



2023 Humana Group Medicare

A Medicare plan that's all about you—the whole you



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.

Alaska Laborers Local
341, 942



We're here for you

Humana Group Medicare Customer Care

800-733-9064 (TTY: 711)

Monday – Friday, 5 a.m. - 6 p.m., Pacific time

Humana is a stand-alone prescription drug plan with a Medicare contract.

Enrollment in this Humana plan depends on contract renewal.

Call **800-733-9064 (TTY: 711)** for more information.

Group Medicare

Prescription drug plan (PDP) guide

Understanding your Medicare plan and how it works is important. Humana is here for you, we give you information to help you feel more confident about managing your costs—and your health.

Inside this guide you'll find:

What Humana offers you.....	2
Welcome letter	3
Important Enrollment Information.....	5
Parts of Medicare	7
MyHumana and MyHumana mobile app.....	8
Choosing a pharmacy	9
Choosing a caregiver.....	10
CenterWell Pharmacy™	11
Prescription drug tiers.....	12
Understanding your vaccines and diabetes coverage	13
Important information about your prescription drug coverage.....	14
Medication therapy management.....	16
SmartSummary®	17
Frequently asked questions.....	18
Pharmacy terms and definitions.....	19
Know your numbers	20



Plan specific information

- Inflation Reduction Act Flyer
- Rx Summary of Benefits
- Prescription Drug Guide

Your healthcare plan should help you on your journey to better health, **which may help you achieve the retirement you want**—so you can spend more time doing what you love most.



Humana offers you a prescription drug plan with:

A large network

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

Almost no claims paperwork

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

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.

Pharmacy finder

An online tool that helps you find in-network 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.

Details you need to know

If you're in a Medicare Advantage plan that has prescription drug coverage and you join a separate prescription drug plan, you could be disenrolled from your Medicare Advantage plan and returned to Original Medicare. Call the Group Medicare Customer Care phone number if you have any questions.

Humana Group Medicare prescription drug plan

Welcome to a more human way to healthcare

Take action to enroll

Dear Group Medicare Beneficiary,

We're excited to let you know that **Alaska Laborers Local 341, 942** has asked Humana to offer you a prescription drug plan that gives you more benefits than Original Medicare.

Your health is more important than ever. That's why Humana has a variety of tools, programs and resources to help you stay on track. At Humana, helping you achieve lifelong well-being is our mission. During our over 30 years of experience with Medicare, we've learned how to be a better partner in health.

Get to know your plan

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

- If you have questions about your premium, please call **Labor First at 866-850-2323 (TTY: 711)**.
- Please see your enclosed prescription drug guide (PDG) to determine if your medications have quantity limits, require a prior authorization or step therapy. You can also visit **Humana.com/Pharmacy** or call Group Medicare Customer Care for assistance.

Enrollment Information

- For enrollment information, please refer to the document titled "Important Enrollment Information," located in this packet.

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.

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

Sincerely,
Group Medicare Operations

Important Enrollment Information

Alaska Laborers Local 341, 942 is offering you the option to enroll in the Humana Group Medicare prescription drug plan (PDP). If you want to enroll in this plan, please follow the instructions below. Your plan will start on the date set by your benefit administrator.
Enrollment in this plan will end your enrollment in any Medicare prescription drug plan or Medicare Advantage prescription drug plan that you are currently enrolled in.

How do I enroll?

If you want to enroll in this Group Medicare health plan, please complete the enclosed application and return to:

Labor First
1000 Midlantic Dr., Ste 100
Mount Laurel, NJ 08054

What do I need to know as a member of the Humana Group Medicare PDP plan?

This enrollment packet includes important information about this plan and what it covers, including a Summary of Benefits document. Please review this information carefully.

Once enrolled, you will receive an Evidence of Coverage document (also known as a member contract or subscriber agreement) from the Humana Group Medicare PDP plan. Please read the document to learn about the plan's coverage and services. As a member of the Humana Group Medicare PDP plan, you can appeal plan decisions about payment or services if you disagree. Enrollment in this plan is generally for the entire year.

Starting on the date your coverage begins, you must use network pharmacies to access Humana benefits, except under limited, non-routine circumstances when you can't reasonably use network pharmacies.

Your Humana Group Medicare PDP plan is in addition to your coverage under Medicare Part A or Part B. Enrolling in the Humana Group Medicare PDP doesn't change your coverage under Medicare Part A or Part B. **If you have Medicare Part B, you must continue to pay your Part B premium. 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.** Let us know about any other prescription drug coverage that you have now or may get in the future.

What happens if I don't join the Humana Group Medicare PDP plan or have questions about enrollment?

