of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were 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: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If we say 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 we say no to your fast appeal,** then your coverage will end on the date we have told you and we 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 ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If we say no to your fast appeal, your case will automatically go on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **we are 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 we say 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 we 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**."

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 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 we 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.
  – 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

Section 9.1 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."

- **If the Administrative Law Judge says yes to your appeal, the appeals process may or may not be 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 Administrative Law Judge says no to your appeal, the appeals process may or may not be over.**
  – If you decide to accept this decision that turns down your appeal, the appeals process is over.
  – If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge 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.

- **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 step of the administrative appeals process.

Section 9.2 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 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."

- **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 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.

- **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. If the Medicare Appeals Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

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

- This is the last step of the appeals process.

MAKING COMPLAINTS

SECTION 10 How to make a complaint about quality of care, waiting times, customer service, or other concerns

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

Section 10.1 What kinds of problems are handled by the complaint process?

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

If you have any of these kinds of problems, you can "make a complaint"

Quality of your medical care
- Are you unhappy with the quality of the care you have received (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 service, or other negative behaviors
- Has someone been rude or disrespectful to you?
- Are you unhappy with how our Customer Care has treated you?
- Do you feel you are being encouraged to leave the plan?

The next page has more examples of possible reasons for making a complaint

Possible complaints (continued)

Waiting times
- Are you having trouble getting an appointment, or waiting too long to get it?
- Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Customer Care or other staff at the plan?
  - Examples include waiting too long on the phone, in the waiting room, when getting a prescription, or in the exam room.

Cleanliness
- Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?

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

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

Section 10.2 The formal name for "making a complaint" is "filing a grievance"

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

Section 10.3 Step-by-step: Making a complaint

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

- **Usually, calling Customer Care is the first step.** If there is anything else you need to do, Customer Care will let you know. 1-800-457-4708 TTY 711 from 8 a.m. to 8 p.m., 7 days a week.

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

Grievance 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 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 right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a "fast 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 an "**expedited grievance**."

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 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 10.4 You can also make complaints about quality of care to the Quality Improvement Organization

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

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

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (without making the complaint to us).
  - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.
  - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

CHAPTER 10. Ending your membership in the plan

SECTION 1 Introduction

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

Ending your membership in HumanaChoice H6609-011 (PPO) 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 only certain times during the year, or certain situations, when you may voluntarily end your membership in the plan. Section 2 tells you when you can end your membership in the plan.
  - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you how to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your medical care and prescription drugs through our plan until your membership ends.

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

You may end your membership in our plan only during certain times of the year, known as enrollment periods. All members have the opportunity to leave the plan during the Annual Enrollment Period and during the annual Medicare Advantage Disenrollment Period. In certain situations, you may also be eligible to leave the plan at other times of the year.

Section 2.1 You can end your membership during the Annual Enrollment Period

You can end your membership during the **Annual Enrollment Period** (also known as the "Annual Coordinated Election Period"). This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

- **When is the Annual Enrollment Period?** This happens from October 15 to December 7 in 2011.
- **What type of plan can you switch to during the Annual Enrollment Period?** During this time, you can review your health coverage and your prescription drug coverage. You can choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:
  - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Original Medicare with a separate Medicare prescription drug plan.
  - - or - Original Medicare without a separate Medicare prescription drug plan.
    - > **If you receive Extra Help from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

  Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average at least as much as Medicare's standard prescription drug coverage.) See Chapter 6, Section 10 for more information about the late enrollment penalty.

- **When will your membership end?** Your membership will end when your new plan's coverage begins on January 1.

Section 2.2 You can end your membership during the annual Medicare Advantage Disenrollment Period, but your choices are more limited

You have the opportunity to make one change to your health coverage during the **annual Medicare Advantage Disenrollment Period**.

