Humana®

We're here for you!

Humana Group Medicare Customer Care
**1-866-396-8810 (TTY: 711)**
Monday – Friday, 8 a.m. – 9 p.m., Eastern time

Humana is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal. Call **1-866-396-8810 (TTY: 711)** for more information.

Limitations on telehealth services, also referred to as virtual visits or telemedicine, vary by state. These services are not a substitute for emergency care and are not intended to replace your primary care provider or other providers in your network. Any descriptions of when to use telehealth services are for informational purposes only and should not be construed as medical advice. Please refer to your Evidence of Coverage for additional details on what your plan may cover or other rules that may apply.

Out-of-network/non-contracted providers are under no obligation to treat plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

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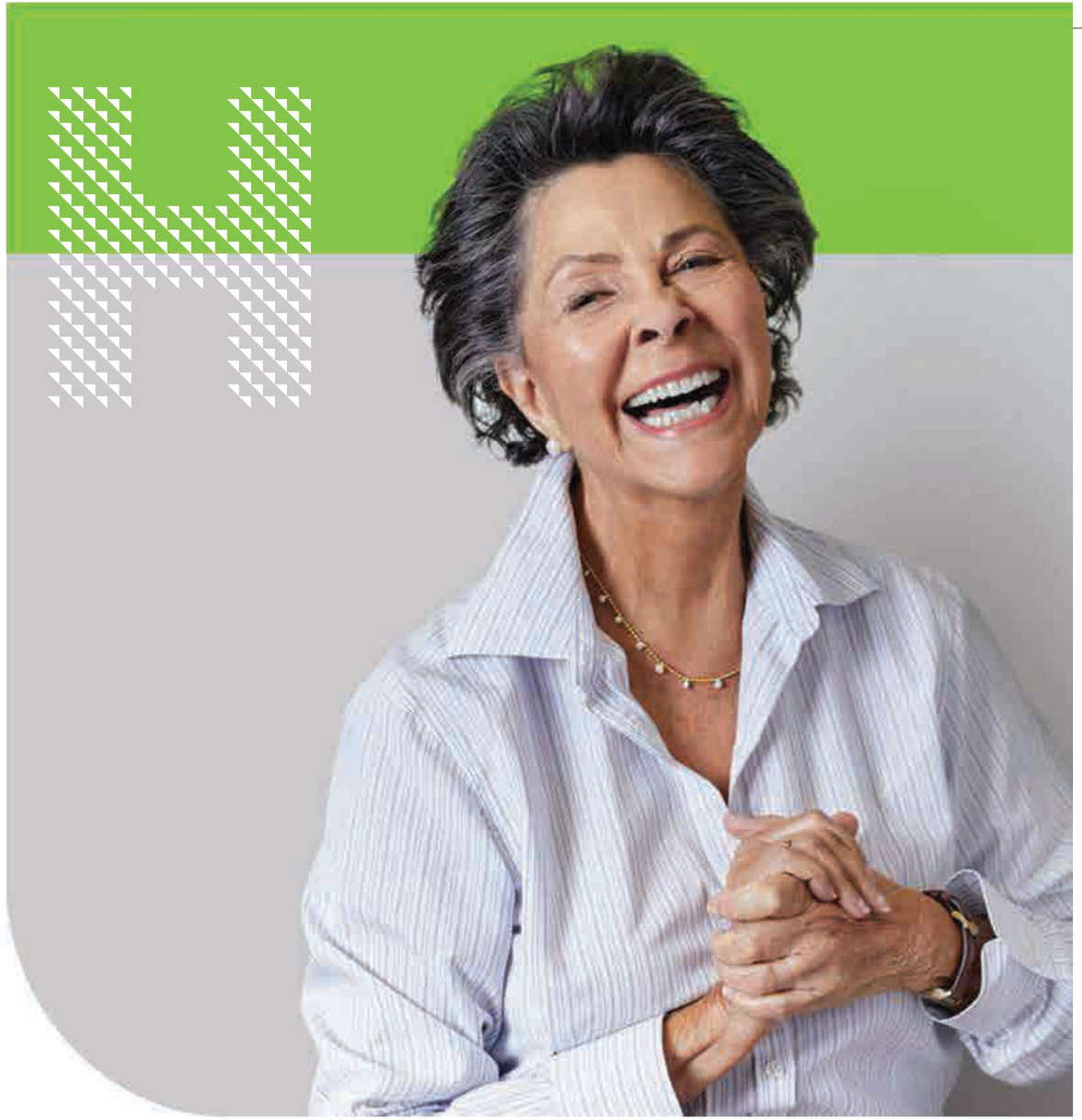
Humana

HUMANA GROUP MEDICARE HEALTH MAINTENANCE ORGANIZATION (HMO) PLAN

HMO



# Group Medicare HMO

Jackson Health System

Humana®

## Beyond healthcare

At Humana, we give you everything you expect from a healthcare plan, but that's just our starting point. We then find more ways to help, and more ways to support your health and your goals. That's human care, and it's just the way things ought to be.

## What's inside

- How to enroll
- Summary of Benefits
- Introduction to Medicare
- Details about your plan
- Tools and programs to help manage your health
- Frequently asked questions

## What to expect after you enroll

**Enrollment confirmation**
You'll receive a letter from Humana once the Centers for Medicare & Medicaid Services (CMS) confirms your enrollment.

**Humana member ID card**
Your Humana member ID card will arrive in the mail shortly after you enroll.

**Evidence of Coverage (EOC)**
This detailed booklet about your healthcare coverage with your plan will arrive in the mail. This will also include your privacy notice.

**Medicare health survey**
CMS requires Humana to ask new members to complete a health survey within their first few months of enrollment. Be on the lookout for information on how to access the survey, which will help us get to know what's important to you.

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Humana®

# Humana Group Medicare Advantage HMO Plan

Take action to enroll

Dear Group Medicare Beneficiary,

We're excited to let you know that **Jackson Health System** has asked Humana to offer you a Medicare Advantage and Prescription Drug HMO plan that gives you more benefits than Original Medicare.

At Humana, helping you achieve lifelong well-being is our mission. During our 30 years of experience with Medicare, we've learned how to be a better partner in health.

## Learn more about the Humana Group Medicare plan

Review the enclosed materials. This packet includes information on your Group Medicare healthcare coverage along with extra services Humana provides.

- If you have questions about your premium, please call your benefits administrator at **1-855-565-4748, Monday - Friday, 7 a.m. - 7 p.m., Eastern Time**.

## How to enroll

- To begin your Humana coverage, please enroll before your effective date by filling out the enrollment form and mailing it in the enclosed envelope.
- You must complete a separate application for each family member eligible for your plan.
- You also have the option to enroll over the phone by calling our Customer Care number. Be sure to have your Medicare ID on hand.
- Please keep a copy of your application for your records.

We look forward to serving you now and for many years to come.

Sincerely,
Group Medicare Operations

## We're here for you

**Humana Group Medicare Customer Care**
**1-866-396-8810 (TTY: 711)**
**Monday – Friday, 8 a.m. – 9 p.m., Eastern time**
**Humana.com**

Please call our Group Medicare Customer Care representatives if you have any questions about the plan or enrollment in the plan.

Our automated phone system may answer your call on weekends and some public holidays. Please leave your name and telephone number and we'll call you back by the end of the next business day.

2021

# Summary of Benefits

**Humana Group Medicare Advantage HMO Plan**
**HMO 076/141**

Humana.

Our service area includes the following: **Florida**: Bay, Charlotte, Citrus, Collier, Escambia, Glades, Lake, Lee, Marion, Martin, Okaloosa, Okeechobee, Orange, Osceola, Santa Rosa, Seminole, St. Lucie, Sumter, Walton

# Let's talk about the **Humana Group Medicare Advantage HMO** Plan.

Find out more about the Humana Group Medicare Advantage HMO plan – including the services it covers – in this easy-to-use guide.

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. For a complete list of services we cover, refer to the "Evidence of Coverage".

## To be eligible

To join the Humana Group Medicare Advantage HMO plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

## Plan name:

Humana Group Medicare Advantage HMO plan

## How to reach us:

Members should call toll-free **1-866-396-8810** for questions **(TTY/TDD 711)**

Call Monday – Friday, 8 a.m. - 9 p.m. Eastern Time.

Or visit our website: **Humana.com**

Humana Group Medicare Advantage HMO plan has a network of doctors, hospitals, and other providers. For more information, please call Group Medicare Customer Care.

## A healthy partnership

Get more from your plan — with extra services and resources provided by Humana!

# Monthly Premium, Deductible and Limits

| | IN-NETWORK |
|---|---|
| **PLAN COSTS** | |
| **Monthly premium**<br>You must keep paying your Medicare Part B premium. | For information concerning the actual premiums you will pay, please contact Humana, your employer/union group, or your employer group benefits plan administrator. |
| **Medical deductible** | This plan does not have a deductible. |
| **Maximum out-of-pocket responsibility**<br>The most you pay for copays, coinsurance and other costs for medical services for the year. | **In-Network Maximum Out-of-Pocket**<br>**$3,000** out-of-pocket limit for Medicare-covered services. The following services do not apply to the maximum out-of-pocket: Part D Pharmacy, Acupuncture (Routine) ; COVID-19 Care Package ; COVID-19 Testing ; COVID-19 Treatment ; Fitness Program ; Health Education Services ; Meal Benefit ; Smoking Cessation (Additional) and the Plan Premium.<br><br>If you reach the limit on out-of-pocket costs, we will pay the full cost for the rest of the year on covered hospital and medical services. |

# Covered Medical and Hospital Benefits

| | IN-NETWORK |
|---|---|
| **ACUTE INPATIENT HOSPITAL CARE** | |
| Our plan covers an unlimited number of days for an inpatient hospital stay. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. | **$95** copay per day for days 1-10 |
| **OUTPATIENT HOSPITAL COVERAGE** | |
| **Outpatient hospital visits** | **$25** to **$95** copay or **20%** of the cost |
| **Ambulatory surgical center** | **$95** copay |
| **DOCTOR OFFICE VISITS** | |
| **Primary care provider (PCP)** | **$0** copay |
| **Specialists** | **$15** copay |

***Note:*** *some services require prior authorization and referrals from providers.*

# Covered Medical and Hospital Benefits

| | IN-NETWORK |
|---|---|
| **PREVENTIVE CARE** | |
| Including: Annual Wellness Visit, flu vaccine, colorectal cancer and breast cancer screenings. Any additional preventive services approved by Medicare during the contract year will be covered. | **Covered at no cost**. |
| **EMERGENCY CARE** | |
| **Emergency room**<br>If you are admitted to the hospital within 24 hours for the same condition, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs. | **$90** copay for Medicare-covered emergency room visit(s) |
| **Urgently needed services**<br>Urgently needed services are care provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention. | **$0** to **$15** copay |
| **DIAGNOSTIC SERVICES, LABS AND IMAGING** | |
| **Diagnostic radiology** | **$0** to **$95** copay |
| **Lab services** | **$0** to **$50** copay |
| **Diagnostic tests and procedures** | **$0** to **$80** copay |
| **Outpatient X-rays** | **$0** to **$80** copay |
| **Radiation therapy** | **$20** to **$95** copay |
| **HEARING SERVICES** | |
| **Medicare-covered hearing** | **$20** copay |
| **Routine hearing**<br><br>HearUSA provider must be used. Contact Customer Service to locate a provider. | • $0 copay for fitting/evaluation, routine hearing exams up to 1 per year.<br>• $500 maximum benefit coverage amount for hearing aids (all types) up to 1 per ear per year.<br>• Note: Includes 1 month battery supply and 2 year warranty. |

***Note:*** *some services require prior authorization and referrals from providers.*

# Covered Medical and Hospital Benefits

| | IN-NETWORK |
|---|---|
| **DENTAL SERVICES** | |
| **Medicare-covered dental** | **$20** copay |
| **Routine dental** | • $0 copay for panoramic film and/or diagnostic x-rays up to 2 every 3 years.<br>• $0 copay for bitewing x-rays up to 1 set(s) per year.<br>• $0 copay for amalgam or composite filling, simple or surgical extraction up to 1 per year.<br>• $0 copay for periodic oral exam and/or comprehensive oral evaluation, prophylaxis (cleaning) up to 2 per year.<br>• $0 copay for necessary anesthesia with covered service up to unlimited per year. |
| **VISION SERVICES** | |
| **Medicare-covered vision services** | **$20** copay |
| **Medicare-covered diabetic eye exam** | **$0** copay |
| **Medicare-covered glaucoma screening** | **$0** copay |
| **Medicare-covered eyewear (post-cataract)** | **$0** copay |
| **Routine vision**<br><br>Premier Eye Care provider must be used. Contact Customer Service to locate a provider. | • $0 copay for refraction, routine exam up to 1 per year.<br>• $100 maximum benefit coverage amount per year for contact lenses, eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames.<br>• Eyeglasses include ultraviolet protection and scratch resistant coating. |
| **MENTAL HEALTH SERVICES** | |
| **Inpatient**<br>The inpatient hospital care limit applies to inpatient mental services provided in a general hospital. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.<br>190 day lifetime limit in a psychiatric facility | **$95** copay per day for days 1-10 |
| **Outpatient group and individual therapy visits** | **$0** to **$80** copay |

***Note:*** *some services require prior authorization and referrals from providers.*

# Covered Medical and Hospital Benefits

| | IN-NETWORK |
|---|---|
| **SKILLED NURSING FACILITY** | |
| Our plan covers up to 100 days in a SNF.<br><br>No 3-day hospital stay is required.<br>Plan pays $0 after 100 days | **$0** copay per day for days 1-20<br>**$150** copay per day for days 21-100 |
| **PHYSICAL THERAPY** | |
| | **$15** to **$25** copay |
| **AMBULANCE** | |
| Per date of service regardless of the number of trips.<br>Limited to Medicare-covered transportation. | **$200** copay |
| **TRANSPORTATION** | |
| LogistiCare provider must be used. Contact Customer Service to locate a provider. | • $0 copay for plan approved location up to unlimited one-way trip(s) per year by car, van, wheelchair access vehicle. |
| **PART B PRESCRIPTION DRUGS** | |
| | **20%** of the cost |
| **ACUPUNCTURE SERVICES** | |
| **Medicare-covered acupuncture** | **$15** copay<br>Limit 20 visit(s) per year |
| **Routine acupuncture** | **$0** copay<br>25 visit(s) per year |
| **ALLERGY** | |
| **Allergy shots & serum** | **$0** copay |
| **CHIROPRACTIC SERVICES** | |
| **Medicare-covered chiropractic visit(s)** | **$15** copay |
| **COVID-19** | |
| **Testing and Treatment** | **$0** copay for testing and treatment services for COVID-19 |
| **Health Essentials Kit** | Kit includes over the counter items useful for preventing the spread of COVID-19 and other viruses. Limited one per year. |
| **DIABETES MANAGEMENT TRAINING** | |
| | **$0** copay |

***Note:*** *some services require prior authorization and referrals from providers.*

# Covered Medical and Hospital Benefits

| | IN-NETWORK |
|---|---|
| **FOOT CARE (PODIATRY)** | |
| **Medicare-covered foot care** | **$20** copay |
| **Routine foot care** | **$35** copay |
| **HOME HEALTH CARE** | |
| | **$0** copay |
| **MEDICAL EQUIPMENT/SUPPLIES** | |
| **Durable medical equipment (like wheelchairs or oxygen)** | **0%** of the cost |
| **Medical supplies** | **$0** copay |
| **Prosthetics (artificial limbs or braces)** | **10%** of the cost |
| **Diabetes monitoring supplies** | **10%** of the cost |
| **OUTPATIENT SUBSTANCE ABUSE** | |
| **Outpatient group and individual substance abuse treatment visits** | **$0** to **$80** copay |
| **OVER-THE-COUNTER ITEMS** | |
| | $50 maximum benefit coverage amount per month for select over-the-counter health and wellness products. |
| **REHABILITATION SERVICES** | |
| **Occupational and speech therapy** | **$15** to **$25** copay |
| **Cardiac rehabilitation** | **$20** copay |
| **Pulmonary rehabilitation** | **$15** to **$30** copay |
| **RENAL DIALYSIS** | |
| **Renal dialysis** | **20%** of the cost |
| **Kidney disease education services** | **$0** copay |
| **SLEEP STUDY** | |
| | **$0** to **$100** copay |
| **TELEHEALTH SERVICES (in addition to Original Medicare)** | |
| **Primary care provider (PCP)** | **$0** copay |
| **Specialist** | **$15** copay |

***Note:*** *some services require prior authorization and referrals from providers.*

# Covered Medical and Hospital Benefits

| | IN-NETWORK |
|---|---|
| **Urgent care services** | **$0** copay |
| **Substance abuse or behavioral health services** | **$0** copay |
| **THERAPEUTIC SHOES AND INSERTS** | |
| | **$0** copay |
| **FITNESS AND WELLNESS** | |
| | SilverSneakers® Fitness Program - Basic fitness center membership including fitness classes. |
| **HOSPICE**<br>You must get care from a Medicare-certified hospice. You must consult with your plan before you select hospice. | |

***Note:*** *some services require prior authorization and referrals from providers.*

# Notes

# Important!

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.
  If you need help filing a grievance, call **1-866-396-8810** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**. Complaint forms are available at https://www.hhs.gov/ocr/office/file/index.html.
- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

## Auxiliary aids and services, free of charge, are available to you. 1-866-396-8810 (TTY: 711)

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برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

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**العربية (Arabic)**

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

# Find out **more**

You can see your plan's provider directory at **Humana.com** or call us at the number listed at the beginning of this booklet and we will send you one.

Humana is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

If you want to compare our plan with other Medicare health plans, you can call your employer or union sponsoring this plan to find out if you have other options through them.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at http://www.medicare.gov or get a copy 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.

Humana®

Humana.com

2021

# Prescription Drug Summary of Benefits

**Humana Group Medicare Advantage Plan**
**Rx 5**

Humana.

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# Let's talk about the **Humana Group Medicare Advantage Rx** Plan.

Find out more about the Humana Group Medicare Advantage Rx plan – including the services it covers – in this easy-to-use guide.

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. For a complete list of services we cover, refer to the "Evidence of Coverage".

# Deductible

**Pharmacy (Part D) deductible** This plan does not have a deductible.

# Prescription Drug Benefits

Initial coverage (after you pay your deductible, if applicable)
You pay the following until your total yearly drug costs reach **$4,130**. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

| Tier | Standard Retail Pharmacy | Standard Mail Order |
|---|---|---|
| **30-day supply** | | |
| **1 (Generic or Preferred Generic)** | **$4** copay | **$4** copay |
| **2 (Preferred Brand)** | **$25** copay | **$25** copay |
| **3 (Non-Preferred Drug)** | **$40** copay | **$40** copay |
| **4 (Specialty Tier)** | **33%** of the cost | **33%** of the cost |
| **90-day supply** | | |
| **1 (Generic or Preferred Generic)** | **$12** copay | **$0** copay |
| **2 (Preferred Brand)** | **$75** copay | **$50** copay |
| **3 (Non-Preferred Drug)** | **$120** copay | **$80** copay |
| **4 (Specialty Tier)** | N/A | N/A |

There may be generic and brand-name drugs, as well as Medicare-covered drugs, in each of the tiers. To identify commonly prescribed drugs in each tier, see the Prescription Drug Guide/Formulary.

## ADDITIONAL DRUG COVERAGE

### Coverage Gap

Most Medicare drug plans have a coverage gap (also called the "donut hole"). The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches **$4,130**.
You will continue to pay the same amount as when you were in the initial coverage stage.

### Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$6,550**, you pay the greater of:

- **$3.70** for generic (including brand drugs treated as generic) and a **$9.20** copay for all other drugs, or
- **5%** coinsurance

# Notes

# Notes

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**العربية (Arabic)**

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

# Find out **more**

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You can see your plan's drug formulary at **www.humana.com/medicaredruglist** or call us at the number listed at the beginning of this booklet and we will send you one.

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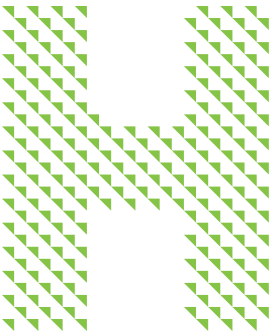
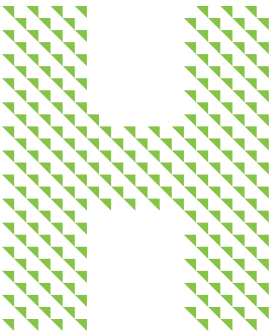
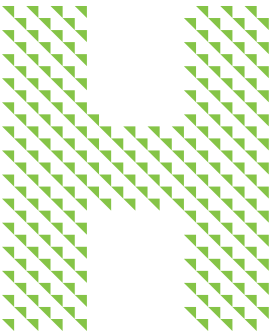
Humana.

