Medicare's Limited Income NET Program (LI NET)

Fact Sheet

Program Overview

LI NET is a temporary Medicare prescription drug plan designed to eliminate gaps in prescription drug coverage for low-income Medicare beneficiaries. Coverage in LI NET typically lasts for one to two months and also provides coverage for a retroactive time period. This allows the beneficiary time to choose a Medicare Part D prescription drug plan that best fits their needs. If a drug plan is not chosen within this timeframe, Medicare will enroll the beneficiary into a Medicare Part D plan available in their area.

How are beneficiaries enrolled in LI NET?

Most beneficiaries are enrolled into the LI NET program through Medicare's Auto Enrollment process. This process occurs when Medicare identifies a beneficiary who is not enrolled in a Medicare Part D plan and qualifies for Low Income Subsidy (LIS), Medicaid, or Supplemental Security Income (SSI). When these individuals are identified, Medicare automatically enrolls them into the LI NET program. Beneficiaries who are not enrolled automatically by Medicare can be enrolled through the claim submission process at the pharmacy counter also known as Point-of-Sale (POS). The pharmacy submits a claim to LI NET and, if the beneficiary is eligible, the claim will process immediately and facilitate the enrollment into the LI NET program. Beneficiaries who were not enrolled via the Auto Enrollment or POS processes can submit claims for reimbursement for eligible periods. See Reimbursement for Out of Pocket Expenses Prior to Being Enrolled in LI NET for more information.

What if I have other coverage?

If you have or are eligible for another type of prescription drug coverage, you may not need drug coverage from Medicare. You or your dependents could lose your other health or drug coverage completely and not get it back if you join a Medicare drug plan. Read all the materials you get from your insurer or plan provider to find out how joining a Medicare drug plan may affect you or your family's current coverage. Please call your insurer or benefits administrator if you have questions.

How to Cancel or Disenroll from LI NET

If you would like to cancel your LI NET coverage, you can do so within 15 days from the date printed on the first page of the included "Welcome Letter" or any time prior to the LI NET coverage effective date. To cancel your LI NET coverage please call us at 1-800-783-1307, TTY 711.

If you missed the cancellation timeframe you can still disenroll from the LI NET program. To disenroll from the LI NET program you will need to send a written request with your Name, Medicare ID number, and a brief description as to why you want to disenroll. You can mail or fax your request to the address or number listed below. You will be disenrolled at the end of the month we receive the request.

Medicare's Limited Income NET Program
PO BOX 14310
Lexington, KY 40512
Fax: 1-877-210-5592

Reimbursement for Out of Pocket Expenses While Enrolled in LI NET

If you paid out of pocket for prescription drugs while you were enrolled in LI NET, you may be eligible for reimbursement. See page 1 of the "Welcome Letter" for your LI NET coverage dates. To request reimbursement for claims paid during your LI NET coverage dates, follow the instructions on the enclosed Prescription Drug Claim Form. You have 36 months from the date the prescription was filled to request reimbursement.

Reimbursement for Out of Pocket Expenses Prior to Being Enrolled in LI NET

If you paid out of pocket for medications prior to your LI NET coverage effective date, you may be eligible for reimbursement. To be eligible for reimbursement prior to your LI NET coverage effective date you must meet the following eligibility requirements on the date the prescription was filled:

1. Eligible for Medicare Part D
2. No other prescription drug coverage (Medicare Part D, Retiree Drug Subsidy)
3. Not enrolled in a Medicare Advantage Plan (Medicare Part C)
4. Have not Opted Out of Medicare's auto-enrollment
5. Permanent address in the 50 States or Washington D.C.
6. Full Dual Eligible

a) You are considered full dual eligible if you qualify for Medicare and Medicaid benefits or Supplemental Security Income (SSI)

Note: For reimbursement requests greater than 36 months, a Medicaid or SSI determination must have been made within the last 90 days. Proof of this determination and the date it was made is required and you must meet all the other eligibility requirements listed above. If you meet the above eligibility requirements on the date the prescription was filled, follow the instructions on the enclosed Prescription Drug Claim Form.

Your Rights: If your request for reimbursement or coverage for a drug was denied, you have the right to appeal

If you want to appeal, you must request your appeal within 60 calendar days after the date of this notice. We can give you more time if you have a good reason for missing the deadline.

Who May Request an Appeal?

You, your prescriber, or your representative may request an expedited (fast) or standard appeal. You can name a relative, friend, advocate, attorney, doctor, or someone else to be your representative. Others may already be authorized under State law to be your representative. You can call us at: 1-800-783-1307 (TTY 711) to learn how to appoint a representative.

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS:

There Are Two Kinds of Appeals You Can Request:

- **Expedited (72 hours):** You, your prescriber, or your representative can request an expedited (fast) appeal if you or your prescriber believe that your health could be seriously harmed by waiting up to 7 days for a decision. You cannot request an expedited appeal if you are asking us to pay you back for a prescription drug you already received. If your request to expedite is granted, we must give you a decision no later than 72 hours after we get your appeal.
- If your prescriber asks for an expedited appeal for you, or supports you in asking for one, and indicates that waiting for 7 days could seriously harm your health, we will automatically expedite your appeal.
- If you ask for an expedited appeal without support from your prescriber, we will decide if your health requires an expedited appeal. We will notify you if we do not give you an expedited appeal and we will decide your appeal within 7 days.

Standard (7 days): You, your prescriber, or your representative can request a standard appeal. We must give you a decision no later than 7 days after we get your appeal.

What Do I Include with My Appeal Request?

You should include your name, address, Member number, the reasons for appealing, and any evidence you wish to attach.