- **When is the annual Medicare Advantage Disenrollment Period?** This happens every year from January 1 to February 14.
- **What type of plan can you switch to during the annual Medicare Advantage Disenrollment Period?** During this time, you can cancel your Medicare Advantage plan enrollment and switch to Original Medicare. If you choose to switch to Original Medicare during this period, you have until February 14 to join a separate Medicare prescription drug plan to add drug coverage.
- **When will your membership end?** Your membership will end on the first day of the month after we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of HumanaChoice H6609-011 (PPO) may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you are eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (http://www.medicare.gov):
  - Usually, when you have moved.
  - If you have Medicaid.
  - If you are eligible for Extra Help with paying for your Medicare prescriptions.
  - If we violate our contract with you.
  - If you are getting care in an institution, such as a nursing home or long-term care hospital.
- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.
- **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
  - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Original Medicare with a separate Medicare prescription drug plan.
  - - or - Original Medicare without a separate Medicare prescription drug plan.
    - > **If you receive Extra Help from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

  Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) See Chapter 6, Section 10 for more information about the late enrollment penalty.

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

Section 2.4 Where can you get more information about when you can end your membership?

If you have any questions or would like more information on when you can end your membership:
- You can **call Customer Care** (phone numbers are on the back cover of this booklet).
- You can find the information in the **Medicare & You 2012** Handbook.
  - Everyone with Medicare receives a copy of Medicare & You each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare website (http://www.medicare.gov). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 3 How do you end your membership in our plan?

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

Usually, to end your membership in our plan, you simply enroll in another Medicare plan during one of the enrollment periods (see Section 2 for information about the enrollment periods). However, if you want to switch from our plan to Original Medicare without a Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:
- You can make a request in writing to us. (Contact Customer Care if you need more information on how to do this.)
- --or--You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) See Chapter 6, Section 10 for more information about the late enrollment penalty.

The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	This is what you should do:
• Another Medicare health plan.	• Enroll in the new Medicare health plan. You will automatically be disenrolled from HumanaChoice H6609-011 (PPO) when your new plan's coverage begins.
• Original Medicare with a separate Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from HumanaChoice H6609-011 (PPO) when your new plan's coverage begins.
• Original Medicare without a separate Medicare prescription drug plan. – **Note:** If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. See Chapter 6, Section 10 for more information about the late enrollment penalty.	• **Send us a written request to disenroll.** Contact Customer Care if you need more information on how to do this (phone numbers are on the back cover of this booklet). • You can also contact **Medicare** at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from HumanaChoice H6609-011 (PPO) when your coverage in Original Medicare begins.

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

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

If you leave HumanaChoice H6609-011 (PPO), it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care and prescription drugs through our plan.

- **You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy, including through our mail-order pharmacy services.
- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 HumanaChoice H6609-011 (PPO) must end your membership in the plan in certain situations

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

HumanaChoice H6609-011 (PPO) must end your membership in the plan if any of the following happen:

- If you do not stay continuously enrolled in Medicare Part A and Part B.
- If you move out of our service area for more than six months.
  - If you move or take a long trip, you need to call Customer Care to find out if the place you are moving or traveling to is in our plan's area.
  - Go to Chapter 4, Section 2.3 for information on getting care when you are away from the service area through our plan's visitor/traveler benefit.
- If you become incarcerated (go to prison).
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
  - We cannot make you leave our plan for this reason unless we get permission from Medicare first.
- If you let someone else use your membership card to get medical care or prescription drugs.
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you do not pay the plan premiums for 6 months.
  - We must notify you in writing that you have 6 months to pay the plan premium before we end your membership.

Where can you get more information?

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

- You can call **Customer Care** for more information (phone numbers are on the back cover of this booklet).

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

What should you do if this happens?

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

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

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can make a complaint about our decision to end your membership. You can also look in Chapter 9, Section 11 for information about how to make a complaint.

CHAPTER 11. Legal notices

SECTION 1 Notice about governing law

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

SECTION 2 Notice about 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 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. We will not seek recovery from any portion of an award that is appropriately designated by the court as payment for losses other than medical services (e.g., property losses).

Where we provide benefits in the form of services, we shall be entitled to reimbursement on the basis of the reasonable value of the benefits provided.