Humana.com







# 2021 Group Medicare Advantage HMO Plan

Humana®

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MAPD | HMO GUIDEBOOK

# We can't wait to care for you

At Humana, we know that people are different, and need our support in different ways. Your Medicare Advantage HMO with prescription drug plan coverage will center around you, your health and your goals. After you enroll, we'll mail you an Evidence of Coverage booklet that will have all the plan information and details, including a full list of benefits.

## What is Medicare?

Medicare is a federal health insurance program for U.S. citizens and legal residents who are 65 and older or qualify due to a disability. You must be entitled to Medicare Part A and enrolled in Medicare Part B as the Humana Group Medicare HMO plan is a Medicare Advantage plan. You must also continue paying Medicare Part B premiums to remain enrolled in this plan.

## Humana offers you a Medicare Advantage HMO

### A HMO offers

- **All the benefits of Original Medicare, plus extra benefits**
- Maximum out-of-pocket protections
- Worldwide emergency coverage
- Programs to help improve health and well-being

### Dedicated team and more

- Your choice of an in-network provider to manage your care
- Large network of providers, specialists and hospitals to pick from
- Coverage for office visits, including routine physical exams
- Coverage for medically necessary stays in the hospital
- Almost no claim forms to fill out or mail—we take care of that for you
- Predictable costs, so you'll know how much your copayments and coinsurance percentages are
- Dedicated Customer Care specialists who serve only our Group Medicare members

## Humana offers you a Medicare Advantage HMO with prescription drug plan which offers:

### A large network

There are more than 66,000 participating pharmacies in our network.

### Maximize Your Benefit® Rx

We want to make sure medication costs aren't keeping you from the care you need. Humana tells you, by telephone and mail, how to save on prescription drugs by switching to ones that cost less.

### Almost no claims paperwork

The plan works with your pharmacist to handle claims for you.

### Pharmacy finder

An online tool that helps you find pharmacies. It also tells you how far they are from you, the hours they're open, if they have a drive-through available, if they offer emergency Rx, delivery options and if they have bilingual employees.

## Discover a more human way to healthcare

### Coverage that fits the way you live

When you become a Humana member, you can expect healthcare designed with you in mind—that meets you where you are today and delivers care that takes you to where you want to be.

### Care delivered how and where you need it

We can help you manage complex or chronic health conditions. A Humana nurse can meet you at home, in the hospital, by phone or email to provide valuable support and help you reduce complications.

### Benefits that put you first

Our health and well-being tools and resources make it easy to set health goals, chart your progress, strengthen your mind and body and build connections with others. It's about giving you everything you expect from an insurance company—and then finding more ways to help make your life better.

## Medicare Part A

HOSPITAL INSURANCE

It helps cover medically necessary inpatient care in a hospital or skilled nursing facility. It also helps cover some home healthcare and hospice care.

## Medicare Part B

MEDICAL INSURANCE

It helps cover medically necessary providers' services, outpatient care and other medical services and supplies. Part B also helps cover some preventive services.

## Medicare Part C

MEDICARE ADVANTAGE PLANS

These are available through private insurance companies, such as Humana. Medicare Part C helps cover everything medically necessary that Part A and Part B cover, including hospital and medical services. You still have Medicare if you elect Medicare Part C coverage. You must be entitled to Medicare Part A and enrolled in Part B to be eligible for a Medicare Part C plan.

## Medicare Part D

PRESCRIPTION DRUG COVERAGE

Like Part C Medicare Advantage plans, Part D is only available through private companies, such as Humana. Many Part C Medicare Advantage plans include Medicare Part D prescription drug coverage. Part D helps pay for the medications your provider prescribes.

# Build healthy provider relationships

Your relationship with your provider is important in helping you protect and manage your health.

With the Humana Group Medicare HMO plan, you'll have a primary care provider who will help you manage your care, who knows your medical history and the medicines you take. You can pick any provider from our network who is taking new patients, or you can change to another network provider if you choose. If you need to see a specialist, your provider will help you find one.

When you need hospital or outpatient care, you may need a referral. Ask your provider to contact us whenever you're admitted to the hospital. We may have advice and special programs your provider can use to help you heal faster.

## Is your provider in Humana's provider network?

Humana respects your relationship with your provider. We want you to be able to select a provider who's close to home and who can focus on your specific needs. If you need help finding a provider, call our Group Medicare Customer Care team or use our online directory. Humana's online provider lookup is an easy way to find doctors, hospitals and other healthcare providers in Humana's network:

- Go to **Humana.com** and select "Find a doctor"
- Get provider phone numbers, addresses and directions
- Customize your search by specialty, location and name

## Is your pharmacy in Humana's network?

Your relationship with your pharmacist is important in protecting and managing your health. You must use network pharmacies to enjoy the benefits of our plan except in an emergency. Pharmacies in the network have agreed to work with Humana to fill prescriptions for our members. If you use a pharmacy outside the network, your costs may be higher.

Our pharmacy network includes mail delivery, specialty, retail, long-term care, home infusion, and Indian, tribal and urban pharmacies.

You can find a complete list of network pharmacies at MyHumana, your personal, secure online account at **Humana.com**, and the MyHumana Mobile app.* Get printable maps and directions, along with many more details to find a pharmacy that fits your needs. Other information at **Humana.com/pharmacy/medicare/tools** includes:

- Printable Drug Lists
- Prior authorization information
- Maximize Your Benefit Rx

## Medical preauthorization

For certain services and procedures, your provider or hospital may need to get advance approval from Humana before your plan will cover any costs. This is called prior authorization or preauthorization. Providers or hospitals will submit the preauthorization request to Humana. If your provider hasn't done this, please call our Customer Care team, as Humana may not be able to pay for these services.

*Standard data rates may apply.

# Connect with a provider or behavioral health professional virtually

### Care when you need it

Your healthcare should always begin with your primary care provider or behavioral health specialist.

Your primary care provider and your specialist may offer virtual visits as another convenient way to be treated by your care team.

### What are virtual visits?

Virtual visits connect you with your provider via telephone or video chat using your phone, tablet* or laptop*. They allow you to get help with chronic condition management, follow-up care after an in-office visit, medication reviews and refills and much more, just like an in-office visit.

### When should I use it?

- For a nonemergency issue, instead of going to the emergency room (ER) or an urgent care center.
- For nonemergency mental and behavioral health conditions (by appointment).

**Remember, when you have a life-threatening injury or major trauma, call 911.**

### What kinds of conditions can be treated?

Providers can help with chronic condition management, follow-up care after an in-office visit, medication reviews and refills in addition to many other conditions including but not limited to:

- Allergies
- Fever
- Cold and flu symptoms
- Sore throat
- Constipation
- Sinus infection
- Diarrhea
- Insect bites
- Depression, anxiety, stress and family and relationship counseling

Call your provider to find out if they offer virtual visits and if so, what you need to do to get started.

If you don't have a primary care provider or if your PCP doesn't offer virtual visits, you can use the "Find a doctor" tool on **Humana.com** or call the number on the back of your member ID card to get connected with a provider that offers this service.

*Standard data rates may apply.

# Knowing how your coverage works can save you from paying out of your pocket for vaccines

The Medicare Part D portion of your plan covers all commercially available vaccines—except for those covered by Part B—as long as the vaccine is reasonable and necessary to prevent illness.

### Get vaccines like the ones listed below at your providers office

The Medicare Part B portion of your plan pays for the following vaccines at your provider's office and at the pharmacy: influenza (flu) vaccine—once per season; pneumococcal vaccines; hepatitis B vaccines for persons at increased risk of hepatitis and vaccines directly related to the treatment of an injury or direct exposure to a disease or condition, such as rabies and tetanus.

### Get vaccines like the ones listed below at a network pharmacy

If you get them at your provider's office, you'll pay the full cost of the vaccine out of pocket. Some common vaccines that you should get at your pharmacy, not from your provider, are shingles, Tdap and hepatitis A.

# Understanding your diabetes coverage

At Humana, we make it easy for you to understand your benefits and get what you need to manage your condition.

### Diabetes prescriptions and supplies, Part B vs. Part D

Medicare Part B

- Diabetic testing supplies
- Insulin pumps
- Insulin administered (or used) in insulin pumps

Medicare Part D

- Diabetes medications
- Insulin administered (or used) with syringes or pens
- Syringes, pen needles or other insulin administration devices that are not durable medical equipment (e.g., Omnipod or VGO)

### Diabetic testing supplies

Your Humana Medicare Advantage Plan helps cover a variety of diabetic glucose testing supplies. Humana Pharmacy® is the preferred durable medical equipment (DME) vendor for the products, and offers the meters listed below and their test strips and lancets:

**Roche Accu-Chek Guide Me®, Roche Accu-Chek Guide and HP® True Metrix® AIR by Trividia.** To order a meter and supplies from Humana Pharmacy, call **1-877-222-5084 (TTY: 711)**, Monday – Friday, 8 a.m. – 8 p.m., Eastern time.

Your doctor can also send prescriptions for meters and other testing supplies by fax or e-prescribe.

You can also request a no-cost meter from the manufacturer by calling Roche at **1-877-264-7263 (TTY: 711)**, or Trividia Health at **1-866-788-9618 (TTY: 711)**, Monday – Friday, 8 a.m. – 8 p.m., Eastern time.

Go to **Humana.com/Diabetes** to learn more about managing your diabetes. MyDiabetesPath® offers a complete guide to living with diabetes and gives you the information and resources to help you stay healthy.

# More and more Humana members are finding Humana Pharmacy to be their choice for value, experience, safety, accuracy, convenience and service.

## Why choose Humana Pharmacy?

- **Savings**. Many Humana plans provide cost savings if you fill a 90-day supply* of your maintenance medicine through a mail-delivery pharmacy, instead of a retail pharmacy. Additionally, the pharmacy team works with you and your provider to find medicine that costs less.
- **Experienced pharmacy team**. Pharmacists are available to answer questions about your medicine and our services.
- **Safe and accurate**. Two pharmacists check your new prescriptions to make sure they're safe to take with your other medications. The dispensing equipment and heat–sealed bottles with tamper-resistant foil help ensure quality and safety. Plus, your order comes in plain packaging for additional security.
- **Timely reminders**. To help make sure you have the medicine and supplies you need when you need them, we can remind you when it's time to refill your medicine. Just set your preferences when you sign up at **HumanaPharmacy.com**.
- **Time-saving mail delivery**. Your medicine will be shipped safely and securely to the location of your choice. That means no more trips to the pharmacy. No more waiting in lines to pick up your medicine. No more hassle. You may be able to order just four times a year and have more time to do the things you enjoy.

## Make Humana Pharmacy your one source

**Maintenance medicine.** Medicine you take all the time for conditions like high cholesterol, high blood pressure and asthma.

**Specialty medicine.** Specialized therapies to treat chronic or complex illnesses like rheumatoid arthritis and cancer.

## Visit HumanaPharmacy.com

After you become a Humana member, you can sign in with your MyHumana identification number or register to get started. You can also sign up by calling **1-800-379-0092 (TTY: 711)**, Monday – Friday, 8 a.m. – 11 p.m., Eastern time, and Saturday, 8 a.m. – 6:30 p.m., Eastern time.

## Online

**HumanaPharmacy.com.** Start a new prescription, order refills, check on your order and get information about how to get started.

## Provider

Let your provider know he or she can send prescriptions electronically through e-prescribe. Providers can also fill out the fax form by downloading it from **HumanaPharmacy.com/forms** and faxing the prescription to Humana Pharmacy at **1-800-379-7617** or Humana Specialty Pharmacy® at **1-877-405-7940**.

## Mail

Download the "Registration & Prescription Order Form" from **HumanaPharmacy.com/forms** and mail your paper prescriptions to:

Humana Pharmacy
P.O. Box 745099
Cincinnati, OH 45274-5099

## Phone

For maintenance medicine, call Humana Pharmacy at **1-800-379-0092 (TTY: 711)**, Monday – Friday, 8 a.m. – 11 p.m., Eastern time, and Saturday, 8 a.m. – 6:30 p.m., Eastern time.

For specialty medicine, call Humana Specialty Pharmacy at **1-800-486-2668 (TTY: 711)**, Monday – Friday, 8 a.m. – 11 p.m., Eastern time, and Saturday, 8 a.m. – 6:30 p.m., Eastern time.

## Humana Pharmacy Mobile app

**HumanaPharmacy.com/about/mobile-apps.cmd**
Download our Humana Pharmacy app form the iTunes App Store or Google Play. Sign in or select "Transfer Rx as guest" from the home screen.

*Some prescriptions are only available in a 30-day supply.

# Preferred generic and generic drugs

**Essentially the same drugs, usually priced differently**

Have the same active ingredients as brand-name 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-name drugs. Your cost for generic drugs is usually lower than your cost for brand-name drugs.

## Preferred drug

**A medicine available to you for less than nonpreferred**

Generic or brand-name drugs that Humana offers at a lower cost to you than nonpreferred drugs.

## Nonpreferred drug

**A more expensive drug than preferred**

More expensive generic or brand-name prescription drugs that Humana offers at a higher cost to you than preferred drugs.

## Specialty

**Drugs for specific uses**

Some injectable and other high-cost drugs.

# Medication therapy management

As part of your Medicare Part D coverage with Humana, you might be able to take part in a program called Medication Therapy Management (MTM) at no extra cost. MTM may help you to:

- Know more about getting the greatest benefit from your medications
- Reduce risk by learning how to avoid harmful side effects
- Possibly save money by finding lower-cost alternatives to prescribed medications

## Who's eligible?

Members are chosen for MTM using the following Centers for Medicare & Medicaid Services (CMS) and Humana criteria:

- Have three of the five multiple chronic conditions:
  - Congestive heart failure (CHF)
  - Dyslipidemia (high or low LDL cholesterol)
  - Diabetes
  - Chronic obstructive pulmonary disease (COPD)
  - Osteoporosis
- Take at least eight chronic/maintenance Part D drugs
- Spend more than $4,376 on prescription drugs per calendar year

## How does the program work?

MTM offers additional information in the SmartSummary that can help to manage medications and drug costs. Members also get a face-to-face or phone consultation with a healthcare professional to talk about their medications.

## Scheduling a consultation

If you qualify for MTM, you will receive an invitation letter and see a note in your SmartSummary to call the MTM call center. If you think you qualify but don't see the note, please call the group Medicare Customer Care phone number. Although the MTM program is a special service offered at no cost to Medicare members, it is not considered a benefit.

"

**time getting to know you, more services—some that you expect and many that you don't—and more ways to help you live the way you want.**

# Important information about your prescription drug coverage

Some drugs covered by Humana may have requirements or limits on coverage. These requirements and limits may include prior authorization, step therapy or quantity limits. You can visit **Humana.com** to register or sign in and select Pharmacy or call Humana's Group Medicare Customer Care team to check coverage on the medications you take.

## Prior authorization

The Humana Group Medicare Plan requires you or your provider to get prior authorization for certain drugs. This means that you will need to get approval from the Humana Group Medicare Plan before you fill your prescriptions. The reason a prior authorization is required can vary depending on the medication. Humana will work with your provider when a prior authorization is required.

If your provider prescribes a drug that needs prior authorization, please be sure the prior authorization has been submitted to Humana before the prescription is filled. The Centers for Medicare & Medicaid Services (CMS) requires a turnaround time of 72 hours for a prior authorization. However, an expedited review can be requested by your provider if waiting 72 hours may be harmful to you.

## Step therapy

In some cases, the Humana Group Medicare Plan requires that you first try certain drugs to treat your medical condition before coverage is available for a more expensive drug prescribed to treat your medical condition. For example, if Drug A and Drug B both treat your medical condition, the Humana Group Medicare Plan may not cover Drug B unless you try Drug A first. If Drug A does not work for you, the Humana Group Medicare Plan can then cover Drug B.

A step therapy prescription can be filled once the necessary requirements are met. If you have already tried other medications that did not provide the desired clinical results, or you had an adverse reaction, your provider may submit this information to Humana for consideration in meeting the step therapy requirements.

## Quantity limits

For some drugs, the Humana Group Medicare Plan limits the quantity of the drug that is covered. The Humana Group Medicare Plan might limit how many refills you can get or quantity of a drug you can get each time you fill your prescription. For example, if it's normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day. Specialty drugs are limited to a 30-day supply regardless of tier placement.

## One-time transition fill

For certain drugs typically requiring prior authorization or step therapy, Humana will cover a one-time, 30-day supply of your Part D covered drug during the first 90 days of your enrollment. Once you have received the transition fill* for your prescription requiring a prior authorization or step therapy, you'll receive a letter from Humana telling you about the requirements or limits on the prescription. The letter will also advise that you will need to get approval before future refills will be covered. A prior authorization will need to be approved or other alternative medicines should be tried if the medication requires step therapy.

*Some drugs do not qualify for a transitional fill, such as drugs that require a Part B vs D determination, CMS Excluded drugs, or those that require a diagnosis review to determine coverage.

## Next steps for you

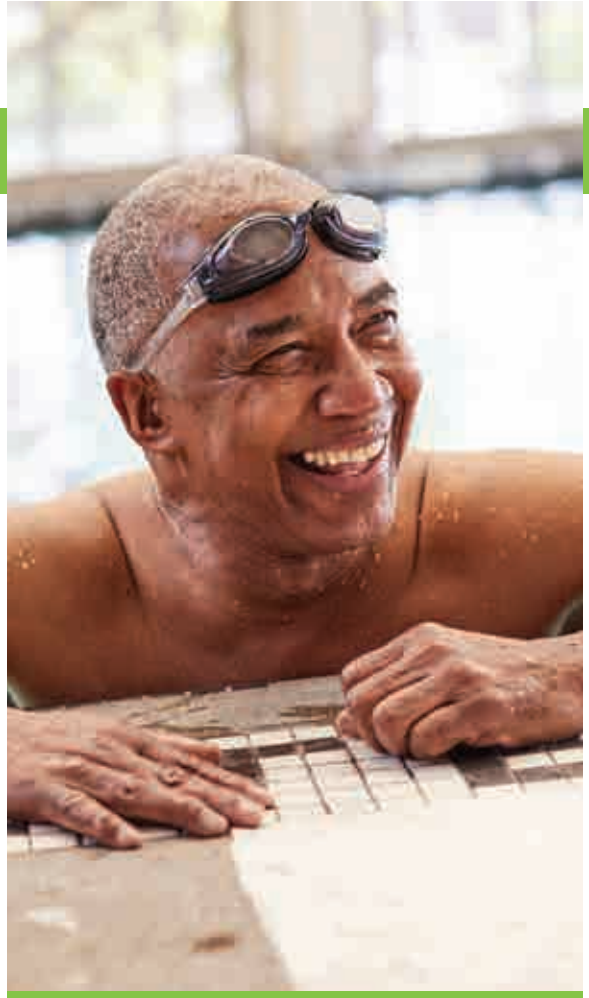
1. Visit **Humana.com/Pharmacy** or call the Customer Care number on the back of your Humana member ID card to see if your medications have quantity limits, or require a prior authorization or step therapy.
2. Talk to your provider about your drugs if they require prior authorization, step therapy is needed or has quantity limits.
3. If you have questions about your prescription drug benefits, please call our Customer Care number on the back of your Humana member ID card.

## What should your provider do to meet quantity limits, prior authorization or step therapy drug requirements?

- Go online to **Humana.com/Provider** and visit our provider prior authorization page. This page has a printable form that can be mailed or faxed to Humana.
- Call **1-800-555-2546 (TTY: 711)** to speak with our Humana Clinical Pharmacy Review team. They are available Monday – Friday, 8 a.m. – 6 p.m., Eastern time.

Remember: Before making a change, you should always talk about treatment options with your provider.

**Whether you choose a pharmacy from our large network or order your medicines through the mail, Humana's prescription drug coverage fits your life. We'll even give you suggestions for saving money.**





## SilverSneakers

SilverSneakers® gives you access to exercise equipment, group fitness classes and social events.