How Do I Request an Appeal?

For an Expedited Appeal**:** You, your prescriber, or your representative should contact us by telephone or fax at the numbers below:

Phone: 1-800-783-1307 (TTY 711)
Fax: 1-877-210-5595
For a Standard Appeal**:** You, your prescriber, or your representative should mail or deliver your written appeal request to the address below:

ATTN: Grievances and Appeals
Medicare's Limited Income NET Program
PO Box 14165
Lexington, KY 40512-4165

What Happens Next?

If you appeal, we will review your case and give you a decision. If any of the prescription drugs you requested are still denied, you can request an independent review of your case by a reviewer outside of your Medicare Drug Plan. If you disagree with that decision, you will have the right to further appeal. You will be notified of your appeal rights if this happens.

Call if you need us:

For additional information, please contact our customer care team:

- 1-800-783-1307 (TTY 711)

Sincerely,

Medicare's Limited Income NET Enrollment Team

Medicare's
Limited Income NET Program
administered by Humana®

PRESCRIPTION DRUG CLAIM FORM FOR MEMBER REIMBURSEMENT

CLAIM FORM INSTRUCTIONS

Part 1: Member Information

1. Complete all information under Part 1. Missing or incomplete information may result in delay or denial of your request.
2. You will have 36 months from the date the prescription is filled to submit your claim. Note: Services incurred outside the United States are not payable under Medicare Part D Plan.
3. For questions or concerns, please contact customer service at 1-800-783-1307 or TTY 711.

Part 2: Receipt Information

1. Include all original pharmacy receipt(s) AND **proof of payment**. Tape receipts to a separate page and submit with claim form. If medication was given in Emergency Room or Doctors office include detailed statement.
2. Receipt(s) must contain the information outlined under Part 2. If your receipt(s) are missing any of this information, please ask your pharmacy to provide a printout with the information required in Part 2.
3. Remember to keep a copy of the completed claim form and receipt(s) for your records.

Part 3: Pharmacy Information

Provide information about the pharmacy where medications were received.

Once all sections have been filled in, please sign and date. Your signature proves that all information is truthfully represented by the completed form and accompanying receipts. If you are a representative of Member and are authorized to submit on their behalf please provide proof of Appointment of Representation.

Mail the completed form and Receipt(s) to: **Medicare's Limited Income NET Program** or Fax to: **877-210-5592**
P.O. Box 14310
Lexington, KY 40512-4310

PART 1: MEMBER INFORMATION

Humana ID Number H - Medicare ID Number

Member Last Name | Member First Name | M.I.

Street Address | Date of Birth (mm/dd/yyyy) – –

City | State | Zip Code

Member Phone Number ( ) –

Gender ☐ Male ☐ Female

Person Completing This Form ☐ Member ☐ Spouse ☐ Child ☐ Other

Patient Residence:
- ☐ Home
- ☐ Nursing Home
- ☐ Assisted Living
- ☐ Group Home
- ☐ Intermediate Care
- ☐ Hospice

PART 2: RECEIPT INFORMATION

Ensure your receipt includes the following information:

- ☐ Date Filled
- ☐ Medication Name
- ☐ RX Number
- ☐ National Drug Code (NDC)
- ☐ Medication Strength
- ☐ Dosage Form
- ☐ Quantity
- ☐ Day(s) Supply
- ☐ RX Price (amount you paid including tax)
- ☐ Physician Name
- ☐ Physician ID (NPI or DEA #)
- ☐ If drug is a compound, list the NDCs for all ingredients and quantity of each

Dispense as Written (DAW): This code is a message from your doctor to the pharmacist about using generics. If it applies to your prescription, it can be found on your pharmacy label or your pharmacy can provide it.

☐ 0 – Not Applicable ☐ 1 – Doctor requires that brand product be dispensed ☐ 2 – Patient requires that brand product be dispensed

☐ 5 – Brand submitted as generic ☐ 7 – Brand mandated by state law

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Medicare's
Limited Income NET Program
administered by Humana®

PRESCRIPTION DRUG CLAIM FORM FOR MEMBER REIMBURSEMENT

PART 3: PHARMACY INFORMATION

Pharmacy Name | Pharmacy NCPDP ID | OR | Pharmacy NPI

Street Address

City | State | Zip Code | Pharmacy Phone Number ( ) –

Pharmacy Service Type

☐ Retail ☐ Compounding ☐ Home Infusion ☐ Institutional ☐ Long Term Care ☐ Managed Care Organization

☐ Mail Order ☐ Specialty

DESCRIPTION OF ISSUE

☐ Pharmacy will not accept my LI NET plan

☐ Pharmacy was unable to process my claim electronically

☐ I did not have my plan information at the time of purchase

☐ I was charged for medications received during an Emergency Room visit

☐ I believe the claim was paid incorrectly

☐ I was administered a Part D covered vaccine in my doctor's office

☐ I filled my medication during an emergency

☐ I have drug coverage with a plan other than LI NET (Coordination of Benefits):
Name of Insurance Co: _____
Insurance Co Phone: _____
Employer Name: _____
Member ID: _____

Please explain the issue:

_____

_____

_____

_____

IMPORTANT CLAIM NOTICE

Caution: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent act.

PLEASE SIGN FORM:

Member Signature X_____ Date ___/___/____

NOTE: If this form is signed by anyone other than the member, additional documentation is required authorizing that representative. This may include an Appointment of Representative (AOR) form or statement, a Power of Attorney (POA), or other legal documentation. An AOR form is available at https://www.humana.com/medicare-support/tools/member-forms for your convenience.

Medicare ID Number

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