Non-duplication of benefits

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

If we do provide benefits to you before any other type of health coverage you may have, we may seek recovery of those benefits in accordance with the Medicare Secondary Payer rules. Please also refer to the **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

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 - An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Annual Enrollment Period - A set time each fall when members can change their health or drugs plans or switch to Original Medicare. The Annual Enrollment Period is from October 15 until December 7, 2011.

Appeal - An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don'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 HumanaChoice H6609-011 (PPO), 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 4, Section 1.6 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 your skilled nursing facility benefits. A benefit period begins the day you go into a skilled nursing facility. The benefit period will accumulate one day for each day you are inpatient at a SNF. The benefit period ends when you haven't received any inpatient skilled care in a SNF for 60 days in a row. If you go into a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

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 **$4,700** in covered drugs during the covered year.

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

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

Combined Maximum Out-of-Pocket Amount - This is the most you will pay in a year for all Part A and Part B services from both network (preferred) providers and out-of-network (non-preferred) 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 and speech-language pathology services, and home environment evaluation services.

Computed Tomography Imaging (CT/CAT) Scan - Combines the use of a digital computer together with a rotating X-ray device to create detailed cross-sectional images of different organs and body parts.

Contracted Rate - The rate the network provider or pharmacy has agreed to accept for covered services or prescription drugs.

Copayment - An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay **$10** or **$20** for a doctor's visit or prescription drug.

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

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

Coverage Determination - A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called "coverage decisions" in this 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 pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care - Custodial care is personal care 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 a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

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

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

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

Durable Medical Equipment - Certain medical equipment that is ordered by your doctor for use at home. Examples are walkers, wheelchairs, or hospital beds.

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

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 is Medicare-certified and licensed by the proper authority.

Freestanding Radiology (Imaging) Center - A freestanding facility that provides one or more of the following services on an outpatient basis for the prevention, diagnosis, and treatment of an injury or illness: X-rays; nuclear medicine; radiation oncology. This type of facility does not provide inpatient room and board and is Medicare-certified and licensed by the proper authority.

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

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

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 Chapter 4 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). TTY users should call 1-877-486-2048.

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 before your total drug expenses have reached **$2,930**, 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 - The most you will pay for covered Part A and Part B services received from network (preferred) providers. After you have reached this limit, you will not have to pay anything when you get covered services from network providers for the rest of the contract year. However, until you reach your combined out-of-pocket amount, you must continue to pay your share of the costs when you seek care from an out-of-network (non-preferred) provider.

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. For example, if you receive Extra Help from Medicare to pay your prescription drug plan costs, the late enrollment penalty rules do not apply to you. If you receive Extra Help, you do not pay a penalty, even if you go without "creditable" prescription drug coverage.

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 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 2, Section 6 for information about how to contact Medicaid in your state.

Medically Accepted Indication - A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3 for more information about a medically accepted indication.

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

Medicare - The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a Medicare Advantage Plan.

Medicare Advantage Disenrollment Period - A set time each year when members in a Medicare Advantage Plan can cancel their plan enrollment and switch to Original Medicare. The Medicare Advantage Disenrollment Period is from January 1 until February 14, 2012.

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 and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private-Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. 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 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, biologicals, and some supplies not covered by Medicare Part A or Part B.

"Medigap" (Medicare Supplement Insurance) Policy - Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or "Plan Member") - A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

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

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.

Non-Preferred Network Pharmacy - A network pharmacy that offers covered drugs to members of our plan at higher cost-sharing levels than apply at a preferred network pharmacy.

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.

Optional Supplemental Benefits - Non-Medicare-covered benefits that can be purchased for an additional premium and are not included in your package of benefits. If you choose to have optional supplemental benefits, you may have to pay an additional premium. You must voluntarily elect Optional Supplemental Benefits in order to get them.