- Use thousands of fitness locations nationwide, with weights, swimming, classes and cardio equipment*,†
- Make friends and enjoy social activities
- Work toward improving muscle strength, bone density, flexibility and balance
- Enjoy group fitness classes outside traditional gyms†
- Start workout programs tailored to your level with the SilverSneakers GO™ app
- Try SilverSneakers On-Demand™ online workout videos that feature tips on fitness and nutrition

Visit **SilverSneakers.com/StartHere** to get your SilverSneakers ID number and find a convenient location near you, or call **1-888-423-4632 (TTY: 711)**, Monday – Friday, 8 a.m. – 8 p.m., Eastern time.

*Participating locations ("PL") are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities are limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL.

†Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location.

## Humana At Home

Supports qualifying members with both short-term and long-term services that can help them remain independent at home. Humana At Home℠ care managers support members by providing education about chronic conditions and medication adherence, helping with discharge instructions, accessing community resources, finding social support and more, all included in the plan at no additional cost.

Visit **Humana.com/caremgmt** or call **1-800-432-4803 (TTY: 711)**, Monday – Friday, 8:30 a.m. – 5:30 p.m., Eastern time

## Humana Well Dine® meal program

After your inpatient stay in a hospital or nursing facility, you're eligible to receive 2 meals per day for 7 days, up to 14 nutritious meals delivered to your door at no additional cost to you. Limited to 4 times per year.

For more information, please contact the number on the back of your Humana member ID card.

**Extras that can help you improve your overall well-being, at no additional cost.**

# Communication counts

As soon as you receive your Humana member ID card, go to **Humana.com** and register for MyHumana. This is your personal, secure online account that allows you to access your specific plan details from your computer or smartphone.

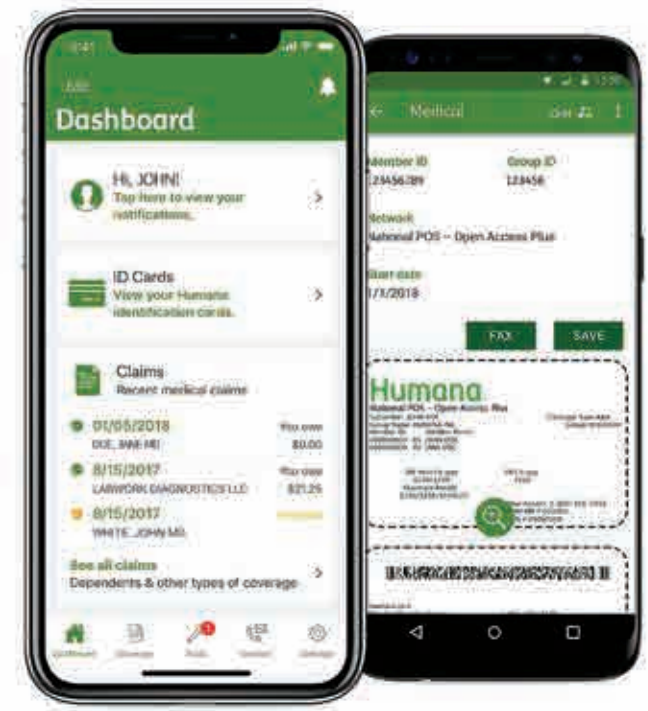
## The MyHumana Mobile app

If you have an iPhone or Android, download the MyHumana Mobile app.* You'll have your plan details with you at all times.

Visit **Humana.com/mobile-apps** to learn about our many mobile apps, the app features and how to use them.

With MyHumana and the MyHumana Mobile app, you can:

- Review your plan benefits and claims
- Find pharmacies in your network
- Find providers in your network
- Compare drug prices
- Access digital ID cards
- Establish communication preferences




### Connect with us on Facebook

Find healthcare information for Medicare members and caregivers to help in your pursuit of lifelong well-being at **facebook.com/Humana**.

*Standard data rates may apply.

**Humana connects you with online tools that put your plan information at your fingertips and make using your coverage easier.**

**Making sure your helpers can help you—so you can focus on living your life.**

## Choose a caregiver to help you

Everyone needs a little help now and then. We're happy to work with you and whomever you designate as a helper. Many people trust a family member or close friend to help them with their healthcare—someone who may help you talk with us about your insurance plan, keep track of your benefits and claims, or ask healthcare questions on your behalf.

Visit **Humana.com/caregiver** to learn more about naming a caregiver and how to submit the Consent for Release of Protected Health Information (PHI) form.

## Consent forms

We need your permission to share your personal information with someone else. To give your permission, you'll need to read and sign a consent form.

**Here are the ways you can do that:**

- Fill out and submit the form online once you have registered on MyHumana
- Print the form from **Humana.com/PHI** and return it by following the instructions on the form
- Call us and we'll mail the form to you to complete and return

A signed consent form allows insurers to share health plan information and protected health information with your designated helper. It's different from granting medical power of attorney, which allows someone to make decisions about your care.

# Your personalized benefits statement

We make it easy for you to understand, track, manage and possibly save money on your healthcare with SmartSummary®. You'll receive this statement after each month you've had a medical and/or prescription claim. You can also sign into MyHumana and see your past SmartSummary statement anytime.

### SmartSummary helps you:

- Understand your total healthcare picture
- Manage your monthly and yearly healthcare costs
- Engage with your providers by having a list of the healthcare services you receive
- Learn about preventive care, health conditions, treatment options and ways to help reduce health expenses

### SmartSummary includes:

- Numbers to watch – SmartSummary shows your total drug costs for the month and year-to-date. It also shows how much of these costs your plan paid and how much you paid—so you can see the value of your prescription benefits.
- Personalized messages – SmartSummary gives you tips on saving money on the prescription drugs you take, information about changes in prescription copayments and how to plan ahead.
- Your Rx record – A personalized prescription manager tells you more about your prescription medications, including information about dosage and the prescribing provider. It also has a refill calendar that helps you know the date of your next refill. This page can be useful to take to your provider appointments or to your pharmacist.
- Healthcare news relevant for you – SmartSummary personalizes a news section to let you know about things you can do for your health, including medicines and treatments for health problems.

**We make it easy for you to understand, track, manage and possibly save money on your healthcare.**

### Do I need to show my red, white and blue Medicare card when I visit the doctor?

No. You'll get a Humana member ID card that will take its place. Keep your Medicare ID card in a safe place—or use it only when it's needed for discounts and other offers from retailers.

### What should I do if I move or have a temporary address change?

If you move to another area or state, it may affect your plan. It's important to contact your group benefits administrator for details and call to notify Humana of the move.

### What should I do if I have to file a claim?

Call Humana Group Medicare Customer Care for more information and assistance. To request reimbursement for a charge you paid for a service, send the provider's itemized receipt and the Health Benefits Claim Form (also available at **Humana.com**) to the claims address on the back of your Humana member ID card. Make sure the receipt includes your name and Humana member ID number.

### What if I have other health insurance coverage?

If you have other health insurance, show your Humana member ID card and your other insurance cards when you see a healthcare provider. The Humana Group Medicare plan may be eligible in combination with other types of health insurance coverage you may have. This is called coordination of benefits. Please notify Humana if you have any other medical coverage.

### When does my coverage begin?

Your former employer or union decides how and when you enroll. Check with your benefits administrator for the proposed effective date of your enrollment. Be sure to keep your current healthcare coverage until your Humana Group Medicare HMO plan enrollment is confirmed.

### What if my service needs a prior authorization?

If your medical service or medication requires a prior authorization, your provider can contact Humana to request it. You can call Customer Care if you have questions regarding what medical services and medications require prior authorization.

### What should I do if I need prescriptions filled before I receive my Humana member ID card?

If you need to fill a prescription after your coverage begins but before you receive your Humana member ID card, take a copy of your temporary proof of membership to any in-network pharmacy.

### How can I get help with my drug plan costs?

People with limited incomes may qualify for assistance from the Extra Help program to pay for their prescription drug costs. To see if you qualify for Extra Help, call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, seven days a week. If you use a TTY, call **1-877-486-2048**. You can also call the Social Security Administration at **1-800-772-1213**. If you use a TTY, call **1-800-325-0778**. Your state's Medical Assistance (Medicaid) Office may also be able to help, or you can apply for Extra Help online at **www.socialsecurity.gov**.

## Coinsurance

**Your share of the cost after deductible**
A percentage of your medical and drug costs that you may pay out of your pocket for services after you pay any plan deductible.

## Copayment

**What you pay at the provider's office for medical services**
The set dollar amount you pay when you receive medical services or have a prescription filled.

## Deductible

**What you pay up front**
The amount you pay for healthcare before your plan begins to pay for your benefits.

## Exclusions and limitations

**Anything not covered or covered under limited situations or conditions**
Specific conditions or circumstances that aren't covered under a plan.

## Maximum out-of-pocket

**The most you'll spend before your plan pays 100% of the cost**
The most you would have to pay for services covered by a health plan, including deductibles, copays and coinsurance. If and when you reach your annual out-of-pocket limit, the Humana Group Medicare plan pays 100% of the Medicare-approved amount for most covered medical charges.

## Network

**Your plan's contracted medical providers**
A group of healthcare providers contracted to provide medical services at discounted rates. The providers include doctors, hospitals and other healthcare professionals and facilities.

## Plan discount

**A way Humana helps you save money**
Amount you are not responsible for due to Humana's negotiated rate with provider.

## Premium

**The regular monthly payment for your plan**
The amount you and/or your employer regularly pay for Medicare or Medicare Advantage coverage.

## Catastrophic coverage

**What you pay for covered drugs after reaching $6,550**
Once your out-of-pocket costs reach the $6,550 maximum, you pay a small coinsurance or a small copayment for covered drug costs until the end of the plan year.

## Coinsurance

**Your share of your prescription's cost**
This is a percentage of the total cost of a drug you pay each time you fill a prescription.

## Copayment

**What you pay at the pharmacy for your prescription**
The set dollar amount you pay when you fill a prescription.

## Deductible

**Your cost for Part D prescription drugs before the plan pays**
The amount you pay for Part D prescription drugs before the plan begins to pay its share.

## Exclusions and limitations

**Anything not covered**
Specific conditions or circumstances that aren't covered under a plan.

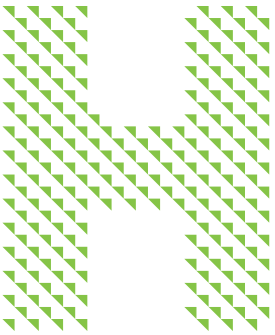
## Formulary

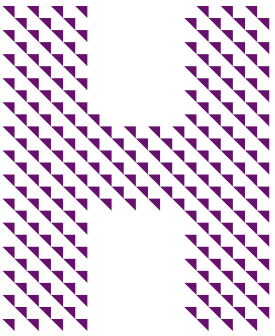
**Drugs covered under your plan**
A list of drugs approved for coverage under the plan. Also called a Drug List.

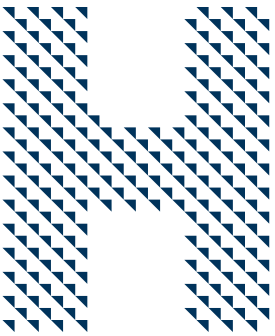
## Out-of-pocket

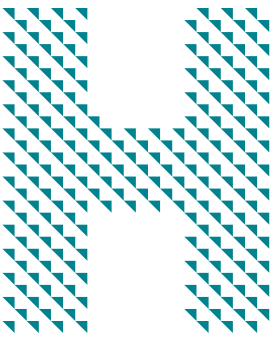
**Portion of costs you pay**
Amount you may have to pay for most plans, including deductibles, copays and coinsurance.

## NOTES







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## Only for Humana members

# A FUN WAY TO EARN REWARDS FOR MAKING HEALTHIER CHOICES

go365™ by Humana.

Welcome to Go365® by Humana, the wellness program that rewards you for completing eligible healthy activities.

## IT'S PART OF YOUR HUMANA MEDICARE PLAN

**There's no extra charge – it's included in your plan.**

Just sign in at **Humana.com** and click on Go365. From there, you'll be able to view your Go365 dashboard, track your activities and manage your connected activity trackers. You may also submit the paper forms enclosed in your paper packet.

## EARN REWARDS YOU CAN REDEEM FOR GIFT CARDS

**More healthy activities = more gift cards for you.**

Complete healthy activities like walking, getting your Annual Wellness Exam, or volunteering to earn rewards to redeem for gift cards. Once you've earned at least $10 in rewards, choose your gift cards from the list of options in the Go365 Mall.


## REGISTER ON MyHUMANA

**Now it's time to get going with Go365.**

To track your activities online anytime you wish, register at **humana.com/registration**. Once you've signed in, click Go365 from your dashboard - it's that easy. Request paper materials by calling the number on the back of your Humana Member ID card.

## TRACK YOUR EXERCISE PROGRAM THE EASY WAY

To earn $5 in rewards for exercise, complete at least 8 or more workouts a month. To earn $10 in rewards for exercise, complete 16 or more workouts a month. Here are three easy ways to track and earn:

1. **Attend a participating SilverSneakers® Fitness class** to earn rewards automatically. Your reward may take up to 45 days to show up in your Go365 account.
2. **Connect a compatible activity tracker to Go365**, log at least 500 steps a day, and earn automatic rewards for workouts.
3. **Log your workouts online** or use a paper workout tracker to record your exercise, and return it to us each month to earn your reward.

**FIND Go365 COMPATIBLE ACTIVITY TRACKERS** Go365 is compatible with activity trackers from a variety of manufacturers like Fitbit and Garmin. For a full list, sign in to **Humana.com** or call the number on the back of your Humana ID card.

Join the Go365 support community
**community.medicare.Go365.com**

**Humana.com**

# EARN HEALTHY REWARDS WITH THESE HEALTHIER CHOICES

Choose activities to help you get healthy, active, or involved and earn rewards for each one you complete. Your rewards can be redeemed for gift cards in the Go365 Mall.

| Activity | Reward | Activity limit |
|---|---|---|
| **GET HEALTHY: Preventive screenings** | | |
| Annual Wellness Exam | $25 | 1 per year |
| Mammogram | $30 | 1 per year |
| Colorectal screening | $30 | 1 per year |
| Cardiovascular disease screening | $10 | 1 per year |
| Bone density screening | $20 | once every 2 years |
| Flu shot | $10 | 1 per year |
| Your reward will show up automatically in your Go365 account if billed through your Humana medical or pharmacy plan. This can take up to 90 days. | | |
| **GET INVOLVED: Social and educational activities** | | |
| Attend a "Humana in your community" class | $5 | 12 times per year ($60 annual maximum) |
| Athletic event[1] (e.g. 5k walk/run, cycling) | $5 | |
| Volunteering[1] | $5 | |
| Connect virtually with friends or family[1] | $5 | |
| Go365 Community post (community.medicare.Go365.com) | $5 | |
| Health education seminar class[1] | $5 | |
| **GET ACTIVE: Exercise and fitness** | | |
| 8-15 workouts per month - SilverSneakers®, connected activity tracker (minimum of 500 steps/day) or paper workout tracker | $5 | Once per month ($120 annual maximum) |
| 16 or more workouts per month | $10 | |

The monetary amounts shown above represent the value of the reward earned for completing the activity, not actual dollars.

[1]You will be required to fill out and submit a Go365 activity form to receive your reward for these activities. The forms can be found when you sign in at Humana.com or by requesting paper materials. The monetary amounts shown above represent the value of the reward earned for completing the activity. Rewards have no cash value.

You must redeem your rewards in the program year they are earned. Any rewards that are not redeemed by 12/31 will be forfeited. Rewards have no cash value.
Some items may be discontinued in the Go365 Mall and new items may be added. For the most updated list, visit Go365.com.
In accordance with the federal requirement of the Centers for Medicare & Medicaid Services, no amounts on the gift cards shall be used to purchase covered medical supplies or prescription drugs nor are they redeemable for cash.
The merchants represented are not sponsors of Go365 or otherwise affiliated with Go365. The logos and other identifying marks attached are trademarks of and owned by each represented company and/or its affiliates. Please visit each company's website for additional terms and conditions.

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  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
  If you need help filing a grievance, call **1-877-320-1235** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.
- **California residents**: You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

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**한국어 (Korean):** 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .
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**Deutsch (German):** Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
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الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

# 2021
# Enrollment Form

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Humana Group Medicare

HMO (Health Maintenance Organization)
A Medicare Advantage plan

### Have your Medicare card ready

Each person applying must fill out a separate form.

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If the enrollment form is not completed and returned within the allotted time period, the enrollment could be denied.

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### Call us with questions

If you have questions, please call a licensed Humana sales agent at **1-800-824-8242 (TTY: 711)**. We're available Monday - Friday, 8 a.m. – 8 p.m. Eastern Time.

However, please note that our automated phone system may answer your call during weekends and holidays. Please leave your name and telephone number, and we'll call you back by the end of the next business day.

Humana®

# Additional Notes

**Asterisks (*) indicate required fields**

## Instructions

- Completely fill the ovals.
- Use black ink only.
- Print only one clear number or capital block letter in each box.
- If you make a mistake, fix it by crossing out the box with an X. Put in the correct letter or number above or below the box as shown:

**Correct numbers and letters**


When inputting your Medicare Number on the enrollment form, print it exactly as it is on your Medicare card. N indicates a number, A indicates an alphabetic character, and E indicates either a number or alphabetic character. Medicare numbers will not start with a zero or contain the letters B, I, L, O, S or Z.

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Stamp Date

**Asterisks (*) indicate required fields**

# Humana Group Medicare HMO Enrollment Form

EMPLOYER OR UNION SPONSOR NAME* Please use the Employer/Union name listed with your mailing address on your materials.

Please print this information exactly as it is on your Medicare card.

**MEDICARE HEALTH INSURANCE**

LAST NAME*

FIRST NAME* MI*

MEDICARE NUMBER*

N A E N – A E N – A A N N

IS ENTITLED TO EFFECTIVE DATE*

HOSPITAL (PART A) M M / 0 1 / Y Y Y Y

MEDICAL (PART B) M M / 0 1 / Y Y Y Y

PROPOSED EFFECTIVE DATE*

M M / 0 1 / 2 0 Y Y

PLAN OPTION*

076 /

You can find the option number on the front page of your Summary of Benefits in the bottom right hand corner.

CATEGORY OF ENROLLEE*

- Medicare Eligible Retiree
- Medicare Eligible Spouse
- Medicare Eligible Dependent

DATE OF BIRTH* M M / D D / Y Y Y Y SEX* M F

RESIDENTIAL ADDRESS* P.O. Box not allowed. Physical address is required.

APT or STE

CITY* ST* ZIP*

COUNTY*

MAILING ADDRESS Your residential address confirms your service area. Print your mailing address/P.O. Box here, if applicable. If your mailing address is your residential address, please fill this oval.

APT or STE

CITY ST ZIP

**Asterisks (*) indicate required fields**

APPLICANT MEDICARE NUMBER*

N A E N – A E N – A A N N

It is important that we can reach you to help you stay informed and take care of your health.
Please provide your telephone number and email address.

TELEPHONE

( ) –

There may be times when Humana will use an automated system to call or text you.
When that happens we will be sure to use the telephone number you provided.

EMAIL By providing your email address, you authorize Humana to send you health information to this address.

PRIMARY CARE PHYSICIAN (PCP)*

PCP ID NUMBER*

**Are you already a patient of the physician you chose?** Yes No

You can obtain the PCP ID number on our website at **Humana-medicare.com** or by using the provider directory.

**Asterisks (*) indicate required fields**

APPLICANT MEDICARE NUMBER*

N A E N – A E N – A A N N

**1. Once enrolled, will you have other medical health coverage where you are the subscriber or are covered as a spouse/dependent?** ○ Yes ○ No

If yes, complete the following:

ID NUMBER FOR THIS COVERAGE

TELEPHONE

( ) –

CARRIER NAME

POLICY NUMBER

CARRIER ADDRESS

CITY

ST

ZIP

**Does your other coverage include prescription drug coverage?** ○ Yes ○ No

**2. Once enrolled, will you or your spouse work?** ○ Yes ○ No

Some individuals may have other drug coverage, including private insurance, Workers' Compensation, TRICARE, federal employee health benefits coverage, VA benefits, or state pharmaceutical assistance programs.

**3. Will you have other prescription drug coverage in addition to this plan for which you are applying?*** ○ Yes ○ No

If yes, complete the following:

NAME OF OTHER COVERAGE

ID NUMBER FOR THIS COVERAGE

GROUP NUMBER FOR THIS COVERAGE

Rx BIN

Rx PCN

TELEPHONE

( ) –

## PLEASE READ THIS IMPORTANT INFORMATION

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Humana, he/she may be paid based on my enrollment in a Humana plan.

**By completing this enrollment form, I agree to the following:**
The Humana Group Medicare HMO plan is a Medicare Advantage plan that has a contract with the federal government and I will need to keep my Medicare Parts A and B, and must continue to pay my Medicare Part B premium. I can only be in one Medicare Advantage plan at a time. It is my responsibility to inform Humana of any prescription drug coverage that I have or may get in the future. **I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.** I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. Once I've enrolled in this Humana plan, I can change or cancel my Humana coverage at any time and return to Medicare Parts A and B or another Medicare Advantage plan using a special election. However, I may not be eligible to return to the group plan or change plans outside of the group's open enrollment period. I can receive details of my options by calling my plan administrator or customer service.

This Humana plan serves a specific service area. If I move out of the area that this Humana plan serves, I need to notify Humana so I can disenroll and find a new plan in my new area. Once I am a member of Humana, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from Humana when I get it to know which rules I must follow in order to get coverage with this Medicare Advantage plan.

I understand that on the date Humana coverage begins, I must get all of my health care from Humana, except for emergency or urgently needed services or out-of-area dialysis. Services authorized by Humana and other services contained in my Humana Evidence of Coverage will be covered. Without authorization, **NEITHER MEDICARE NOR HUMANA WILL PAY FOR THE SERVICES.**

I understand that I am enrolling into a Humana Medicare Advantage plan and not a Medicare Supplement, Medigap, Medicare Select or Medicaid plan.

The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

**Release of Information:**
By joining this Medicare plan, I acknowledge that Humana will release my information to Medicare and other plans and providers as is necessary for treatment, payment and healthcare operations. I also acknowledge that Humana will release my information to Medicare (including prescription drug event data), who may release it for research and other purposes that follow all applicable federal statutes and regulations.

If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the Railroad Retirement Board. Do NOT pay Humana the Part D-IRMAA.

**Asterisks (*) indicate required fields**

APPLICANT MEDICARE NUMBER*

N A E N – A E N – A A N N

I have read and understand the important information on the preceding pages. I have reviewed and received a copy of the Summary of Benefits.

SIGNATURE OF APPLICANT* or authorized legal representative (including valid Power of Attorney, Legal Guardian, etc.)

SIGNATURE DATE*

M M / D D / 2 0 Y Y

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the state where the individual resides) on this enrollment form means that I have read and understand the contents of this enrollment form. If signed by an authorized individual (as described above), the signature certifies that: 1) this person is authorized under state law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

If you are the authorized legal representative, you **MUST** sign above and provide the following information:*

LAST NAME FIRST NAME MI

STREET ADDRESS

CITY ST ZIP

TELEPHONE ( ) – RELATIONSHIP TO APPLICANT

Preferred Language

English Spanish Chinese Korean Other _____

If an accessible format is needed, please select one option

Audio Large print Accessible screen reader PDF

Oral over the phone Braille

Please call a licensed Humana sales agent at **1-800-824-8242 (TTY: 711)** if you need information in another format or language.

**INTERNAL MARKETPOINT AGENTS ONLY**

WRITING AGENT NAME*

AGENT NUMBER (SAN)* DATE*

M M / D D / 2 0 Y Y

REFERRING AGENT NAME

AGENT NUMBER (SAN) DATE

M M / D D / 2 0 Y Y

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Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to individuals with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

## Language assistance services, free of charge, are available to you. **1-877-320-1235 (TTY: 711)**

**Español (Spanish):** Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
**繁體中文 (Chinese):** 撥打上面的電話號碼即可獲得免費語言援助服務。
**Tiếng Việt (Vietnamese):** Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
**한국어 (Korean):** 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오.
**Tagalog (Tagalog – Filipino):** Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.
**Русский (Russian):** Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.
**Kreyòl Ayisyen (French Creole):** Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.
**Français (French):** Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.
**Polski (Polish):** Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.
**Português (Portuguese):** Ligue para o número acima indicado para receber serviços linguísticos, grátis.
**Italiano (Italian):** Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.
**Deutsch (German):** Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
**日本語 (Japanese):** 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。
**فارسی (Farsi)**
برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

**Diné Bizaad (Navajo):** Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę́ę́ niká'adoowoł.
**العربية (Arabic)**
الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

Stamp Date

**Asterisks (*) indicate required fields**

# Humana Group Medicare HMO Enrollment Form

EMPLOYER OR UNION SPONSOR NAME* Please use the Employer/Union name listed with your mailing address on your materials.

Please print this information exactly as it is on your Medicare card.

**MEDICARE HEALTH INSURANCE**

LAST NAME*

FIRST NAME* MI*

MEDICARE NUMBER*

N A E N – A E N – A A N N

IS ENTITLED TO EFFECTIVE DATE*

HOSPITAL (PART A) M M / 0 1 / Y Y Y Y

MEDICAL (PART B) M M / 0 1 / Y Y Y Y

PROPOSED EFFECTIVE DATE*

M M / 0 1 / 2 0 Y Y

PLAN OPTION*

076 /

You can find the option number on the front page of your Summary of Benefits in the bottom right hand corner.

CATEGORY OF ENROLLEE*

- Medicare Eligible Retiree
- Medicare Eligible Spouse
- Medicare Eligible Dependent

DATE OF BIRTH* M M / D D / Y Y Y Y SEX* M F

RESIDENTIAL ADDRESS* P.O. Box not allowed. Physical address is required.

APT or STE

CITY* ST* ZIP*

COUNTY*

MAILING ADDRESS Your residential address confirms your service area. Print your mailing address/P.O. Box here, if applicable. If your mailing address is your residential address, please fill this oval.

APT or STE

CITY ST ZIP

**Asterisks (*) indicate required fields**

APPLICANT MEDICARE NUMBER*

N A E N – A E N – A A N N

It is important that we can reach you to help you stay informed and take care of your health.
Please provide your telephone number and email address.

TELEPHONE

( ) –

There may be times when Humana will use an automated system to call or text you.
When that happens we will be sure to use the telephone number you provided.

EMAIL By providing your email address, you authorize Humana to send you health information to this address.

PRIMARY CARE PHYSICIAN (PCP)*

PCP ID NUMBER*

**Are you already a patient of the physician you chose?** Yes No

You can obtain the PCP ID number on our website at **Humana-medicare.com** or by using the provider directory.

**Asterisks (*) indicate required fields**

APPLICANT MEDICARE NUMBER*

N A E N – A E N – A A N N

**1. Once enrolled, will you have other medical health coverage where you are the subscriber or are covered as a spouse/dependent?** ○ Yes ○ No

If yes, complete the following:

ID NUMBER FOR THIS COVERAGE

TELEPHONE

( ) –

CARRIER NAME

POLICY NUMBER

CARRIER ADDRESS

CITY

ST

ZIP

**Does your other coverage include prescription drug coverage?** ○ Yes ○ No

**2. Once enrolled, will you or your spouse work?** ○ Yes ○ No

Some individuals may have other drug coverage, including private insurance, Workers' Compensation, TRICARE, federal employee health benefits coverage, VA benefits, or state pharmaceutical assistance programs.

**3. Will you have other prescription drug coverage in addition to this plan for which you are applying?*** ○ Yes ○ No

If yes, complete the following:

NAME OF OTHER COVERAGE

ID NUMBER FOR THIS COVERAGE

GROUP NUMBER FOR THIS COVERAGE

Rx BIN

Rx PCN

TELEPHONE

( ) –

## PLEASE READ THIS IMPORTANT INFORMATION

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Humana, he/she may be paid based on my enrollment in a Humana plan.

**By completing this enrollment form, I agree to the following:**
The Humana Group Medicare HMO plan is a Medicare Advantage plan that has a contract with the federal government and I will need to keep my Medicare Parts A and B, and must continue to pay my Medicare Part B premium. I can only be in one Medicare Advantage plan at a time. It is my responsibility to inform Humana of any prescription drug coverage that I have or may get in the future. **I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.** I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. Once I've enrolled in this Humana plan, I can change or cancel my Humana coverage at any time and return to Medicare Parts A and B or another Medicare Advantage plan using a special election. However, I may not be eligible to return to the group plan or change plans outside of the group's open enrollment period. I can receive details of my options by calling my plan administrator or customer service.

This Humana plan serves a specific service area. If I move out of the area that this Humana plan serves, I need to notify Humana so I can disenroll and find a new plan in my new area. Once I am a member of Humana, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from Humana when I get it to know which rules I must follow in order to get coverage with this Medicare Advantage plan.

I understand that on the date Humana coverage begins, I must get all of my health care from Humana, except for emergency or urgently needed services or out-of-area dialysis. Services authorized by Humana and other services contained in my Humana Evidence of Coverage will be covered. Without authorization, **NEITHER MEDICARE NOR HUMANA WILL PAY FOR THE SERVICES.**

I understand that I am enrolling into a Humana Medicare Advantage plan and not a Medicare Supplement, Medigap, Medicare Select or Medicaid plan.

The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

**Release of Information:**
By joining this Medicare plan, I acknowledge that Humana will release my information to Medicare and other plans and providers as is necessary for treatment, payment and healthcare operations. I also acknowledge that Humana will release my information to Medicare (including prescription drug event data), who may release it for research and other purposes that follow all applicable federal statutes and regulations.

If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the Railroad Retirement Board. Do NOT pay Humana the Part D-IRMAA.

**Asterisks (*) indicate required fields**

APPLICANT MEDICARE NUMBER*

N A E N – A E N – A A N N

I have read and understand the important information on the preceding pages. I have reviewed and received a copy of the Summary of Benefits.

SIGNATURE OF APPLICANT* or authorized legal representative (including valid Power of Attorney, Legal Guardian, etc.)

SIGNATURE DATE*

M M / D D / 2 0 Y Y

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the state where the individual resides) on this enrollment form means that I have read and understand the contents of this enrollment form. If signed by an authorized individual (as described above), the signature certifies that: 1) this person is authorized under state law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

If you are the authorized legal representative, you **MUST** sign above and provide the following information:*

LAST NAME FIRST NAME MI

STREET ADDRESS

CITY ST ZIP

TELEPHONE ( ) – RELATIONSHIP TO APPLICANT

Preferred Language

English Spanish Chinese Korean Other _____

If an accessible format is needed, please select one option

Audio Large print Accessible screen reader PDF

Oral over the phone Braille

Please call a licensed Humana sales agent at **1-800-824-8242 (TTY: 711)** if you need information in another format or language.

**INTERNAL MARKETPOINT AGENTS ONLY**

WRITING AGENT NAME*

AGENT NUMBER (SAN)* DATE*

M M / D D / 2 0 Y Y

REFERRING AGENT NAME

AGENT NUMBER (SAN) DATE

M M / D D / 2 0 Y Y

Humana®

Humana.com

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NECESSARY
IF MAILED
IN THE
UNITED STATES

# BUSINESS REPLY MAIL

FIRST-CLASS MAIL PERMIT NO.434 LEXINGTON, KY

POSTAGE WILL BE PAID BY ADDRESSEE

HUMANA MEDICARE ENROLLMENT
PO BOX 14309
LEXINGTON KY 40512-9801

2021 GROUP MEDICARE ENVELOPE

FILE NAME: Y0040_GHHKX88EN_21_C_9.5X6_Env
DATE: September 25, 2020 1:20 PM
FINAL SIZE: 9.5 X 6 BLEED: NO
COLOR: 1C (BLACK)
CONTACT: SONIA BOEHNLEIN

HUMANA COLOR PALETTE

| | | | |
|---|---|---|---|
| 00/00/00/90 | 52/00/96/00 | 66/09/100/43 | 08/100/09/20 |
| 00/00/00/23 | 100/57/10/57 | 56/100/00/29 | 98/25/40/09 |
| 58/07/23/00 | 00/16/94/00 | 00/80/37/00 | |

# Important Information – Please Read

Humana must receive your application before the effective date you've requested. You can either mail or fax it.

- If mailing your application, please allow 7 days mailing time so we receive your application before the effective date.
- If faxing the application, fax it to **1-877-889-9936** before the effective date. Be sure to keep your fax confirmation as proof of your submission.

Applications not received before your effective date will be processed for the first day of the following month.

**Be sure to include the following on your application.**

- ☐ Proposed Effective Date
- ☐ First and Last Name
- ☐ Residential Address
- ☐ Employer or Union Sponsor Name
- ☐ Medicare Claim Number
- ☐ Signature of Applicant or POA and Signature Date

Humana®

Y0040_GHHKX88EN_21_C

2021 GROUP MEDICARE ENVELOPE

FILE NAME: Y0040_GHHKX88EN_21_C_9.5X6_Env
DATE: September 25, 2020 1:20 PM
FINAL SIZE: 9.5 X 6 BLEED: NO
COLOR: 1C (BLACK)
CONTACT: SONIA BOEHNLEIN

HUMANA COLOR PALETTE

| | | | |
|---|---|---|---|
| 00/00/00/90 | 52/00/96/00 | 66/09/100/43 | 08/100/09/20 |
| 00/00/00/23 | 100/57/10/57 | 56/100/00/29 | 98/25/40/09 |
| 58/07/23/00 | 00/16/94/00 | 00/80/37/00 | |

2021

# Prescription Drug Guide

## Humana Medicare Employer Plan Abbreviated Formulary

Partial list of covered drugs

PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT SOME OF THE DRUGS WE COVER IN THIS PLAN.

2

This abridged formulary was updated on 11/19/2020 and is not a complete list of drugs covered by our plan. For a complete listing, or other questions, please contact Humana Medicare Employer Plan at the number on the back of your membership card or, for TTY users, 711, Monday through Friday, from 8 a.m. - 9 p.m. Eastern Time. The automated phone system may answer your call on Saturdays, Sundays, and some public holidays. Please leave your name and telephone number, and we'll call you back by the end of the next business day, or visit **Humana.com**.

Instructions for getting information about all covered drugs are inside.

Humana.

# Welcome to Humana Medicare Employer Plan!

**Note to existing members:** This formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take. When this drug list (formulary) refers to "we," "us", or "our," it means Humana. When it refers to "plan" or "our plan," it means the Humana Medicare Employer Plan . This document includes a partial list of the drugs (formulary) for our plan which is current as of January 1, 2021. For a complete, updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages. You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1 of each year, and from time to time during the year.

**What is the abridged Humana Medicare Employer formulary?**

A formulary is the entire list of covered drugs or medicines selected by the Humana Medicare Employer Plan. The terms formulary and Drug List may be used interchangeably throughout communications regarding changes to your pharmacy benefits. The Humana Medicare Employer Plan worked with a team of doctors and pharmacists to make a formulary that represents the prescription drugs we think you need for a quality treatment program. The Humana Medicare Employer Plan will generally cover the drugs listed in the formulary as long as the drug is medically necessary, the prescription is filled at a Humana Medicare Employer Plan network pharmacy, and other plan rules are followed. For more information on how to fill your medicines, please review your Evidence of Coverage.

This document is a partial formulary, which means it includes only some of the drugs covered by the Humana Medicare Employer Plan. To search the complete list of all prescription drugs Humana covers, you can visit **Humana.com/medicaredruglist**. The Drug List Search tool lets you search for your drug by name or drug type.

If you're thinking about enrolling in a Humana Medicare Employer Plan and need help or a complete list of covered drugs, call the Group Medicare Customer Care number listed in your enrollment materials. If you're a current member, call the number or visit the website listed in your Annual Notice of Change (ANOC) or Evidence of Coverage (EOC), or call the number on the back of your Humana member identification card Monday through Friday, from 8 a.m. - 9 p.m. Eastern Time. The automated phone system may answer your call on Saturdays, Sundays, and some public holidays. Please leave your name and telephone number, and we'll call you back by the end of the next business day.

**Can the formulary change?**

Most changes in drug coverage happen on January 1, but we may add or remove drugs on the Drug List during the year, move them to different cost sharing tiers, or add new restrictions. We must follow Medicare rules in making these changes.

**Changes that can affect you this year:** In the below cases, you will be affected by coverage changes during the year:

- **New generic drugs**. We may immediately remove a brand name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost sharing tier or add new restrictions. If you are currently taking that brand name drug, we may not tell you in advance before we make that change, but we will later provide you with information about the specific change(s) we have made.
  - If we make such a change, you or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled "How do I request an exception to the Formulary?"
- **Drugs removed from the market**. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.

- **Other changes**. We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to market to replace a brand name drug currently on the formulary or add new restrictions to the brand name drug or move it to a different cost sharing tier or both. Or we may make changes based on new clinical guidelines. If we remove drugs from our formulary, or add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 30-day supply of the drug.

We'll notify members who are affected by the following changes to the formulary:
- When a drug is removed from the formulary
- When prior authorization, quantity limits, or step-therapy restrictions are added to a drug or made more restrictive
- When a drug is moved to a higher cost sharing tier

If we make these other changes, you or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled "How do I request an exception to the Formulary?"

**Changes that will not affect you if you are currently taking the drug.** Generally, if you are taking a drug on our 2021 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2021 coverage year except as described above. This means these drugs will remain available at the same cost sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs.

**What if you're affected by a Drug List change?**

We'll notify you by mail at least 30 days before one of these changes happens or we will provide a 30-day refill of the affected medicine with notice of the change.

The enclosed formulary is current as of January 1, 2021. We'll update the printed formularies each month and they'll be available on **Humana.com/medicaredruglist**.

To get updated information about the drugs that Humana covers, please visit **Humana.com/medicaredruglist**. The Drug List Search tool lets you search for your drug by name or drug type.

**How do I use the formulary?**

There are two ways to find your drug in the formulary:

**Medical condition**

The formulary starts on page 10. We've put the drugs into groups depending on the type of medical conditions that they're used to treat. For example, drugs that treat a heart condition are listed under the category "Cardiovascular Agents." If you know what medical condition your drug is used for, look for the category name in the list that begins on page 10. Then look under the category name for your drug. The formulary also lists the Tier and Utilization Management Requirements for each drug (see page 5 for more information on Utilization Management Requirements).

**Alphabetical listing**

If you're not sure about your drug's group, you should look for your drug in the Index that begins on page 30. The Index is an alphabetical list of all of the drugs included in this document. Both brand-name drugs and generic drugs are listed. Look in the Index to search for your drug. Next to each drug, you'll see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of the drug in the first column of the list.

Prescription drugs are grouped into one of four tiers.
The Humana Medicare Employer Plan covers both brand-name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

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

**How much will I pay for covered drugs?**

The Humana Medicare Employer Plan pays part of the costs for your covered drugs and you pay part of the costs, too.

**The amount of money you pay depends on:**

- Which tier your drug is on
- Whether you fill your prescription at a network pharmacy
- Your current drug payment stage - please read your Evidence of Coverage (EOC) for more information

**If you qualified for extra help with your drug costs, your costs may be different from those described above. Please refer to your Evidence of Coverage (EOC) or call Group Medicare Customer Care to find out what your costs are.**

**Are there any restrictions on my coverage?**

Some covered drugs may have additional requirements or limits on coverage. These are called Utilization Management Requirements. These requirements and limits may include:

- **Prior Authorization (PA):** The Humana Medicare Employer Plan requires you to get prior authorization for certain drugs to be covered under your plan. This means that you'll need to get approval from the Humana Medicare Employer Plan before you fill your prescriptions. If you don't get approval, the Humana Medicare Employer Plan may not cover the drug.
- **Quantity Limits (QL):** For some drugs, the Humana Medicare Employer Plan limits the amount of the drug that is covered. The Humana Medicare Employer 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's normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day. Some drugs are limited to a 30-day supply regardless of tier placement.
- **Step Therapy (ST):** In some cases, the Humana Medicare Employer Plan requires that you first try certain drugs to treat your medical condition before coverage is available for another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, the Humana Medicare Employer Plan may not cover Drug B unless you try Drug A first. If Drug A does not work for you, the Humana Medicare Employer Plan will then cover Drug B.
- **Part B versus Part D (B vs D):** Some drugs may be covered under Medicare Part B or Part D depending upon the circumstances. Information may need to be submitted to the Humana Medicare Employer Plan that describes the use and the place where you receive and take the drug so a determination can be made.

For drugs that need prior authorization or step therapy, or drugs that fall outside of quantity limits, your health care provider can fax information about your condition and need for those drugs to the Humana Medicare Employer Plan at **1-877-486-2621**. Representatives are available Monday - Friday, 8 a.m. - 8 p.m.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 10.

You can also visit **Humana.com/medicaredruglist** to get more information about the restrictions applied to specific covered drugs.

You can ask the Humana Medicare Employer Plan to make an exception to these restrictions or limits. See the section "**How do I request an exception to the formulary?**" on page 6 for information about how to request an exception.