Organization Determination - The Medicare Advantage organization has made an organization determination when it, or one of its providers, makes a decision about whether services are covered or how much you have to pay for covered services. Organization determinations are called "coverage decisions" in this booklet. Chapter 9 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 such as Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Our plan - The plan you are enrolled in, HumanaChoice H6609-011 (PPO).

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-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-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.

Plan Provider - see "Network Provider".

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 Network Pharmacy - A network pharmacy that offers covered drugs to members of our plan at lower cost-sharing levels than apply at a non-preferred network pharmacy.

Preferred Provider Organization (PPO) Plan - A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they 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 (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

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

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

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 physician before you see any other health care provider. See Chapter 3, Section 2.1 for information about Primary Care Physicians.

Prior Authorization - Approval in advance to get services or certain drugs that may or may not be on our formulary. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other network provider gets "prior authorization" from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. 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) - A group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the QIO 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 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.

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

Special Needs Plan - A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

Step Therapy - A utilization tool that requires you to first try another drug to treat your medical condition before we 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, but the plan's network of providers is temporarily unavailable or inaccessible.

State Agency Contact Information

This section provides the contact information for the state agencies referenced in Chapter 2 and in other locations within this Evidence of Coverage. If you have trouble locating the information you seek, please contact Customer Care at the phone number on the back cover of this booklet.

State	Idaho
SHIP Name and Contact Information	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
Quality Improvement Organization	QualisHealth 720 Park Blvd. Suite 120 Boise,ID 83712 1-800-445-6941 (toll free) 1-208-343-4617 (local) 1-208-343-4705 fax http://www.qualishealthmedicare.org/
State Medicaid Office	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/
State Pharmacy Assistance Program(s)	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/Health/FamilyPlanningSTDHIV/HIVCarea

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HumanaChoice H6609-011 (PPO) Customer Care

CALL	1-800-457-4708 Calls to this number are free. Customer Care is available seven days a week, from 8 a.m. to 8 p.m. (A customer care representative will be available to answer your call directly during the annual enrollment period and 60 days after from 8 a.m. until 8 p.m.) However, beginning February 15, 2012, your call may be handled by our automated phone system on Saturdays, Sundays, and some Public Holidays. When leaving a message, simply select the reason for your call from the automated list and a knowledgeable representative will return your call by the end of the next working day. Customer Care also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	1-877-837-7741
WRITE	Humana, P.O. Box 14168, Lexington, KY 40512-4168
WEBSITE	**Humana.com**

State Health Insurance Assistance Program

The State Health Insurance Assistance Program (SHIP) is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

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

HUMANA®

Humana Health and Wellness Order Form

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As a Humana plan member, you may be able to purchase health and wellness products from the *Right*SourceRx® mail-order pharmacy, depending on your current Humana plan.

Call a Customer Care specialist to verify your eligibility or request an order form at **1-800-457-4708**. TTY users call **711**, seven days a week, 8 a.m. – 8 p.m.

How to order

For each item you would like to order, darken the circle for the appropriate quantity.

Please **print clearly** and **press hard**
Use blue or blank ink only

Correct Mark

Incorrect Mark

For credit-card orders only: Please complete the order form and fax it along with your credit card information to **1-800-379-7617.**

To order by mail, send the completed form on the following pages along with your check or credit card information to:

***Right*SourceRx®**
P.O. Box 745099
Cincinnati, OH 45274-5099

Humana Health and Wellness Order Form

QUANTITY		GENERIC NAME	COMPARE TO	SIZE	PRICE
VITAMINS / MINERALS (DUAL-PURPOSE ITEMS*)					
OTCN11	①②③④⑤	Antioxidant Tablets	Antioxidant Tablets	60	**$5**
OTCN3	①②③④⑤	B-Complex with B-12	B-Complex with B-12	100	**$4**
OTCN2	①②③④⑤	Co-Enzyme Q-10 30 mg	Co-Enzyme Q-10 30 mg	30	**$10**
OTC63	①②③④⑤	Complete Senior Vitamins and Minerals	Centrum® Silver	60	**$7**
OTC11	①②③④⑤	Daily Multivitamin and Mineral	Advanced Formula Centrum®	130	**$5**
OTCN7	①②③④⑤	Eye Care Vitamins	Ocuvite® Lutein	36	**$5**
OTC13	①②③④⑤	Ferrous Sulfate 5 gr	Feosol®	100	**$3**
OTC14	①②③④⑤	Folic Acid 400 mcg	Folic Acid 400 mcg	100	**$3**
OTC240	①②③④⑤	Folic Acid 800 mcg	Folic Acid 800 mcg	100	**$4**
OTCN10	①②③④⑤	Selenium 200 mcg	Selenium 200 mcg	60	**$4**
OTCN9	①②③④⑤	Timed Release Niacin 500 mg	Timed Release Niacin 500 mg	100	**$5**
OTC238	①②③④⑤	Vitamin B12 1000 mcg	Vitamin B12 1000 mcg	100	**$7**
OTC10	①②③④⑤	Vitamin-C 500 mg	Vitamin-C 500 mg	100	**$4**
OTC209	①②③④⑤	Vitamin D 1000 IU	Vitamin D 1000 IU	100	**$5**
OTC239	①②③④⑤	Vitamin D 5000 IU	Vitamin D 5000 IU	100	**$7**
OTC12	①②③④⑤	Vitamin-E 400 IU Synthetic	Vitamin-E 400 IU Synthetic	100	**$5**
PAIN RELIEVERS					
OTC2	①②③④⑤	Acetaminophen 500 mg	Extra Strength Tylenol®	100	**$4**
OTC20	①②③④⑤	Acetaminophen 80 mg chewable	Tylenol® Children's Chewable	30	**$3**
OTC21	①②③④⑤	Acetaminophen Elixir	Children's Tylenol Elixir	120 ml	**$3**
OTC22	①②③④⑤	Acetaminophen Suspension Drops	Tylenol®	15 ml	**$3**
OTC17	①②③④⑤	Aspirin 81 mg Chewable	Bayer® Chewable Aspirin	36	**$3**
OTC47	①②③④⑤	Aspirin 325 mg	Bayer®	100	**$3**
OTC16	①②③④⑤	Aspirin Low Dose 81 mg EC	Bayer® Adult Low Strength EC	120	**$3**
OTC229	①②③④⑤	Enteric Aspirin 325 mg	Ecotrin®	100	**$5**
OTC125	①②③④⑤	Headache Formula - Aspirin/ Acetaminophen/ Caffeine	Excedrin®	100	**$7**
OTC19	①②③④⑤	Ibuprofen 200 mg	Advil®	50	**$4**
OTC94	①②③④⑤	Ibuprofen Suspension	Children's Motrin®	120 ml	**$6**
OTC214	①②③④⑤	Naproxen Sodium 220 mg- Pain Reliever	Aleve® Caplets	50	**$6**
COUGH / COLD / ALLERGY					
OTC113	①②③④⑤	Antihistamine - Cetirizine HCL 10 mg	Zyrtec® 10 mg	30	**$10**
OTC24	①②③④⑤	Antihistamine - Diphenhydramine Liquid	Benadryl® Allergy	120 ml	**$3**
OTC110	①②③④⑤	Antihistamine - Loratadine 10 mg	Claritin®	30	**$7**
OTC23	①②③④⑤	Antihistamine - Diphenhydramine 25 mg	Benadryl®	24	**$3**
OTC28	①②③④⑤	Cough Formula - Expectorant	Robitussin®	120 ml	**$4**
OTC210	①②③④⑤	Cough Suppressant DM (Sugar free)	Robitussin® Sugar Free DM	118 ml	**$5**
OTC26	①②③④⑤	Cough Suppressant/Expectorant	Robitussin® DM	120 ml	**$4**
OTC96	①②③④⑤	Cough Supp./Nasal Decon./Expectorant	Robitussin® CF	120 ml	**$4**
OTC215	①②③④⑤	Effervescent Pain Relief	Alka-Seltzer®	36	**$5**
OTC111	①②③④⑤	Expectorant - Guaifenesin 400 mg	Mucus Relief 400 mg	30	**$10**
OTC219	①②③④⑤	Eye Drops - Redness Reliever	Visine® Original	15 ml	**$5**
OTC228	①②③④⑤	Nasal Decongestant PE Max Strength	Sudafed® PE Tablets	36	**$6**