**What if my drug isn't on the formulary?**

If your drug isn't included in this list of covered drugs, visit **Humana.com/medicaredruglist** to see if your plan covers your drug. You can also call Group Medicare Customer Care and ask if your drug is covered.

If the Humana Medicare Employer Plan doesn't cover your drug, you have two options:

- You can ask Group Medicare Customer Care for a list of similar drugs that the Humana Medicare Employer Plan covers. Show the list to your doctor and ask him or her to prescribe a similar drug that is covered by the Humana Medicare Employer Plan.
- You can ask the Humana Medicare Employer Plan to make an exception and cover your drug. See below for information about how to request an exception.

Talk to your health care provider to decide if you should switch to another drug that is covered or if you should request a formulary exception so that it can be considered for coverage.

**How do I request an exception to the formulary?**

You can ask the Humana Medicare Employer Plan to make an exception to the coverage rules. There are several types of exceptions that you can ask to be made.

- **Formulary exception:** You can request that your drug be covered if it's not on the formulary. If approved, this drug will be covered at a pre-determined cost sharing level, and you would not be able to ask us to provide the drug at a lower cost sharing level.
- **Utilization restriction exception:** You can request coverage restrictions or limits not be applied to your drug. For example, if your drug has a quantity limit, you can ask for the limit not to be applied and to cover more doses of the drug.
- **Tier exception:** You can request a higher level of coverage for your drug. For example, if your drug is usually considered a non-preferred drug, you can request it to be covered as a preferred drug instead. This would lower how much money you must pay for your drug. Please remember a higher level of coverage cannot be requested for the drug if approval was granted to cover a drug that was not on the formulary.

Generally, the Humana Medicare Employer Plan will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower cost sharing drug, or other restrictions wouldn't be as effective in treating your health condition and/or would cause adverse medical effects.

You should contact us to ask for an initial coverage decision for a formulary, tier, or utilization restriction exception.

**When you ask for an exception, you should submit a statement from your health care provider that supports your request. This is called a supporting statement.**

Generally, we must make the decision within 72 hours of receiving your health care provider's supporting statement. You can request a fast, or expedited, exception if you or your health care provider thinks your health would seriously suffer if you wait as long as 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get your health care provider's supporting statement.

**Will my plan cover my drugs if they are not on the formulary?**

You may take drugs that your plan doesn't cover. Or, you may talk to your provider about taking a different drug that your plan covers, but that drug might have a Utilization Management Requirement, such as a Prior Authorization or Step Therapy, that keeps you from getting the drug right away. In certain cases, we may cover as much as a 30-day supply of your drug during the first 90 days you're a member of the plan.

Here is what we'll do for each of your current Part D drugs that aren't on the formulary, or if you have limited ability to get your drugs:

- We'll temporarily cover a 30-day supply of your drug unless you have a prescription written for fewer days (in which case we will allow multiple fills to provide up to a total of 30 days of a drug) when you go to a pharmacy.
- There will be no coverage for the drugs after your first 30-day supply, even if you've been a member of the plan for less than 90 days, unless a formulary exception has been approved.

If you're a resident of a long-term care facility and you take Part D drugs that aren't on the formulary, we'll cover a 31-day supply unless you have a prescription written for fewer days (in which case we will allow multiple fills to provide up to a total of 31 days of a drug) during the first 90 days you're a member of our plan. We'll cover a 31-day emergency supply of your drug unless you have a prescription for fewer days (in which we will allow multiple fills to provide up to a total of 31 days of a drug) while you request a formulary exception if:

- You need a drug that's not on the formulary *or*
- You have limited ability to get your drugs *and*
- You're past the first 90 days of membership in the plan

Throughout the plan year, your treatment setting (the place where you receive and take your medicine) may change. These changes 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 use a different pharmacy
- Members who end their skilled-nursing facility Medicare Part A stay (where payments include all pharmacy charges) and who now need to use their Part D plan benefit
- Members who give up Hospice Status and go 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, the Humana Medicare Employer Plan will cover as much as a 31-day temporary supply of a Part D-covered drug when you fill your prescription 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. The Humana Medicare Employer Plan will review requests for continuation of therapy on a case-by-case basis understanding when you're on a stabilized drug regimen that, if changed, is known to have risks.

**Transition extension**

The Humana Medicare Employer Plan will consider on a case-by-case basis an extension of the transition period if your exception request or appeal hasn't been processed by the end of your initial transition period. We'll continue to provide necessary drugs to you if your transition period is extended.

A Transition Policy is available on Humana's Medicare website, **Humana.com**, in the same area where the Prescription Drug Guides are displayed.

**Humana Pharmacy® makes it easy to manage your prescriptions with mail delivery solutions**

You may be able to fill your medicines through Humana Pharmacy – Humana's mail-delivery pharmacy. You can have your maintenance medicines, specialty medicines, or supplies mailed to a place that's most convenient for you. You should get your new prescription by mail in 7 – 10 days after Humana Pharmacy has received your prescription and all the necessary information. Refills should arrive within 5 – 7 days. To get started or learn more, visit hprxweb.com. You can also call Humana Pharmacy at 1-855-899-3134 (TTY: 711) Monday – Friday, 8 a.m. to 11 p.m., and Saturday, 8 a.m. to 6:30 p.m., Eastern time.

Other pharmacies are available in our network.

## For More Information

For more detailed information about your Humana Medicare Employer Plan prescription drug coverage, please read your Evidence of Coverage (EOC) and other plan materials.

If you have questions about Humana, please visit our website at **Humana.com/medicaredruglist**. The Drug List Search tool lets you search for your drug by name or drug type.

If you have general questions about Medicare prescription drug coverage, please call Medicare at **1-800-MEDICARE** (**1-800-633-4227**) 24 hours a day, seven days a week. TTY users should call **1-877-486-2048**. You can also visit **www.medicare.gov**.

# Humana Medicare Employer Plan Formulary

The formulary that begins on the next page provides coverage information about the drugs covered by the Humana Medicare Employer Plan. If you have trouble finding your drug in the list, turn to the Index that begins on page 30.

**Remember: This is only a partial list of drugs covered by Humana.** If your prescription drug isn't listed in this partial formulary, please visit our website at **Humana.com**. Our additional contact information is listed on the previous page.

**How to read your formulary**

The first column of the chart lists categories of medical conditions in alphabetical order. The drug names are then listed in alphabetical order within each category. Brand-name drugs are CAPITALIZED and generic drugs are listed in lower-case italics. Next to the drug name you may see an indicator to tell you about additional coverage information for that drug. You might see the following indicators:
**DL** - Dispensing Limit; Drugs that may be limited to a 30 day supply, regardless of tier placement.
**MO** - Drugs that are typically available through mail-order. Please contact your mail-order pharmacy to make sure your drug is available.
The second column lists the tier of the drug. See page 5 for more details on the drug tiers in your plan.

The third column shows the Utilization Management Requirements for the drug. The Humana Medicare Employer Plan may have special requirements for covering that drug. If the column is blank, then there are no utilization requirements for that drug. The supply for each drug is based on benefits and whether your health care provider prescribes a supply for 30, 60, or 90 days. The amount of any quantity limits will also be in this column (Example: "QL - 30 for 30 days" means you can only get 30 doses every 30 days). See page 5 for more information about these requirements.

| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| **Analgesics** | | |
| *acetaminophen-cod #3 tablet* **DL** | 1 | QL (360 per 30 days) |
| *celecoxib 100 mg, 200 mg, 400 mg, 50 mg capsule* **MO** | 1 | QL (60 per 30 days) |
| *diclofenac sod ec 25 mg, 50 mg, 75 mg tab* **MO** | 1 | |
| *diclofenac sodium 1% gel* **MO** | 1 | |
| *fentanyl 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 37.5 mcg/hour, 50 mcg/hr, 62.5 mcg/hour, 75 mcg/hr, 87.5 mcg/hour patch; fentanyl 37.5 mcg/hr patch; fentanyl 62.5 mcg/hr patch; fentanyl 87.5 mcg/hr patch* **DL** | 1 | QL (20 per 30 days) |
| *hydrocodone-acetamin 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg; hydrocodone-acetamin 2.5-325; hydrocodone-acetamin 7.5-325* **DL** | 1 | QL (360 per 30 days) |
| *ibuprofen 400 mg, 600 mg, 800 mg tablet* **MO** | 1 | |
| *meloxicam 15 mg tablet* **MO** | 1 | QL (30 per 30 days) |
| *morphine sulf er 15 mg, 30 mg, 60 mg tablet* **DL** | 1 | QL (120 per 30 days) |
| *naproxen 250 mg, 375 mg, 500 mg tablet; naproxen dr 250 mg, 375 mg, 500 mg tablet* **MO** | 1 | |
| *oxycodone hcl 10 mg, 15 mg, 20 mg, 30 mg, 5 mg tablet* **DL** | 1 | QL (360 per 30 days) |
| *oxycodon-acetaminophen 2.5-325; oxycodon-acetaminophen 7.5-325; oxycodone-acetaminophen 10-325; oxycodone-acetaminophen 5-325* **DL** | 1 | QL (360 per 30 days) |
| *tramadol hcl 50 mg tablet* **DL** | 1 | QL (240 per 30 days) |
| XTAMPZA ER 13.5 MG, 18 MG, 27 MG, 36 MG, 9 MG CAPSULE SPRINKLE **DL** | 2 | QL (60 per 30 days) |
| **Anti-Addiction/Substance Abuse Treatment Agents** | | |
| NARCAN 4 MG/ACTUATION NASAL SPRAY **MO** | 2 | QL (2 per 30 days) |
| VIVITROL 380 MG INTRAMUSCULAR SUSPENSION,EXTENDED RELEASE **DL** | 4 | QL (1 per 28 days) |
| ZUBSOLV 0.7 MG-0.18 MG SUBLINGUAL TABLET; ZUBSOLV 1.4 MG-0.36 MG SUBLINGUAL TABLET; ZUBSOLV 2.9 MG-0.71 MG SUBLINGUAL TABLET; ZUBSOLV 5.7 MG-1.4 MG SUBLINGUAL TABLET **MO** | 1 | QL (90 per 30 days) |
| ZUBSOLV 11.4 MG-2.9 MG SUBLINGUAL TABLET **MO** | 1 | QL (30 per 30 days) |
| ZUBSOLV 8.6 MG-2.1 MG SUBLINGUAL TABLET **MO** | 1 | QL (60 per 30 days) |
| **Antibacterials** | | |
| *amoxicillin 250 mg, 500 mg capsule* **MO** | 1 | |
| *amox-clav 250-125 mg, 500-125 mg, 875-125 mg tablet* **MO** | 1 | |
| *azithromycin 250 mg, 500 mg, 600 mg tablet* **MO** | 1 | |
| BETHKIS 300 MG/4 ML SOLUTION FOR NEBULIZATION **DL** | 4 | PA |
| *cefdinir 300 mg capsule* **MO** | 1 | |
| *cephalexin 250 mg, 500 mg, 750 mg capsule* **MO** | 1 | |
| *ciprofloxacin hcl 100 mg, 250 mg, 500 mg, 750 mg tab* **MO** | 1 | |
| *clindamycin hcl 150 mg, 300 mg, 75 mg capsule* **MO** | 1 | |

Need more information about the indicators displayed by the drug names? Please go to page 9.

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization • B vs D - Part B versus Part D
MD – Maintenance Drug • DL – Dispensing Limit

| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| *daptomycin 350 mg, 500 mg vial* **DL** | 4 | |
| DIFICID 200 MG TABLET **DL** | 4 | |
| *doxycycline hyclate 100 mg, 50 mg cap* **MO** | 1 | |
| *imipenem-cilastatin 250 mg, 500 mg vl* **MO** | 1 | |
| *levofloxacin 250 mg, 500 mg, 750 mg tablet* **MO** | 1 | |
| *meropenem iv 1 gm vial; meropenem iv 1 gram, 500 mg vial* **MO** | 1 | |
| *meropenem-0.9% nacl 1 gram/50; meropenem-0.9% nacl 500 mg/50* **MO** | 1 | |
| *metronidazole 250 mg, 500 mg tablet* **MO** | 1 | |
| *nafcillin 1 gm add-van vial; nafcillin 1 gm vial; nafcillin 10 gm bulk vial; nafcillin 2 gm add-vant vial; nafcillin 2 gm vial* **MO** | 1 | |
| *nafcillin 1 gm/ 50 ml inj; nafcillin 2 gm/ 100 ml inj* **DL** | 4 | |
| *nitrofurantoin mono-mcr 100 mg* **MO** | 1 | |
| NUZYRA 100 MG INTRAVENOUS SOLUTION **DL** | 4 | B vs D |
| NUZYRA 150 MG TABLET **DL** | 4 | QL (30 per 14 days) |
| *piperacil-tazobact 13.5 gm vl; piperacil-tazobact 13.5 gram, 2.25 gram, 3.375 gram, 4.5 gram, 40.5 gram; piperacil-tazobact 2.25 gm vl; piperacil-tazobact 3.375 gm vl; piperacil-tazobact 4.5 gm vial* **MO** | 1 | |
| *polymyxin b sulfate vial* **MO** | 1 | |
| *sulfamethoxazole-tmp ds tablet; sulfamethoxazole-tmp ss tablet* **MO** | 1 | |
| *vanco 1 gram/200 ml, 500 mg/100 ml, 750 mg/150 ml-0.9% nacl; vancomycin 1 g/200ml-0.9% nacl* **MO** | 3 | |
| **ANTICONVULSANTS** | | |
| *divalproex sod dr 125 mg, 250 mg, 500 mg tab* **MO** | 1 | |
| *divalproex sod er 250 mg, 500 mg tab* **MO** | 1 | |
| *gabapentin 100 mg, 300 mg, 400 mg capsule* **MO** | 1 | QL (270 per 30 days) |
| *lamotrigine 100 mg, 150 mg, 200 mg, 25 mg, 25 mg (21) -50 mg (7), 25 mg (35), 25 mg (42) -100 mg (7), 25 mg (84) -100 mg (14), 25 mg(14)-50 mg (14)-100 mg (7), 50 mg, 50 mg (42) -100 mg (14) tablet; lamotrigine odt 100 mg, 150 mg, 200 mg, 25 mg, 25 mg (21) -50 mg (7), 25 mg (35), 25 mg (42) -100 mg (7), 25 mg (84) -100 mg (14), 25 mg(14)-50 mg (14)-100 mg (7), 50 mg, 50 mg (42) -100 mg (14) tablet; lamotrigine odt kit (blue); lamotrigine odt kit (green); lamotrigine odt kit (orange); lamotrigine tab start kit-blue; lamotrigine tab start kt-green; lamotrigine tab start kt-orang* **MO** | 1 | |
| *levetiracetam 1,000 mg, 500 mg, 750 mg tablet* **MO** | 1 | |
| *topiramate 100 mg, 200 mg, 50 mg tablet* **MO** | 1 | QL (120 per 30 days) |
| VIMPAT 10 MG/ML ORAL SOLUTION **MO** | 3 | QL (1395 per 30 days) |
| VIMPAT 100 MG, 150 MG, 200 MG, 50 MG TABLET **MO** | 3 | QL (60 per 30 days) |
| VIMPAT 200 MG/20 ML INTRAVENOUS SOLUTION **MO** | 3 | |

Need more information about the indicators displayed by the drug names? Please go to page 9.

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MD – Maintenance Drug • DL – Dispensing Limit

| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| **ANTIDEMENTIA AGENTS** | | |
| *donepezil hcl 10 mg tablet* **MO** | 1 | QL (60 per 30 days) |
| *donepezil hcl 10 mg, 23 mg, 5 mg tablet; donepezil hcl odt 10 mg, 23 mg, 5 mg tablet* **MO** | 1 | QL (30 per 30 days) |
| *memantine hcl 10 mg, 5 mg tablet* **MO** | 1 | PA,QL (60 per 30 days) |
| NAMZARIC 14 MG-10 MG CAPSULE SPRINKLE,EXTENDED RELEASE; NAMZARIC 21 MG-10 MG CAPSULE SPRINKLE,EXTENDED RELEASE; NAMZARIC 28 MG-10 MG CAPSULE SPRINKLE,EXTENDED RELEASE; NAMZARIC 7 MG-10 MG CAPSULE SPRINKLE,EXTENDED RELEASE **MO** | 2 | QL (30 per 30 days) |
| NAMZARIC 7/14/21/28 MG-10 MG CAPSULE,SPRINKLE,EXTEND RELEASE,DOSE PACK **MO** | 2 | QL (28 per 28 days) |
| **Antidepressants** | | |
| *amitriptyline hcl 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg tab* **MO** | 1 | |
| *bupropion hcl sr 150 mg tablet* **MO** | 1 | QL (90 per 30 days) |
| *bupropion hcl xl 300 mg tablet* **MO** | 1 | QL (60 per 30 days) |
| *citalopram hbr 20 mg tablet* **MO** | 1 | QL (60 per 30 days) |
| *duloxetine hcl dr 20 mg, 30 mg, 40 mg, 60 mg cap* **MO** | 1 | QL (60 per 30 days) |
| *escitalopram 10 mg tablet* **MO** | 1 | QL (45 per 30 days) |
| *fluoxetine hcl 10 mg, 40 mg capsule* **MO** | 1 | QL (60 per 30 days) |
| *fluoxetine hcl 20 mg capsule* **MO** | 1 | QL (120 per 30 days) |
| *mirtazapine 15 mg, 30 mg, 45 mg, 7.5 mg tablet* **MO** | 1 | |
| *paroxetine hcl 10 mg, 20 mg tablet* **MO** | 1 | QL (30 per 30 days) |
| *paroxetine hcl 30 mg, 40 mg tablet* **MO** | 1 | QL (60 per 30 days) |
| *sertraline hcl 100 mg tablet* **MO** | 1 | QL (60 per 30 days) |
| *sertraline hcl 25 mg, 50 mg tablet* **MO** | 1 | QL (90 per 30 days) |
| *trazodone 100 mg, 150 mg, 300 mg, 50 mg tablet* **MO** | 1 | |
| TRINTELLIX 10 MG, 20 MG, 5 MG TABLET **MO** | 3 | ST,QL (30 per 30 days) |
| *venlafaxine hcl er 150 mg cap* **MO** | 1 | QL (60 per 30 days) |
| *venlafaxine hcl er 75 mg cap* **MO** | 1 | QL (90 per 30 days) |
| **Antiemetics** | | |
| *meclizine 12.5 mg, 25 mg tablet* **MO** | 1 | |
| *ondansetron odt 4 mg, 8 mg tablet* **MO** | 1 | B vs D,QL (90 per 30 days) |
| *ondansetron hcl 4 mg, 8 mg tablet* **MO** | 1 | B vs D,QL (90 per 30 days) |
| *promethazine 12.5 mg, 25 mg, 50 mg tablet* **MO** | 1 | |
| SANCUSO 3.1 MG/24 HOUR TRANSDERMAL PATCH **MO** | 3 | QL (4 per 30 days) |
| **Antifungals** | | |
| *clotrimazole-betamethasone crm* **MO** | 1 | QL (180 per 30 days) |

Need more information about the indicators displayed by the drug names? Please go to page 9.

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization • B vs D - Part B versus Part D
MD – Maintenance Drug • DL – Dispensing Limit

| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| *fluconazole 100 mg, 150 mg, 200 mg, 50 mg tablet* **MO** | 1 | |
| *ketoconazole 2% shampoo* **MO** | 1 | QL (120 per 30 days) |
| *nystatin 100,000 unit/gm cream* **MO** | 1 | |
| **Antigout Agents** | | |
| *allopurinol 100 mg, 300 mg tablet* **MO** | 1 | |
| MITIGARE 0.6 MG CAPSULE **MO** | 2 | |
| **ANTIMIGRAINE AGENTS** | | |
| AIMOVIG AUTOINJECTOR 140 MG/ML SUBCUTANEOUS AUTO-INJECTOR **MO** | 3 | PA,QL (1 per 30 days) |
| AIMOVIG AUTOINJECTOR 70 MG/ML SUBCUTANEOUS AUTO-INJECTOR **MO** | 3 | PA,QL (2 per 30 days) |
| AIMOVIG 140 MG DOSE-2 AUTOINJ **MO** | 3 | PA,QL (2 per 30 days) |
| EMGALITY PEN 120 MG/ML SUBCUTANEOUS PEN INJECTOR **MO** | 3 | PA,QL (2 per 30 days) |
| EMGALITY 120 MG/ML SUBCUTANEOUS SYRINGE **MO** | 3 | PA,QL (2 per 30 days) |
| EMGALITY 300 MG/3 ML (100 MG/ML X 3) SUBCUTANEOUS SYRINGE **MO** | 3 | PA,QL (3 per 30 days) |
| *sumatriptan succ 100 mg, 25 mg, 50 mg tablet* **MO** | 1 | QL (9 per 30 days) |
| **Antineoplastics** | | |
| AFINITOR 10 MG, 2.5 MG, 5 MG, 7.5 MG TABLET **DL** | 4 | PA,QL (30 per 30 days) |
| AFINITOR DISPERZ 2 MG, 3 MG, 5 MG TABLET FOR ORAL SUSPENSION **DL** | 4 | PA |
| ALUNBRIG 180 MG, 90 MG, 90 MG (7)- 180 MG (23) TABLET; ALUNBRIG 90 MG (7)-180 MG (23) TABLETS IN A DOSE PACK **DL** | 4 | PA,QL (30 per 30 days) |
| ALUNBRIG 30 MG TABLET **DL** | 4 | PA,QL (180 per 30 days) |
| CABOMETYX 20 MG, 40 MG, 60 MG TABLET **DL** | 4 | PA,QL (30 per 30 days) |
| ERIVEDGE 150 MG CAPSULE **DL** | 4 | PA,QL (28 per 28 days) |
| ERLEADA 60 MG TABLET **DL** | 4 | PA,QL (120 per 30 days) |
| HERCEPTIN 150 MG, 440 MG INTRAVENOUS SOLUTION; HERCEPTIN 150 MG, 440 MG VIAL **DL** | 4 | PA |
| HERCEPTIN HYLECTA 600 MG-10,000 UNIT/5 ML SUBCUTANEOUS SOLUTION **DL** | 4 | PA,QL (5 per 21 days) |
| IBRANCE 100 MG, 125 MG, 75 MG CAPSULE **DL** | 4 | PA,QL (21 per 28 days) |
| NUBEQA 300 MG TABLET **DL** | 4 | PA,QL (120 per 30 days) |
| RITUXAN 10 MG/ML CONCENTRATE,INTRAVENOUS **DL** | 4 | PA |
| SPRYCEL 100 MG, 50 MG, 70 MG, 80 MG TABLET **DL** | 4 | PA,QL (60 per 30 days) |
| SPRYCEL 140 MG TABLET **DL** | 4 | PA,QL (30 per 30 days) |
| SPRYCEL 20 MG TABLET **DL** | 4 | PA,QL (90 per 30 days) |
| VERZENIO 100 MG, 150 MG, 200 MG, 50 MG TABLET **DL** | 4 | PA,QL (60 per 30 days) |
| XTANDI 40 MG CAPSULE **DL** | 4 | PA,QL (120 per 30 days) |

Need more information about the indicators displayed by the drug names? Please go to page 9.

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MD – Maintenance Drug • DL – Dispensing Limit

| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| **Antiparasitics** | | |
| *hydroxychloroquine 200 mg tab* **MO** | 1 | |
| *ivermectin 3 mg tablet* **MO** | 1 | |
| **ANTIPARKINSON AGENTS** | | |
| *benztropine mes 0.5 mg, 1 mg, 2 mg tab; benztropine mes 0.5 mg, 1 mg, 2 mg tablet* **MO** | 1 | |
| *carbidopa-levo 10-100 mg, 25-100 mg, 25-250 mg odt; carbidopa-levodopa 10-100 tab; carbidopa-levodopa 25-100 tab; carbidopa-levodopa 25-250 tab* **MO** | 1 | |
| NEUPRO 1 MG/24 HOUR, 2 MG/24 HOUR, 3 MG/24 HOUR, 4 MG/24 HOUR, 6 MG/24 HOUR, 8 MG/24 HOUR TRANSDERMAL 24 HOUR PATCH **MO** | 3 | QL (30 per 30 days) |
| *pramipexole 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg tablet* **MO** | 1 | |
| *ropinirole hcl 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg tablet* **MO** | 1 | |
| RYTARY 23.75 MG-95 MG CAPSULE,EXTENDED RELEASE; RYTARY 48.75 MG-195 MG CAPSULE,EXTENDED RELEASE **MO** | 3 | ST,QL (360 per 30 days) |
| RYTARY 36.25 MG-145 MG CAPSULE,EXTENDED RELEASE **MO** | 3 | ST,QL (270 per 30 days) |
| RYTARY 61.25 MG-245 MG CAPSULE,EXTENDED RELEASE **MO** | 3 | ST,QL (300 per 30 days) |
| **Antipsychotics** | | |
| ABILIFY MAINTENA 300 MG, 400 MG INTRAMUSCULAR SUSPENSION,EXTENDED RELEASE **DL** | 4 | QL (1 per 28 days) |
| ABILIFY MAINTENA 300 MG, 400 MG SUSPENSION,EXTENDED REL. INTRAMUSCULAR SYRINGE **DL** | 4 | QL (1 per 28 days) |
| *aripiprazole 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg tablet* **MO** | 1 | |
| ARISTADA 1,064 MG/3.9 ML SUSPENSION, EXTEND.REL. IM SYRINGE **MO** | 4 | QL (3.9 per 56 days) |
| ARISTADA 441 MG/1.6 ML SUSPENSION, EXTEND.REL. IM SYRINGE **DL** | 4 | QL (1.6 per 28 days) |
| ARISTADA 662 MG/2.4 ML SUSPENSION, EXTEND.REL. IM SYRINGE **DL** | 4 | QL (2.4 per 28 days) |
| ARISTADA 882 MG/3.2 ML SUSPENSION, EXTEND.REL. IM SYRINGE **DL** | 4 | QL (3.2 per 28 days) |
| ARISTADA INITIO 675 MG/2.4 ML SUSPENSION, EXTEND.REL. IM SYRINGE **DL** | 4 | QL (2.4 per 42 days) |
| INVEGA SUSTENNA 117 MG/0.75 ML, 234 MG/1.5 ML, 78 MG/0.5 ML INTRAMUSCULAR SYRINGE **DL** | 4 | QL (1.5 per 28 days) |
| INVEGA SUSTENNA 156 MG/ML INTRAMUSCULAR SYRINGE **DL** | 4 | QL (1 per 28 days) |
| INVEGA SUSTENNA 39 MG/0.25 ML INTRAMUSCULAR SYRINGE **MO** | 3 | QL (1.5 per 28 days) |
| INVEGA TRINZA 273 MG/0.875 ML INTRAMUSCULAR SYRINGE **MO** | 4 | QL (0.87 per 90 days) |
| INVEGA TRINZA 410 MG/1.315 ML INTRAMUSCULAR SYRINGE **MO** | 4 | QL (1.31 per 90 days) |
| INVEGA TRINZA 546 MG/1.75 ML INTRAMUSCULAR SYRINGE **MO** | 4 | QL (1.75 per 90 days) |
| INVEGA TRINZA 819 MG/2.625 ML INTRAMUSCULAR SYRINGE **MO** | 4 | QL (2.62 per 90 days) |
| *olanzapine 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg tablet* **MO** | 1 | |

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MD – Maintenance Drug • DL – Dispensing Limit

| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| PERSERIS 120 MG, 90 MG ABDOMINAL SUBCUTANEOUS EXTEND RELEASE SUSP SYRINGE KIT DL | 4 | QL (1 per 28 days) |
| *quetiapine fumarate 200 mg, 25 mg, 50 mg tab* MO | 1 | QL (120 per 30 days) |
| RISPERDAL CONSTA 12.5 MG/2 ML, 25 MG/2 ML INTRAMUSCULAR SUSP,EXTENDED RELEASE MO | 3 | QL (2 per 28 days) |
| RISPERDAL CONSTA 37.5 MG/2 ML, 50 MG/2 ML INTRAMUSCULAR SUSP,EXTENDED RELEASE DL | 4 | QL (2 per 28 days) |
| *risperidone 0.25 mg, 1 mg, 2 mg, 3 mg, 4 mg odt; risperidone 0.25 mg, 1 mg, 2 mg, 3 mg, 4 mg tablet* MO | 1 | QL (60 per 30 days) |
| **Antispasticity Agents** | | |
| *baclofen 10 mg, 20 mg tablet* MO | 1 | |
| *dantrolene sodium 100 mg, 25 mg, 50 mg cap* MO | 1 | |
| *tizanidine hcl 2 mg, 4 mg tablet* MO | 1 | |
| **Antivirals** | | |
| *acyclovir 400 mg, 800 mg tablet* MO | 1 | |
| BIKTARVY 50 MG-200 MG-25 MG TABLET DL | 4 | QL (30 per 30 days) |
| DESCOVY 200 MG-25 MG TABLET DL | 4 | QL (30 per 30 days) |
| EPCLUSA 200 MG-50 MG TABLET; EPCLUSA 400 MG-100 MG TABLET DL | 4 | PA,QL (28 per 28 days) |
| GENVOYA 150 MG-150 MG-200 MG-10 MG TABLET DL | 4 | QL (30 per 30 days) |
| HARVONI 45 MG-200 MG TABLET; HARVONI 90 MG-400 MG TABLET DL | 4 | PA,QL (28 per 28 days) |
| *ledipasvir-sofosbuvir 90-400mg* DL | 4 | PA,QL (28 per 28 days) |
| ODEFSEY 200 MG-25 MG-25 MG TABLET DL | 4 | QL (30 per 30 days) |
| *oseltamivir phos 45 mg, 75 mg capsule* MO | 1 | QL (112 per 365 days) |
| VOSEVI 400 MG-100 MG-100 MG TABLET DL | 4 | PA,QL (28 per 28 days) |
| XOFLUZA 20 MG, 40 MG TABLET MO | 3 | QL (10 per 365 days) |
| **Anxiolytics** | | |
| *alprazolam 0.25 mg, 0.5 mg, 1 mg tablet* DL | 1 | QL (120 per 30 days) |
| *buspirone hcl 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg tablet* MO | 1 | |
| *clonazepam 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg dis tab; clonazepam 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg dis tablet; clonazepam 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg odt; clonazepam 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg tablet* DL | 1 | |
| *diazepam 2 mg, 5 mg tablet* DL | 1 | QL (90 per 30 days) |
| *hydroxyzine hcl 10 mg, 25 mg, 50 mg tablet* MO | 1 | |
| *lorazepam 0.5 mg, 1 mg tablet* DL | 1 | QL (90 per 30 days) |
| **Blood Glucose Regulators** | | |
| BAQSIMI 3 MG/ACTUATION NASAL SPRAY MO | 2 | |

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| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| BYDUREON 2 MG VIAL MO | 3 | QL (4 per 28 days) |
| BYDUREON 2 MG/0.65 ML SUBCUTANEOUS PEN INJECTOR MO | 3 | QL (4 per 28 days) |
| BYDUREON BCISE 2 MG/0.85 ML SUBCUTANEOUS AUTO-INJECTOR MO | 3 | QL (3.4 per 28 days) |
| FARXIGA 10 MG, 5 MG TABLET MO | 3 | QL (30 per 30 days) |
| FIASP FLEXTOUCH U-100 INSULIN 100 UNIT/ML (3 ML) SUBCUTANEOUS PEN MO | 2 | |
| FIASP PENFILL U-100 INSULIN 100 UNIT/ML (3 ML) SUBCUTANEOUS CARTRIDGE MO | 2 | |
| FIASP U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS SOLUTION MO | 2 | |
| *glimepiride 1 mg, 2 mg, 4 mg tablet* MO | 1 | |
| *glipizide 10 mg, 5 mg tablet* MO | 1 | |
| *glipizide er 10 mg, 2.5 mg, 5 mg tablet* MO | 1 | |
| GLUCAGEN HYPOKIT 1 MG INJECTION MO | 2 | |
| GLYXAMBI 10 MG-5 MG TABLET; GLYXAMBI 25 MG-5 MG TABLET MO | 2 | QL (30 per 30 days) |
| GVOKE PFS 1-PACK 0.5 MG/0.1 ML, 1 MG/0.2 ML SUBCUTANEOUS SYRINGE MO | 2 | |
| GVOKE PFS 2-PACK 0.5 MG/0.1 ML, 1 MG/0.2 ML SUBCUTANEOUS SYRINGE MO | 2 | |
| HUMALOG MIX 75-25 (U-100) INSULIN 100 UNIT/ML SUBCUTANEOUS SUSPENSION MO | 3 | ST |
| HUMULIN 70/30 U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS SUSPENSION MO | 3 | ST |
| HUMULIN 70/30 U-100 INSULIN KWIKPEN 100 UNIT/ML SUBCUTANEOUS MO | 3 | ST |
| HUMULIN SUBCUTAN | | |
| HUMULIN SUBCUTAN | | |
| HUMULIN MO | | |
| HUMULIN SUBCUTAN | | |
| HUMULIN SUBCUTAN | | |
| INSULIN A | | |
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MD – Maint

| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| INSULIN LISPRO MIX 75-25 KWKPN MO | 3 | ST |
| INVOKAMET 150 MG-1,000 MG TABLET; INVOKAMET 150 MG-500 MG TABLET; INVOKAMET 50 MG-1,000 MG TABLET; INVOKAMET 50 MG-500 MG TABLET MO | 2 | QL (60 per 30 days) |
| INVOKAMET XR 150 MG-1,000 MG TABLET, EXTENDED RELEASE; INVOKAMET XR 150 MG-500 MG TABLET, EXTENDED RELEASE; INVOKAMET XR 50 MG-1,000 MG TABLET, EXTENDED RELEASE; INVOKAMET XR 50 MG-500 MG TABLET, EXTENDED RELEASE MO | 2 | QL (60 per 30 days) |
| INVOKANA 100 MG, 300 MG TABLET MO | 2 | QL (30 per 30 days) |
| JANUMET 50 MG-1,000 MG TABLET; JANUMET 50 MG-500 MG TABLET MO | 2 | QL (60 per 30 days) |
| JANUMET XR 100 MG-1,000 MG TABLET,EXTENDED RELEASE MO | 2 | QL (30 per 30 days) |
| JANUMET XR 50 MG-1,000 MG TABLET,EXTENDED RELEASE; JANUMET XR 50 MG-500 MG TABLET,EXTENDED RELEASE MO | 2 | QL (60 per 30 days) |
| JANUVIA 100 MG, 25 MG, 50 MG TABLET MO | 2 | QL (30 per 30 days) |
| JARDIANCE 10 MG, 25 MG TABLET MO | 2 | QL (30 per 30 days) |
| JENTADUETO 2.5 MG-1,000 MG TABLET; JENTADUETO 2.5 MG-500 MG TABLET; JENTADUETO 2.5 MG-850 MG TABLET MO | 2 | QL (60 per 30 days) |
| JENTADUETO XR 2.5 MG-1,000 MG TABLET, EXTENDED RELEASE MO | 2 | QL (60 per 30 days) |
| JENTADUETO XR 5 MG-1,000 MG TABLET, EXTENDED RELEASE MO | 2 | QL (30 per 30 days) |
| KOMBIGLYZE XR 2.5 MG-1,000 MG TABLET,EXTENDED RELEASE MO | 3 | QL (60 per 30 days) |
| KOMBIGLYZE XR 5 MG-1,000 MG TABLET,EXTENDED RELEASE; KOMBIGLYZE XR 5 MG-500 MG TABLET EXTENDED RELEASE MO | 3 | QL (30 per 30 days) |



HEAD

| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| NOVOLOG FLEXPEN U-100 INSULIN ASPART 100 UNIT/ML (3 ML) SUBCUTANEOUS MO | 2 | |
| NOVOLOG MIX 70-30 U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS SOLUTION MO | 2 | |
| NOVOLOG MIX 70-30 FLEXPEN U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS PEN MO | 2 | |
| NOVOLOG PENFILL U-100 INSULIN ASPART 100 UNIT/ML SUBCUTANEOUS CARTRIDG MO | 2 | |
| NOVOLOG U-100 INSULIN ASPART 100 UNIT/ML SUBCUTANEOUS SOLUTION MO | 2 | |
| ONGLYZA 2.5 MG, 5 MG TABLET MO | 3 | QL (30 per 30 days) |
| OZEMPIC 0.25 MG OR 0.5 MG (2 MG/1.5 ML) SUBCUTANEOUS PEN INJECTOR MO | 2 | QL (1.5 per 28 days) |
| OZEMPIC 1 MG/DOSE (2 MG/1.5 ML) SUBCUTANEOUS PEN INJECTOR MO | 2 | QL (3 per 28 days) |
| *pioglitazone hcl 15 mg, 30 mg, 45 mg tablet* MO | 1 | QL (30 per 30 days) |
| RYBELSUS 14 MG, 3 MG, 7 MG TABLET MO | 2 | QL (30 per 30 days) |
| SOLIQUA 100/33 100 UNIT-33 MCG/ML SUBCUTANEOUS INSULIN PEN MO | 2 | QL (15 per 24 days) |
| SYNJARDY 12.5 MG-1,000 MG TABLET; SYNJARDY 12.5 MG-500 MG TABLET; SYNJARDY 5 MG-1,000 MG TABLET; SYNJARDY 5 MG-500 MG TABLET MO | 2 | QL (60 per 30 days) |
| SYNJARDY XR 10 MG-1,000 MG TABLET, EXTENDED RELEASE; SYNJARDY XR 25 MG-1,000 MG TABLET, EXTENDED RELEASE MO | 2 | QL (30 per 30 days) |
| SYNJARDY XR 12.5 MG-1,000 MG TABLET, EXTENDED RELEASE; SYNJARDY XR , EXTENDED RELEASE MO | 2 | QL (60 per 30 days) |
| LOSTAR 300 UNIT/ML (3 ML) SUBCUTANEOUS | 2 | |
| 00 INSULIN 300 UNIT/ML (1.5 ML) SUBCUTANEOUS | 2 | |
| ET MO | 2 | QL (30 per 30 days) |
| -100 INSULIN 100 UNIT/ML (3 ML) SUBCUTANEOUS | 2 | |
| -200 INSULIN 200 UNIT/ML (3 ML) SUBCUTANEOUS | 2 | |
| N 100 UNIT/ML SUBCUTANEOUS SOLUTION MO | 2 | |
| MG-1,000 MG TABLET, EXTENDED RELEASE; TRIJARDY MG TABLET, EXTENDED RELEASE MO | 2 | QL (30 per 30 days) |
| 2.5 MG-1,000 MG TABLET, EXTENDED RELEASE; MG-1,000 MG TABLET, EXTENDED RELEASE MO | 2 | QL (60 per 30 days) |
| ML, 1.5 MG/0.5 ML, 3 MG/0.5 ML, 4.5 MG/0.5 ML NJECTOR MO | 2 | QL (2 per 28 days) |

about the indicators displayed by the drug names? Please go to page 9.