Humana Health and Wellness Order Form *(continued)*

QUANTITY		GENERIC NAME	COMPARE TO	SIZE	PRICE
COUGH / COLD / ALLERGY *(continued)*					
OTC95	①②③④⑤	Nasal Decongestant Spray	Afrin®	30 ml	**$3**
OTC99	①②③④⑤	Saline Nasal Spray	Ocean® Saline Nasal Spray	45 ml	**$3**
OTC97	①②③④⑤	Sinus-Acetaminophen/Phenylephrine HCl	Tylenol® Sinus	24	**$3**
OTC117	①②③④⑤	Sore Throat Lozenges-Menthol/Benzocaine	Chloraseptic® Lozenges	18	**$5**
OTC220	①②③④⑤	Sore Throat Spray	Chloraseptic®	180 ml	**$6**
ANTI-DIARRHEALS / ANTACIDS / LAXATIVES / ETC.					
OTC112	①②③④⑤	Acid Reducer - Omeprazole 20 mg	Prilosec OTC® 20 mg	14	**$10**
OTC75	①②③④⑤	Antacid / Anti-Gas Chew Tab	Maalox® Plus	100	**$4**
OTC32	①②③④⑤	Antacid/Anti-Gas Liquid	Mylanta®	360 ml	**$3**
OTC89	①②③④⑤	Antacid Double-Strength Chew Tab	Mylanta® Double Strength	70	**$5**
OTC29	①②③④⑤	Anti-Diarrheal Tablets - Loperamide 2 mg	Imodium® A-D	12	**$3**
OTC31	①②③④⑤	Anti-Hemorrhoidal Ointment	Preparation H®	60 gm	**$5**
OTC227	①②③④⑤	Calcium Carbonate Antacid- Chewable	Extra Strength Tums E-X®	96	**$5**
OTC116	①②③④⑤	Dairy Digestive Supplement - Lactase Enzyme	Lactaid® Tabs	60	**$9**
OTC3	①②③④⑤	Enema	Fleet® Enema	270 ml	**$3**
OTC98	①②③④⑤	Extra Strength Gas Relief Tablets	Gas-X® Extra Strength	30	**$4**
OTC208	①②③④⑤	Fiber Laxative Tablets	FiberCon®	90	**$9**
OTC234	①②③④⑤	Glycerine Suppositories, Adult	Fleet	12	**$3**
OTC216	①②③④⑤	Hemorrhoidal Suppositories	Preparation H® Suppositories	12	**$6**
OTC93	①②③④⑤	Laxative - Bisacodyl 5 mg	Dulcolax®	25	**$3**
OTC33	①②③④⑤	Milk of Magnesia - Laxative/Antacid	Phillips® Milk of Magnesia	360 ml	**$4**
OTC115	①②③④⑤	Pink Bismouth - Chewable Tablets	Pepto-Bismol® Chewable Tabs	30	**$5**
OTC104	①②③④⑤	Ranitidine 75 mg Tablets - Antacid	Zantac®	30	**$7**
OTC233	①②③④⑤	Senna Laxative Tabs	Senokot	100	**$10**
OTC101	①②③④⑤	Stool Softener Capsules	Colace®	100	**$4**
FIRST AID / MEDICAL SUPPLIES					
OTC35	①②③④⑤	Alcohol Prep Pads	B-D® Alcohol Swabs	100	**$4**
OTC217	①②③④⑤	Allergy Cream- Itching and Pain Relief	Benadryl® Extra Strength Cream	30 gm	**$5**
OTC243	①②③④⑤	Bladder Control Pads (Regular)	Poise® Moderate Pads	20	**$7**
OTC242	①②③④⑤	Blood Pressure Home Kit (manual pump w/stethoscope	Blood Pressure Home Kit (manual pump w/stethoscope	1	**$15**
OTC37	①②③④⑤	Calamine Lotion	Caladryl®	120 ml	**$3**
OTC38	①②③④⑤	Clotrimazole Cream 1% - Athlete's Foot	Lotrimin AF®	15 gm	**$4**
OTC213	①②③④⑤	Cold and Hot Patches- Pain Relief	Icy Hot® Patch	5	**$7**
OTC36	①②③④⑤	Cotton Swabs	Q-Tips®	300	**$3**
OTC224	①②③④⑤	Dental Floss	Dental Floss	1	**$3**
OTC225	①②③④⑤	Denture Adhesive	Fixodent®	45 gm	**$5**
OTC118	①②③④⑤	Earwax Removal Drops - Carbamide Peroxide Tablets	Debrox® Earwax Removal Drops	15 ml	**$5**
OTC235	①②③④⑤	Effervescent Denture Tabs	Efferdent®	40	**$5**
OTC226	①②③④⑤	Elastic Bandage	Ace® Bandage	1	**$6**
OTC232	①②③④⑤	First Aid Tape	J&J®	1	**$2**
OTC223	①②③④⑤	Glucose Chewable Tablets	DEX4® Glucose Tablets	10	**$2**