Quantity Limit • PA - Prior Authorization • B vs D - Part B versus Part D
• DL – Dispensing Limit

| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| VICTOZA 2-PAK 0.6 MG/0.1 ML (18 MG/3 ML) SUBCUTANEOUS PEN INJECTOR MO | 2 | QL (9 per 30 days) |
| VICTOZA 3-PAK 0.6 MG/0.1 ML (18 MG/3 ML) SUBCUTANEOUS PEN INJECTOR MO | 2 | QL (9 per 30 days) |
| XIGDUO XR 10 MG-1,000 MG TABLET,EXTENDED RELEASE; XIGDUO XR 10 MG-500 MG TABLET,EXTENDED RELEASE; XIGDUO XR 5 MG-500 MG TABLET,EXTENDED RELEASE MO | 3 | QL (30 per 30 days) |
| XIGDUO XR 2.5 MG-1,000 MG TABLET,EXTENDED RELEASE; XIGDUO XR 5 MG-1,000 MG TABLET,EXTENDED RELEASE MO | 3 | QL (60 per 30 days) |
| XULTOPHY 100/3.6 100 UNIT-3.6 MG/ML (3 ML) SUBCUTANEOUS INSULIN PEN MO | 2 | QL (15 per 30 days) |
| **BLOOD PRODUCTS AND MODIFIERS** | | |
| BRILINTA 60 MG, 90 MG TABLET MO | 2 | QL (60 per 30 days) |
| *clopidogrel 75 mg tablet* MO | 1 | QL (30 per 30 days) |
| ELIQUIS 2.5 MG TABLET MO | 2 | QL (60 per 30 days) |
| ELIQUIS 5 MG TABLET MO | 2 | QL (74 per 30 days) |
| ELIQUIS DVT-PE TREATMENT 30-DAY STARTER 5 MG (74 TABLETS) IN DOSE PACK MO | 2 | QL (74 per 30 days) |
| *enoxaparin 100 mg/ml, 150 mg/ml syringe* MO | 1 | QL (28 per 28 days) |
| *enoxaparin 120 mg/0.8 ml, 80 mg/0.8 ml syr* MO | 1 | QL (22.4 per 28 days) |
| *enoxaparin 30 mg/0.3 ml, 60 mg/0.6 ml syr* MO | 1 | QL (16.8 per 28 days) |
| *enoxaparin 300 mg/3 ml vial* MO | 1 | QL (84 per 28 days) |
| *enoxaparin 40 mg/0.4 ml syr* MO | 1 | QL (11.2 per 28 days) |
| NEULASTA 6 MG/0.6 ML SUBCUTANEOUS SYRINGE DL | 4 | PA,QL (1.2 per 28 days) |
| NEULASTA ONPRO 6 MG/0.6 ML WITH WEARABLE SUBCUTANEOUS INJECTOR DL | 4 | PA,QL (1.2 per 28 days) |
| NEUPOGEN 300 MCG/0.5 ML INJECTION SYRINGE DL | 4 | PA,QL (7 per 30 days) |
| NEUPOGEN 300 MCG/ML INJECTION SOLUTION DL | 4 | PA,QL (14 per 30 days) |
| NEUPOGEN 480 MCG/0.8 ML INJECTION SYRINGE DL | 4 | PA,QL (11.2 per 30 days) |
| NEUPOGEN 480 MCG/1.6 ML INJECTION SOLUTION DL | 4 | PA,QL (22.4 per 30 days) |
| NIVESTYM 300 MCG/0.5 ML SUBCUTANEOUS SYRINGE DL | 4 | PA,QL (7 per 30 days) |
| NIVESTYM 300 MCG/ML INJECTION SOLUTION DL | 4 | PA,QL (14 per 30 days) |
| NIVESTYM 480 MCG/0.8 ML SUBCUTANEOUS SYRINGE DL | 4 | PA,QL (11.2 per 30 days) |
| PRADAXA 110 MG, 150 MG, 75 MG CAPSULE MO | 3 | QL (60 per 30 days) |
| RETACRIT 10,000 UNIT/ML, 2,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML, 40,000 UNIT/ML INJECTION SOLUTION MO | 3 | PA,QL (14 per 30 days) |
| UDENYCA 6 MG/0.6 ML SUBCUTANEOUS SYRINGE DL | 4 | PA,QL (1.2 per 28 days) |

Need more information about the indicators displayed by the drug names? Please go to page 9.

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization • B vs D - Part B versus Part D
MD – Maintenance Drug • DL – Dispensing Limit

| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| *warfarin sodium 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg tablet* **MO** | 1 | |
| XARELTO 10 MG, 20 MG TABLET **MO** | 2 | QL (30 per 30 days) |
| XARELTO 15 MG, 2.5 MG TABLET **MO** | 2 | QL (60 per 30 days) |
| XARELTO DVT-PE TREATMENT 30-DAY STARTER 15 MG(42)-20 MG(9) TABLET PACK **MO** | 2 | QL (51 per 30 days) |
| ZARXIO 300 MCG/0.5 ML INJECTION SYRINGE **DL** | 4 | PA,QL (7 per 30 days) |
| ZARXIO 480 MCG/0.8 ML INJECTION SYRINGE **DL** | 4 | PA,QL (11.2 per 30 days) |
| ZIEXTENZO 6 MG/0.6 ML SUBCUTANEOUS SYRINGE **DL** | 4 | PA,QL (1.2 per 28 days) |
| **Cardiovascular Agents** | | |
| *amiodarone hcl 100 mg, 200 mg tablet* **MO** | 1 | |
| *amlodipine besylate 2.5 mg, 5 mg tab* **MO** | 1 | |
| *amlodipine-benazepril 10-20 mg, 2.5-10 mg, 5-10 mg, 5-20 mg; amlodipine-benazepril 2.5-10* **MO** | 1 | QL (60 per 30 days) |
| *atenolol 100 mg, 25 mg, 50 mg tablet* **MO** | 1 | |
| *atorvastatin 10 mg, 20 mg, 40 mg, 80 mg tablet* **MO** | 1 | |
| *benazepril hcl 10 mg, 20 mg, 40 mg, 5 mg tablet* **MO** | 1 | |
| *bumetanide 0.5 mg, 1 mg, 2 mg tablet* **MO** | 1 | |
| BYSTOLIC 10 MG TABLET **MO** | 2 | QL (120 per 30 days) |
| BYSTOLIC 2.5 MG, 5 MG TABLET **MO** | 2 | QL (30 per 30 days) |
| BYSTOLIC 20 MG TABLET **MO** | 2 | QL (60 per 30 days) |
| *carvedilol 12.5 mg, 25 mg, 3.125 mg, 6.25 mg tablet* **MO** | 1 | |
| *chlorthalidone 25 mg, 50 mg tablet* **MO** | 1 | |
| *clonidine hcl 0.1 mg, 0.2 mg, 0.3 mg tablet* **MO** | 1 | |
| CORLANOR 5 MG, 7.5 MG TABLET **MO** | 3 | PA,QL (60 per 30 days) |
| *digoxin 125 mcg tablet; digoxin 250 mcg tablet* **MO** | 1 | QL (30 per 30 days) |
| *diltiazem 24h er(cd) 120 mg, 180 mg, 240 mg cp; diltiazem 24hr er 120 mg, 180 mg, 240 mg cap* **MO** | 1 | QL (60 per 30 days) |
| *doxazosin mesylate 1 mg, 2 mg, 4 mg, 8 mg tab* **MO** | 1 | |
| *enalapril maleate 10 mg, 2.5 mg, 20 mg, 5 mg tab; enalapril maleate 10 mg, 2.5 mg, 20 mg, 5 mg tablet* **MO** | 1 | |
| ENTRESTO 24 MG-26 MG TABLET; ENTRESTO 49 MG-51 MG TABLET; ENTRESTO 97 MG-103 MG TABLET **MO** | 2 | QL (60 per 30 days) |
| *ezetimibe 10 mg tablet* **MO** | 1 | QL (30 per 30 days) |
| *fenofibrate 120 mg, 160 mg tablet* **MO** | 1 | QL (30 per 30 days) |
| *furosemide 20 mg, 40 mg, 80 mg tablet* **MO** | 1 | |
| *hydralazine 10 mg, 100 mg, 25 mg, 50 mg tablet* **MO** | 1 | |

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ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization • B vs D - Part B versus Part D
MD – Maintenance Drug • DL – Dispensing Limit

| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| *hydrochlorothiazide 12.5 mg, 25 mg, 50 mg tab; hydrochlorothiazide 12.5 mg, 25 mg, 50 mg tb* **MO** | 1 | |
| *irbesartan 150 mg, 300 mg, 75 mg tablet* **MO** | 1 | QL (30 per 30 days) |
| *isosorbide mononit er 120 mg, 30 mg, 60 mg; isosorbide mononit er 120 mg, 30 mg, 60 mg tb* **MO** | 1 | |
| *lisinopril 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg tablet* **MO** | 1 | |
| *lisinopril-hctz 10-12.5 mg, 20-12.5 mg, 20-25 mg tab* **MO** | 1 | |
| *losartan potassium 100 mg, 25 mg, 50 mg tab* **MO** | 1 | QL (60 per 30 days) |
| *losartan-hctz 100-12.5 mg, 100-25 mg, 50-12.5 mg tab* **MO** | 1 | QL (60 per 30 days) |
| *lovastatin 10 mg, 20 mg, 40 mg tablet* **MO** | 1 | |
| *metoprolol succ er 100 mg, 200 mg, 25 mg, 50 mg tab* **MO** | 1 | QL (60 per 30 days) |
| *metoprolol tartrate 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg tab; metoprolol tartrate 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg tb* **MO** | 1 | |
| MULTAQ 400 MG TABLET **MO** | 2 | QL (60 per 30 days) |
| *nifedipine er 30 mg, 60 mg, 90 mg tablet* **MO** | 1 | QL (60 per 30 days) |
| *nitroglycerin 0.3 mg, 0.4 mg, 0.6 mg tablet sl* **MO** | 1 | |
| *olmesartan medoxomil 20 mg, 40 mg, 5 mg tab* **MO** | 1 | QL (30 per 30 days) |
| *pravastatin sodium 10 mg, 20 mg, 40 mg, 80 mg tab* **MO** | 1 | |
| *propranolol 10 mg, 20 mg, 40 mg, 60 mg, 80 mg tablet* **MO** | 1 | |
| *ramipril 1.25 mg, 10 mg, 2.5 mg, 5 mg capsule* **MO** | 1 | |
| REPATHA PUSHTRONEX 420 MG/3.5 ML SUBCUTANEOUS WEARABLE INJECTOR **MO** | 2 | PA,QL (3.5 per 28 days) |
| REPATHA SURECLICK 140 MG/ML SUBCUTANEOUS PEN INJECTOR **MO** | 2 | PA,QL (3 per 28 days) |
| REPATHA SYRINGE 140 MG/ML SUBCUTANEOUS SYRINGE **MO** | 2 | PA,QL (3 per 28 days) |
| *rosuvastatin calcium 10 mg, 20 mg, 40 mg, 5 mg tab* **MO** | 1 | |
| *simvastatin 10 mg, 20 mg, 40 mg, 5 mg, 80 mg tablet* **MO** | 1 | |
| *spironolactone 100 mg, 25 mg, 50 mg tablet* **MO** | 1 | |
| TEKTURNA 150 MG, 300 MG TABLET **MO** | 3 | PA,QL (30 per 30 days) |
| TEKTURNA HCT 150 MG-12.5 MG TABLET; TEKTURNA HCT 150 MG-25 MG TABLET; TEKTURNA HCT 300 MG-12.5 MG TABLET; TEKTURNA HCT 300 MG-25 MG TABLET **MO** | 2 | QL (30 per 30 days) |
| *torsemide 10 mg, 100 mg, 20 mg, 5 mg tablet* **MO** | 1 | |
| *triamterene-hctz 37.5-25 mg, 75-50 mg tab; triamterene-hctz 37.5-25 mg, 75-50 mg tb* **MO** | 1 | |
| *valsartan 160 mg, 320 mg, 40 mg, 80 mg tablet* **MO** | 1 | QL (60 per 30 days) |
| WELCHOL 3.75 GRAM ORAL POWDER PACKET **MO** | 3 | PA,QL (30 per 30 days) |
| WELCHOL 625 MG TABLET **MO** | 3 | PA,QL (180 per 30 days) |

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MD – Maintenance Drug • DL – Dispensing Limit

| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| **Central Nervous System Agents** | | |
| AUSTEDO 12 MG, 9 MG TABLET DL | 4 | PA,QL (120 per 30 days) |
| AUSTEDO 6 MG TABLET DL | 4 | PA,QL (60 per 30 days) |
| BETASERON 0.3 MG SUBCUTANEOUS KIT DL | 4 | PA,QL (15 per 30 days) |
| COPAXONE 20 MG/ML SUBCUTANEOUS SYRINGE DL | 4 | PA,QL (30 per 30 days) |
| COPAXONE 40 MG/ML SUBCUTANEOUS SYRINGE DL | 4 | PA,QL (12 per 28 days) |
| *dextroamp-amphetam 10 mg, 12.5 mg, 15 mg, 20 mg, 5 mg, 7.5 mg tab; dextroamp-amphetamin 10 mg, 12.5 mg, 15 mg, 20 mg, 5 mg, 7.5 mg tab; dextroamp-amphetamine 10 mg, 12.5 mg, 15 mg, 20 mg, 5 mg, 7.5 mg tab* MO | 1 | QL (90 per 30 days) |
| GILENYA 0.25 MG, 0.5 MG CAPSULE DL | 4 | PA,QL (30 per 30 days) |
| *pregabalin 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg capsule* MO | 1 | QL (90 per 30 days) |
| SAVELLA 100 MG, 12.5 MG, 12.5 MG (5)-25 MG(8)-50 MG(42), 25 MG, 50 MG TABLET; SAVELLA 12.5 MG (5)-25 MG(8)-50MG(42) TABLETS IN A DOSE PACK MO | 2 | QL (60 per 30 days) |
| TECFIDERA 120 MG (14)- 240 MG (46), 240 MG CAPSULE,DELAYED RELEASE; TECFIDERA 120 MG (14)-240 MG (46) CAPSULE,DELAYED RELEASE DL | 4 | PA,QL (60 per 30 days) |
| TECFIDERA 120 MG CAPSULE,DELAYED RELEASE DL | 4 | PA,QL (14 per 30 days) |
| **Dental & Oral Agents** | | |
| *chlorhexidine 0.12% rinse* MO | 1 | |
| *triamcinolone 0.1% paste* MO | 1 | |
| **DERMATOLOGICAL AGENTS** | | |
| ENSTILAR 0.005 %-0.064 % TOPICAL FOAM MO | 3 | QL (120 per 30 days) |
| *hydrocortisone 1% cream; hydrocortisone 2.5% cream* MO | 1 | QL (240 per 30 days) |
| *mupirocin 2% ointment* MO | 1 | |
| PICATO 0.015 % TOPICAL GEL MO | 3 | QL (3 per 30 days) |
| PICATO 0.05 % TOPICAL GEL MO | 3 | QL (2 per 30 days) |
| SANTYL 250 UNIT/GRAM TOPICAL OINTMENT MO | 2 | QL (180 per 30 days) |
| TACLONEX 0.005 %-0.064 % TOPICAL OINTMENT DL | 4 | PA,QL (60 per 30 days) |
| TACLONEX 0.005 %-0.064 % TOPICAL SUSPENSION MO | 2 | QL (420 per 30 days) |
| **Electrolytes/Minerals/Metals/Vitamins** | | |
| AURYXIA 210 MG IRON TABLET MO | 3 | PA,QL (360 per 30 days) |
| EXJADE 125 MG, 250 MG, 500 MG DISPERSIBLE TABLET DL | 4 | PA |
| JADENU 180 MG, 360 MG, 90 MG TABLET DL | 4 | PA |
| LOKELMA 10 GRAM, 5 GRAM ORAL POWDER PACKET MO | 2 | QL (30 per 30 days) |
| *potassium cl er 10 meq, 20 meq tablet* MO | 1 | |

Need more information about the indicators displayed by the drug names? Please go to page 9.

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization • B vs D - Part B versus Part D
MD – Maintenance Drug • DL – Dispensing Limit

| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| **GASTROINTESTINAL AGENTS** | | |
| DEXILANT 30 MG, 60 MG CAPSULE, DELAYED RELEASE **MO** | 3 | QL (30 per 30 days) |
| *dicyclomine 10 mg capsule* **MO** | 1 | |
| *esomeprazole mag dr 20 mg, 40 mg cap* **MO** | 1 | QL (30 per 30 days) |
| *famotidine 20 mg, 40 mg tablet* **MO** | 1 | |
| LINZESS 145 MCG, 290 MCG, 72 MCG CAPSULE **MO** | 2 | QL (30 per 30 days) |
| MOVANTIK 12.5 MG, 25 MG TABLET **MO** | 2 | QL (30 per 30 days) |
| *omeprazole dr 10 mg, 20 mg, 40 mg capsule* **MO** | 1 | QL (60 per 30 days) |
| *pantoprazole sod dr 20 mg, 40 mg tab* **MO** | 1 | QL (60 per 30 days) |
| PYLERA 140 MG-125 MG-125 MG CAPSULE **MO** | 3 | QL (120 per 30 days) |
| RELISTOR 12 MG/0.6 ML SUBCUTANEOUS SOLUTION **MO** | 3 | QL (36 per 30 days) |
| RELISTOR 12 MG/0.6 ML SUBCUTANEOUS SYRINGE **MO** | 3 | QL (36 per 28 days) |
| RELISTOR 150 MG TABLET **MO** | 3 | QL (90 per 30 days) |
| RELISTOR 8 MG/0.4 ML SUBCUTANEOUS SYRINGE **MO** | 3 | QL (12 per 30 days) |
| *sucralfate 1 gm tablet* **MO** | 1 | |
| SUPREP BOWEL PREP KIT 17.5 GRAM-3.13 GRAM-1.6 GRAM ORAL SOLUTION **MO** | 2 | |
| XIFAXAN 200 MG TABLET **DL** | 4 | PA,QL (9 per 30 days) |
| XIFAXAN 550 MG TABLET **DL** | 4 | PA,QL (84 per 28 days) |
| **GENETIC/ENZYME/PROTEIN DISORDER: REPLACEMENT, MODIFIERS, TREATMENT** | | |
| CERDELGA 84 MG CAPSULE **DL** | 4 | PA |
| CEREZYME 400 UNIT INTRAVENOUS SOLUTION **DL** | 4 | PA |
| CREON 12,000-38,000-60,000 UNIT CAPSULE,DELAYED RELEASE; CREON 24,000-76,000-120,000 UNIT CAPSULE,DELAYED RELEASE; CREON 3,000 UNIT-9,500 UNIT-15,000 UNIT CAPSULE,DELAYED RELEASE; CREON 36,000 UNIT-114,000 UNIT-180,000 UNIT CAPSULE,DELAYED RELEASE; CREON 6,000-19,000-30,000 UNIT CAPSULE,DELAYED RELEASE **MO** | 2 | |
| ELELYSO 200 UNIT INTRAVENOUS SOLUTION **DL** | 4 | PA |
| PROLASTIN-C 1,000 MG (+/-)/20 ML INTRAVENOUS SOLUTION; PROLASTIN-C 1,000 MG, 1,000 MG (+/-)/20 ML INTRAVENOUS POWDER FOR SOLUTION **DL** | 4 | PA |

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ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization • B vs D - Part B versus Part D
MD – Maintenance Drug • DL – Dispensing Limit

| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| STRENSIQ 18 MG/0.45 ML, 28 MG/0.7 ML, 40 MG/ML, 80 MG/0.8 ML SUBCUTANEOUS SOLUTION **DL** | 4 | PA |
| ZENPEP 10,000 UNIT-32,000 UNIT-42,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP 15,000 UNIT-47,000 UNIT-63,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP 20,000 UNIT-63,000 UNIT-84,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP 25,000 UNIT-79,000 UNIT-105,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP 3,000 UNIT-10,000 UNIT-14,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP 40,000 UNIT-126,000 UNIT-168,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP 5,000 UNIT-17,000 UNIT-24,000 UNIT CAPSULE,DELAYED RELEASE **MO** | 3 | |
| **Genitourinary Agents** | | |
| *finasteride 5 mg tablet* **MO** | 1 | QL (30 per 30 days) |
| MYRBETRIQ 25 MG, 50 MG TABLET,EXTENDED RELEASE **MO** | 2 | QL (30 per 30 days) |
| *oxybutynin 5 mg tablet* **MO** | 1 | |
| *oxybutynin cl er 10 mg, 15 mg, 5 mg tablet* **MO** | 1 | QL (60 per 30 days) |
| *tamsulosin hcl 0.4 mg capsule* **MO** | 1 | |
| TOVIAZ 4 MG, 8 MG TABLET,EXTENDED RELEASE **MO** | 2 | QL (30 per 30 days) |
| **Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal)** | | |
| *methylprednisolone 4 mg dosepk* **MO** | 1 | |
| *prednisone 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg tablet* **MO** | 1 | B vs D |
| *triamcinolone 0.025% cream; triamcinolone 0.1% cream; triamcinolone 0.5% cream* **MO** | 1 | |
| **Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary)** | | |
| *desmopressin acetate 0.1 mg tb* **MO** | 1 | QL (180 per 30 days) |
| *desmopressin acetate 0.2 mg tb* **MO** | 1 | |
| OMNITROPE 10 MG/1.5 ML (6.7 MG/ML), 5 MG/1.5 ML (3.3 MG/ML) SUBCUTANEOUS CARTRIDGE **DL** | 4 | PA |
| OMNITROPE 5.8 MG SUBCUTANEOUS SOLUTION **DL** | 4 | PA |
| **Hormonal Agents, Stimulant/Replacement/Modifying (Sex Hormones/Modifiers)** | | |
| *estradiol 0.5 mg, 1 mg, 10 mcg, 2 mg tablet; estradiol 0.5 mg, 1 mg, 10 mcg, 2 mg vaginal insrt* **MO** | 1 | |
| OSPHENA 60 MG TABLET **MO** | 2 | PA |
| PREMARIN 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG TABLET **MO** | 3 | |
| PREMARIN 0.625 MG/GRAM VAGINAL CREAM **MO** | 2 | |
| PREMARIN 25 MG SOLUTION FOR INJECTION **MO** | 3 | |
| **Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid)** | | |
| *levothyroxine 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg tablet* **MO** | 1 | |