Humana Health and Wellness Order Form *(continued)*

QUANTITY		GENERIC NAME	COMPARE TO	SIZE	PRICE
FIRST AID / MEDICAL SUPPLIES *(continued)*					
OTC4	①②③④⑤	Hydrocortisone Cream 1%	Cortizone 10®	30 gm	**$3**
OTC114	①②③④⑤	Lubricant Eye Drops (Sterile)	Liquifilm Tears®	15 ml	**$5**
OTC43	①②③④⑤	Medicated Chest Rub	Vicks VapoRub®	99 gm	**$5**
OTC105	①②③④⑤	Medicated Lip Balm	Medicated Lip Balm	1	**$1**
OTC46	①②③④⑤	Muscle Rub	Ben-Gay®	120 gm	**$5**
OTC48	①②③④⑤	Oral Thermometer (Digital Display)	B-D® Oral Thermometer	1	**$5**
OTC44	①②③④⑤	Plastic Bandages	Band-Aids®	100	**$3**
OTC106	①②③④⑤	Sunblock	Coppertone®	120 ml	**$5**
OTC230	①②③④⑤	Therapeutic Mineral Ice Gel	Mineral Ice®	227 gm	**$5**
OTC221	①②③④⑤	Toothbrush	Toothbrush	1	**$2**
OTC222	①②③④⑤	Toothpaste	Toothpaste	180 gm	**$4**
OTC218	①②③④⑤	Tolnaftate Antifungal Cream	Tinactin® Cream	30 gm	**$8**
OTC119	①②③④⑤	Topical Analgesic Cream - Capsicum Cream 0.025%	Zostrix® Cream	60 gm	**$8**
OTC40	①②③④⑤	Triple Antibiotic Ointment	Neosporin®	30 gm	**$5**
OTC231	①②③④⑤	Triple Antibiotic Ointment Plus Ointment	Neosporin Plus®	30 gm	**$7**
MOTION SICKNESS					
OTC120	①②③④⑤	Motion Sickness Tablets - Dimenhydrinate 50 mg	Dramamine® Tabs	12	**$5**
SLEEPING AIDS					
OTC121	①②③④⑤	Acetaminophen 500 mg and Diphenhydramine 25 mg	Tylenol® PM Extra Strength Tabs	50	**$5**
OTC122	①②③④⑤	Diphenhydramine 25 mg - Night-Time Sleep Aid Tabs	Sominex® Tablets	50	**$4**
SMOKING CESSATION					
OTC123	①②③④⑤	Stop Smoking Gum - Nicotine Polacrilex gum 2 mg	Nicorette® 2 mg gum	50	**$10**
OTC124	①②③④⑤	Stop Smoking Gum - Nicotine Polacrilex gum 4 mg	Nicorette® 4 mg gum	50	**$10**