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| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| *liothyronine sod 10 mcg/ml vl* **MO** | 1 | |
| *liothyronine sod 25 mcg, 5 mcg, 50 mcg tab* **MO** | 1 | |
| SYNTHROID 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG, 50 MCG, 75 MCG, 88 MCG TABLET **MO** | 2 | |
| **Hormonal Agents, Suppressant (Pituitary)** | | |
| SOMATULINE DEPOT 120 MG/0.5 ML SUBCUTANEOUS SYRINGE **DL** | 4 | PA,QL (0.5 per 28 days) |
| SOMATULINE DEPOT 60 MG/0.2 ML SUBCUTANEOUS SYRINGE **DL** | 4 | PA,QL (0.2 per 28 days) |
| SOMATULINE DEPOT 90 MG/0.3 ML SUBCUTANEOUS SYRINGE **DL** | 4 | PA,QL (0.3 per 28 days) |
| **IMMUNOLOGICAL AGENTS** | | |
| COSENTYX 150 MG/ML SUBCUTANEOUS SYRINGE **DL** | 4 | PA,QL (8 per 28 days) |
| COSENTYX 300 MG/2 SYRINGES (150 MG/ML) SUBCUTANEOUS **DL** | 4 | PA,QL (8 per 28 days) |
| COSENTYX PEN 150 MG/ML SUBCUTANEOUS **DL** | 4 | PA,QL (8 per 28 days) |
| COSENTYX PEN 300 MG/2 PENS (150 MG/ML) SUBCUTANEOUS **DL** | 4 | PA,QL (8 per 28 days) |
| DUPIXENT 200 MG/1.14 ML SUBCUTANEOUS SYRINGE **DL** | 4 | PA,QL (3.42 per 28 days) |
| DUPIXENT 300 MG/2 ML SUBCUTANEOUS SYRINGE **DL** | 4 | PA,QL (6 per 28 days) |
| ENBREL 25 MG (1 ML), 25 MG/0.5 ML SUBCUTANEOUS POWDER FOR SOLUTION; ENBREL 25 MG (1 ML), 25 MG/0.5 ML SUBCUTANEOUS SOLUTION **DL** | 4 | PA,QL (8 per 28 days) |
| ENBREL 25 MG/0.5 ML (0.5 ML) SUBCUTANEOUS SYRINGE; ENBREL 25 MG/0.5 ML (0.5), 50 MG/ML (1 ML) SUBCUTANEOUS SYRINGE **DL** | 4 | PA,QL (8 per 28 days) |
| ENBREL MINI 50 MG/ML (1 ML) SUBCUTANEOUS CARTRIDGE **DL** | 4 | PA,QL (8 per 28 days) |
| ENBREL SURECLICK 50 MG/ML (1 ML) SUBCUTANEOUS PEN INJECTOR **DL** | 4 | PA,QL (8 per 28 days) |
| GAMUNEX-C 1 GRAM/10 ML (10 %), 10 GRAM/100 ML (10 %), 2.5 GRAM/25 ML (10 %), 20 GRAM/200 ML (10 %), 40 GRAM/400 ML (10 %), 5 GRAM/50 ML (10 %) INJECTION SOLUTION **DL** | 4 | PA |
| HIZENTRA 1 GRAM/5 ML (20 %), 10 GRAM/50 ML (20 %), 2 GRAM/10 ML (20 %), 4 GRAM/20 ML (20 %) SUBCUTANEOUS SOLUTION **DL** | 4 | PA |
| HUMIRA 10 MG/0.2 ML SUBCUTANEOUS SYRINGE KIT **DL** | 4 | PA,QL (2 per 28 days) |
| HUMIRA 20 MG/0.4 ML, 40 MG/0.8 ML SUBCUTANEOUS SYRINGE KIT **DL** | 4 | PA,QL (6 per 28 days) |
| HUMIRA PEDI CROHN 40 MG/0.8 ML **DL** | 4 | PA,QL (6 per 28 days) |
| HUMIRA PEN 40 MG/0.8 ML SUBCUTANEOUS KIT **DL** | 4 | PA,QL (6 per 28 days) |
| HUMIRA PEN CROHN'S-ULC COLITIS-HID SUP STARTER 40 MG/0.8 ML SUBCUT KIT **DL** | 4 | PA,QL (6 per 28 days) |
| HUMIRA PEN PSORIASIS-UVEITIS-ADOL HID SUP START 40 MG/0.8 ML SUBCUT KT **DL** | 4 | PA,QL (6 per 28 days) |
| HUMIRA(CF) 10 MG/0.1 ML SUBCUTANEOUS SYRINGE KIT **DL** | 4 | PA,QL (2 per 28 days) |
| HUMIRA(CF) 20 MG/0.2 ML, 40 MG/0.4 ML SUBCUTANEOUS SYRINGE KIT **DL** | 4 | PA,QL (6 per 28 days) |

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MD – Maintenance Drug • DL – Dispensing Limit

| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| HUMIRA(CF) PEDI CROHN'S START 80 MG/0.8 ML, 80 MG/0.8 ML-40 MG/0.4 ML SUBCUT SYR KIT; HUMIRA(CF) PEDIATRIC CROHN'S STARTER 80 MG/0.8 ML, 80 MG/0.8 ML-40 MG/0.4 ML SUBCUT SYRINGE KIT **DL** | 4 | PA,QL (6 per 28 days) |
| HUMIRA(CF) PEN 40 MG/0.4 ML, 80 MG/0.8 ML SUBCUTANEOUS KIT **DL** | 4 | PA,QL (6 per 28 days) |
| HUMIRA(CF) PEN CROHN'S-ULC COLITIS-HID SUP STRT 80 MG/0.8 ML SUBCUT KT **DL** | 4 | PA,QL (6 per 28 days) |
| HUMIRA(CF) PEN PS-UV-ADOL HS 80 MG/0.8 ML(1)-40 MG/0.4 ML(2)SUBCUT KIT **DL** | 4 | PA,QL (6 per 28 days) |
| INFLECTRA 100 MG INTRAVENOUS SOLUTION **DL** | 4 | PA |
| KEVZARA 150 MG/1.14 ML, 200 MG/1.14 ML SUBCUTANEOUS PEN INJECTOR **DL** | 4 | PA,QL (2.28 per 28 days) |
| KEVZARA 150 MG/1.14 ML, 200 MG/1.14 ML SUBCUTANEOUS SYRINGE **DL** | 4 | PA,QL (2.28 per 28 days) |
| *methotrexate 2.5 mg tablet* **MO** | 1 | B vs D |
| REMICADE 100 MG INTRAVENOUS SOLUTION **DL** | 4 | PA |
| RINVOQ 15 MG TABLET,EXTENDED RELEASE **DL** | 4 | PA,QL (30 per 30 days) |
| RUCONEST 2,100 UNIT INTRAVENOUS SOLUTION **DL** | 4 | PA,QL (8 per 28 days) |
| SHINGRIX (PF) 50 MCG/0.5 ML INTRAMUSCULAR SUSPENSION, KIT **DL** | 2 | QL (2 per 999 days) |
| SIMPONI ARIA 12.5 MG/ML INTRAVENOUS SOLUTION **DL** | 4 | PA,QL (20 per 28 days) |
| SKYRIZI 150 MG/1.66 ML(75 MG/0.83 ML X 2) SUBCUTANEOUS SYRINGE KIT **MO** | 4 | PA,QL (6 per 365 days) |
| STELARA 130 MG/26 ML INTRAVENOUS SOLUTION **DL** | 4 | PA,QL (104 per 30 days) |
| STELARA 45 MG/0.5 ML SUBCUTANEOUS SOLUTION **DL** | 4 | PA,QL (1.5 per 84 days) |
| STELARA 45 MG/0.5 ML SUBCUTANEOUS SYRINGE **DL** | 4 | PA,QL (1.5 per 84 days) |
| STELARA 90 MG/ML SUBCUTANEOUS SYRINGE **DL** | 4 | PA,QL (3 per 84 days) |
| **Metabolic Bone Disease Agents** | | |
| *alendronate sodium 35 mg, 70 mg tab* **MO** | 1 | QL (4 per 28 days) |
| FORTEO 20 MCG/DOSE (600 MCG/2.4 ML) SUBCUTANEOUS PEN INJECTOR **MO** | 3 | PA,QL (2.4 per 28 days) |
| PROLIA 60 MG/ML SUBCUTANEOUS SYRINGE **MO** | 3 | B vs D,QL (1 per 180 days) |
| XGEVA 120 MG/1.7 ML (70 MG/ML) SUBCUTANEOUS SOLUTION **DL** | 4 | PA,QL (1.7 per 28 days) |
| **Miscellaneous Therapeutic Agents** | | |
| BD ALCOHOL SWABS **MO** | 1 | |
| OMNIPOD DASH 5 PACK INSULIN POD SUBCUTANEOUS CARTRIDGE **MO** | 2 | |
| OMNIPOD INSULIN MANAGEMENT **MO** | 2 | |
| OMNIPOD INSULIN REFILL SUBCUTANEOUS CARTRIDGE **MO** | 2 | |
| RECTIV 0.4 % (W/W) OINTMENT **MO** | 3 | QL (30 per 30 days) |
| V-GO 20 DEVICE **MO** | 2 | |

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| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| V-GO 30 DEVICE MO | 2 | |
| V-GO 40 DEVICE MO | 2 | |
| **OPHTHALMIC AGENTS** | | |
| ALPHAGAN P 0.1 % EYE DROPS MO | 2 | |
| ALPHAGAN P 0.15 % EYE DROPS MO | 3 | PA |
| *brimonidine 0.2% eye drop; brimonidine tartrate 0.15% drp* MO | 1 | |
| COMBIGAN 0.2 %-0.5 % EYE DROPS MO | 2 | QL (5 per 25 days) |
| *dorzolamide-timolol eye drops* MO | 1 | QL (10 per 30 days) |
| DUREZOL 0.05 % EYE DROPS MO | 2 | |
| ILEVRO 0.3 % EYE DROPS,SUSPENSION MO | 2 | QL (3 per 30 days) |
| *latanoprost 0.005% eye drops* MO | 1 | QL (5 per 25 days) |
| LOTEMAX 0.5 % EYE DROPS,SUSPENSION; LOTEMAX 0.5 % EYE GEL DROPS MO | 3 | ST |
| LOTEMAX 0.5 % EYE OINTMENT MO | 3 | ST |
| LUMIGAN 0.01 % EYE DROPS MO | 2 | QL (2.5 per 25 days) |
| PAZEO 0.7 % EYE DROPS MO | 2 | QL (2.5 per 25 days) |
| *prednisolone ac 1% eye drop* MO | 1 | |
| RESTASIS 0.05 % EYE DROPS IN A DROPPERETTE MO | 2 | QL (60 per 30 days) |
| RESTASIS MULTIDOSE 0.05 % EYE DROPS MO | 2 | QL (5.5 per 25 days) |
| RHOPRESSA 0.02 % EYE DROPS MO | 2 | ST,QL (2.5 per 25 days) |
| ROCKLATAN 0.02 %-0.005 % EYE DROPS MO | 2 | ST,QL (2.5 per 25 days) |
| *timolol 0.5% eye drop; timolol maleate 0.25% eye drop; timolol maleate 0.5% eye drops* MO | 1 | |
| VYZULTA 0.024 % EYE DROPS MO | 3 | QL (5 per 30 days) |
| **RESPIRATORY TRACT/PULMONARY AGENTS** | | |
| ADEMPAS 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG TABLET DL | 4 | PA,QL (90 per 30 days) |
| ADVAIR DISKUS 100 MCG-50 MCG/DOSE POWDER FOR INHALATION; ADVAIR DISKUS 250 MCG-50 MCG/DOSE POWDER FOR INHALATION; ADVAIR DISKUS 500 MCG-50 MCG/DOSE POWDER FOR INHALATION MO | 2 | QL (60 per 30 days) |
| ADVAIR HFA 115 MCG-21 MCG/ACTUATION AEROSOL INHALER; ADVAIR HFA 230 MCG-21 MCG/ACTUATION AEROSOL INHALER; ADVAIR HFA 45 MCG-21 MCG/ACTUATION AEROSOL INHALER MO | 2 | QL (12 per 30 days) |
| *albuterol hfa 90 mcg inhaler* MO | 1 | QL (36 per 30 days) |
| ANORO ELLIPTA 62.5 MCG-25 MCG/ACTUATION POWDER FOR INHALATION MO | 3 | PA,QL (60 per 30 days) |
| ARNUITY ELLIPTA 100 MCG/ACTUATION, 200 MCG/ACTUATION, 50 MCG/ACTUATION POWDER FOR INHALATION MO | 2 | QL (30 per 30 days) |
| BEVESPI AEROSPHERE 9 MCG-4.8 MCG HFA AEROSOL INHALER MO | 3 | QL (10.7 per 30 days) |

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| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| BREO ELLIPTA 100 MCG-25 MCG/DOSE POWDER FOR INHALATION; BREO ELLIPTA 200 MCG-25 MCG/DOSE POWDER FOR INHALATION **MO** | 2 | QL (60 per 30 days) |
| COMBIVENT RESPIMAT 20 MCG-100 MCG/ACTUATION SOLUTION FOR INHALATION **MO** | 3 | QL (4 per 20 days) |
| DALIRESP 250 MCG TABLET **MO** | 2 | QL (28 per 365 days) |
| DALIRESP 500 MCG TABLET **MO** | 2 | QL (30 per 30 days) |
| ESBRIET 267 MG CAPSULE **DL** | 4 | PA,QL (270 per 30 days) |
| ESBRIET 267 MG TABLET **DL** | 4 | PA,QL (270 per 30 days) |
| ESBRIET 801 MG TABLET **DL** | 4 | PA,QL (90 per 30 days) |
| FASENRA PEN 30 MG/ML SUBCUTANEOUS AUTO-INJECTOR **DL** | 4 | PA,QL (1 per 28 days) |
| FLOVENT DISKUS 100 MCG/ACTUATION, 250 MCG/ACTUATION, 50 MCG/ACTUATION POWDER FOR INHALATION **MO** | 2 | QL (60 per 30 days) |
| FLOVENT HFA 110 MCG/ACTUATION, 220 MCG/ACTUATION AEROSOL INHALER **MO** | 2 | QL (24 per 30 days) |
| FLOVENT HFA 44 MCG/ACTUATION AEROSOL INHALER **MO** | 2 | QL (10.6 per 30 days) |
| *fluticasone prop 50 mcg spray* **MO** | 1 | QL (16 per 30 days) |
| *hydroxyzine pam 100 mg, 25 mg, 50 mg cap* **MO** | 1 | |
| INCRUSE ELLIPTA 62.5 MCG/ACTUATION POWDER FOR INHALATION **MO** | 3 | PA,QL (30 per 30 days) |
| *levocetirizine 5 mg tablet* **MO** | 1 | QL (30 per 30 days) |
| *montelukast sod 10 mg tablet* **MO** | 1 | QL (30 per 30 days) |
| NUCALA 100 MG, 100 MG/ML SUBCUTANEOUS AUTO-INJECTOR; NUCALA 100 MG, 100 MG/ML SUBCUTANEOUS SOLUTION **DL** | 4 | PA,QL (3 per 28 days) |
| NUCALA 100 MG/ML SUBCUTANEOUS SYRINGE **DL** | 4 | PA,QL (3 per 28 days) |
| OFEV 100 MG, 150 MG CAPSULE **DL** | 4 | PA,QL (60 per 30 days) |
| PERFOROMIST 20 MCG/2 ML SOLUTION FOR NEBULIZATION **MO** | 3 | PA,QL (120 per 30 days) |
| SEREVENT DISKUS 50 MCG/DOSE POWDER FOR INHALATION **MO** | 3 | PA,QL (60 per 30 days) |
| SPIRIVA RESPIMAT 1.25 MCG/ACTUATION, 2.5 MCG/ACTUATION SOLUTION FOR INHALATION **MO** | 2 | QL (4 per 28 days) |
| SPIRIVA WITH HANDIHALER 18 MCG AND INHALATION CAPSULES **MO** | 2 | QL (30 per 30 days) |
| STIOLTO RESPIMAT 2.5 MCG-2.5 MCG/ACTUATION SOLUTION FOR INHALATION **MO** | 2 | QL (4 per 28 days) |
| STRIVERDI RESPIMAT 2.5 MCG/ACTUATION SOLUTION FOR INHALATION **MO** | 2 | QL (4 per 30 days) |
| SYMBICORT 160 MCG-4.5 MCG/ACTUATION HFA AEROSOL INHALER; SYMBICORT 80 MCG-4.5 MCG/ACTUATION HFA AEROSOL INHALER **MO** | 2 | QL (10.2 per 30 days) |
| TOBI PODHALER 28 MG CAPSULE WITH INHALATION DEVICE; TOBI PODHALER 28 MG INHALE CAP **DL** | 4 | PA,QL (224 per 28 days) |

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| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| TRELEGY ELLIPTA 100 MCG-62.5 MCG-25 MCG POWDER FOR INHALATION; TRELEGY ELLIPTA 200 MCG-62.5 MCG-25 MCG POWDER FOR INHALATION **MO** | 2 | QL (60 per 30 days) |
| VENTOLIN HFA 90 MCG/ACTUATION AEROSOL INHALER **MO** | 2 | QL (36 per 30 days) |
| **Skeletal Muscle Relaxants** | | |
| *cyclobenzaprine 10 mg, 5 mg tablet* **MO** | 1 | |
| *methocarbamol 500 mg, 750 mg tablet* **MO** | 1 | |
| **SLEEP DISORDER AGENTS** | | |
| BELSOMRA 10 MG TABLET **MO** | 2 | QL (60 per 30 days) |
| BELSOMRA 15 MG, 20 MG TABLET **MO** | 2 | QL (30 per 30 days) |
| BELSOMRA 5 MG TABLET **MO** | 2 | QL (120 per 30 days) |
| *temazepam 15 mg, 22.5 mg, 30 mg, 7.5 mg capsule* **DL** | 1 | QL (30 per 30 days) |
| *zolpidem tart 1.75 mg, 10 mg, 12.5 mg, 3.5 mg, 5 mg, 6.25 mg tab sl; zolpidem tart 1.75 mg, 10 mg, 12.5 mg, 3.5 mg, 5 mg, 6.25 mg tablet sl; zolpidem tart er 1.75 mg, 10 mg, 12.5 mg, 3.5 mg, 5 mg, 6.25 mg tab; zolpidem tartrate 1.75 mg, 10 mg, 12.5 mg, 3.5 mg, 5 mg, 6.25 mg tablet* **MO** | 1 | QL (30 per 30 days) |

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Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.

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1-866-396-8810 (TTY: 711)

**Español (Spanish):** Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
**繁體中文 (Chinese):** 撥打上面的電話號碼即可獲得免費語言援助服務。
**Tiếng Việt (Vietnamese):** Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
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**Tagalog (Tagalog – Filipino):** Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.
**Русский (Russian):** Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.
**Kreyòl Ayisyen (French Creole):** Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.
**Français (French):** Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.
**Polski (Polish):** Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.
**Português (Portuguese):** Ligue para o número acima indicado para receber serviços linguísticos, grátis.
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**فارسی (Farsi)**
برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.
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**العربية (Arabic)**
الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

# Notes

# Notes

This abridged formulary was updated on 11/19/2020 and is not a complete list of drugs covered by our plan. For a complete listing, more recent information or other questions, please contact Humana Medicare Employer Plan at  the number on the back of your membership card or, for TTY users, 711, Monday through Friday, from 8 a.m.  - 9 p.m. Eastern Time. The automated phone system may answer your call on Saturdays, Sundays, and some public holidays. Please leave your name and telephone number, and we'll call you back by the end of the next business day, or visit **Humana.com**.

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|---|---|---|---|
| HUMULIN 70/30 U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS SUSPENSION **MO** | 3 | ST | |
| HUMULIN 70/30 U-100 INSULIN KWIKPEN 100 UNIT/ML SUBCUTANEOUS **MO** | 3 | ST | |
| KOMBIGLYZE XR 2.5 MG-1,000 MG TABLET,EXTENDED RELEASE **MO** | 3 | QL (60 per 30 days) | |
| KOMBIGLYZE XR 5 MG-1,000 MG TABLET,EXTENDED RELEASE; KOMBIGLYZE XR 5 MG-500 MG TABLET EXTENDED RELEASE **MO** | 3 | QL (30 per 30 days) | |

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