Women's Wellness

WOMEN'S HEALTH					
OTC16	①②③④⑤	Aspirin Low Dose 81 mg EC	Bayer® Adult Low Strength EC	120	**$3**
OTC109	①②③④⑤	Calcium Citrate + Vitamin D	Citracal® Caplets+D	60	**$4**
OTC41	①②③④⑤	Clotrimazole Vaginal Cream	Gyne-Lotrimin®	45 gm	**$6**
OTC19	①②③④⑤	Ibuprofen 200 mg	Advil®	50	**$4**
OTC42	①②③④⑤	Miconazole-7 Vaginal Cream	Monistat-7®	45 gm	**$6**
OTC107	①②③④⑤	One a Day Women's Multivitamin	One-A-Day Women's®	60	**$4**
OTC15	①②③④⑤	Oyster Calcium + Vitamin D	Os-Cal® 500+D	60	**$4**
OTC108	①②③④⑤	Phenazopyridine 95 mg	Azo-Standard®	30	**$5**

* For Dual-Purpose items noted above: Prior to purchase (1) the enrollee must have appropriate conversations with the enrollee's personal provider, and (2) the enrollee's personal provider orally recommends the OTC item for a specific diagnosable condition. Other items on this order form are classified as eligible. These eligible items may be purchased by the enrollee without further action. OTC items may only be purchased for the plan enrollee. It is prohibited to purchase OTC items for family members and friends. Select items qualify for manual reimbursement under certain circumstances. The following items are not covered under this OTC benefit (non-eligible items): Alternative medicines (Includes botanicals, herbals, probiotics and neutraceuticals including fish oil, glucosamine & chondroitin, garlic, echinacea, saw palmetto, ginkgo biloba, etc), Baby items, Contraceptives, Convenience (non medical items), Cosmetics, Food Supplements, Replacement items, attachments, and peripherals (Includes: Hearing aid batteries, contact-lens containers, etc. when not factory packaged with original item).

Humana Health and Wellness Order Form

Member ID (found on Humana ID card) – Date of Birth MM / DD / YYYY

Gender ○ Male ○ Female

First Name Last Name MI

Street Number Street Name Apt/Suite #

City State Zip Code –

Daytime Phone – – Evening Phone – –

Your Total Order Amount **$ _____**

Humana Monthly Credit **- $10**

You Pay **$_____**

For orders more than $10, please make checks payable to "*Right*SourceRx". Please do not send cash.

To pay by credit card, please complete the following:

Credit/Debit Card # Exp. Date MM / YY

Exp. Date MM / YY

Cardholder First Name Cardholder Last Name

Cardholder Signature:

Please check box if this is a new address: ☐
(no charge to you if your order is **$10** or less)

How to order

To order, just mail the completed form - four pages total- along with your check or credit card information to:

***Right*SourceRx®**
P.O. Box 745099
Cincinnati, OH 45274-5099

Notes: Orders will be shipped to your home by UPS or the U.S. Postal Service, with no extra charge to you for shipping. Please allow 10 to 14 working days from the time we receive your order. You'll receive a generic comparable to the name-brand product. Please consult your doctor before using any over-the-counter (OTC) product. This product list is subject to change. This benefit is only available if your plan offers the OTC service as a benefit. To confirm your eligibility, call Customer Care at **1-800-457-4708**. TTY users call 711, seven days a week, 8 a.m. – 8 p.m.
There is a $25 charge for all returned checks.

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A health plan with a Medicare contract, available to anyone enrolled in both Part A and Part B of Medicare.
Medicare beneficiaries may enroll in the plan only during specific times of the year.
Contact Humana for more information. Limitations, copayments and restrictions may apply.

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