You aren't required to be enrolled in this plan. If you don't want to enroll or have enrollment questions, please contact **Labor First at 866-850-2323 (TTY: 711), Monday – Friday, 8 a.m. – 5 p.m., Pacific time.**

If you choose to join a different Medicare plan, you can contact **800-MEDICARE** anytime,

- continued on next page

24 hours a day, 7 days a week, for help in learning how. TTY users can call **877-486-2048**. Your state may have counseling services through the State Health Insurance Assistance Program (SHIP). They can provide you with personalized counseling and assistance when selecting a plan, including Medicare Supplement plans, Medicare Advantage plans and prescription drug plans. They can also help you find medical assistance through your state Medicaid program and the Medicare Savings Program.

What if I want to leave the Humana Group Medicare PDP plan?

You can change or cancel your Humana coverage at any time and return to Original Medicare or another Medicare Advantage plan by using a special election. If you choose to disenroll or cancel your plan, please contact **Labor First at 866-850-2323 (TTY: 711), Monday – Friday, 8 a.m. – 5 p.m., Pacific time.**

What happens if I move?

The Humana Group Medicare PDP plan serves a specific service area. **If you move to another area or state, it may affect your plan.** It's important to contact **Labor First at 866-850-2323 (TTY: 711), Monday – Friday, 8 a.m. – 5 p.m., Pacific time,** to provide your new address and phone number.

If you leave this plan and don't have creditable prescription drug coverage (as good as Medicare's prescription drug coverage), you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.

Release of Information

By joining this Medicare prescription drug plan, you give us permission to share your information with Medicare and other plans as needed for treatment, payment and health care operations. Medicare may also use this information for research and other reasons allowed by Federal law.

Parts of Medicare

What is Medicare?

Medicare is a federal health insurance program for U.S. citizens and legal residents who are 65 and older or those younger than 65 and qualify due to a disability.

How does it work?

Medicare is divided into parts A, B, C and D. Parts A and B are called Original Medicare. Individuals who have Original Medicare, Part A and/or Part B, or a Medicare Advantage plan (Medicare Part C) are eligible to enroll into a Medicare Part D Prescription Drug Plan (PDP).



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

It helps pay for the medications your provider prescribes and is available in a stand-alone prescription drug plan or included in a Medicare Advantage prescription drug plan. 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.

Your health at your fingertips with MyHumana

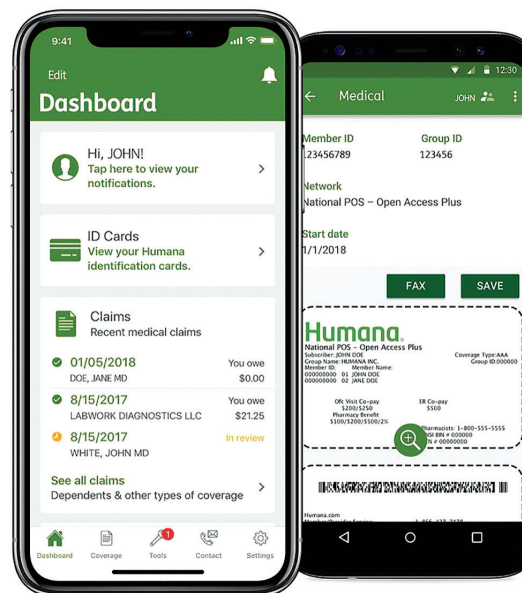
Get your personalized health information on MyHumana

A valuable part of your Humana plan is a secure online account called MyHumana where you can keep track of your claims and benefits, view important plan documents and more.

Get the most out of MyHumana by keeping your account profile up to date. Whether you prefer using a desktop, laptop, or smartphone, you can access your account anytime.*

Getting started is easy—just have your Humana member ID card ready and follow these three steps:

- 1 Create your account.**
Visit [Humana.com/registration](https://www.humana.com/registration) and select the “Start activation now” button.
- 2 Choose your preferences.**
The first time you sign into your MyHumana account, be sure to choose how you want to receive information from us—online or mailed to your home. You can update your communication preferences at any time.
- 3 View your plan benefits.**
After you set up your account, be sure to view your plan documents so you understand your benefits and costs. You can also update your member profile if your contact information has changed.



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](https://www.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
- Compare drug prices
- View or print your Humana member ID card
- Select your communication preferences

Have questions?

If you need help using MyHumana, try our Chat feature or call Customer Care at the number listed on the back of your Humana member ID card.

*Standard data rates may apply.

Choosing a pharmacy

Building healthy relationships

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 access to mail delivery, specialty, retail, long-term care, home infusion, and Indian, tribal and urban pharmacies.

*Standard data rates may apply.

Is your pharmacy in Humana's network?

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



Our **wide network of pharmacies** means less time searching for a pharmacy, and more time building a relationship with the one that's right for you.

Making sure your caregiver can help you—so you can focus on living your life

Everyone needs a little help now and then. 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.

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

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

Visit [Humana.com/caregiver](https://www.humana.com/caregiver) to learn more about naming a caregiver and how to submit the Consent for Release of Protected Health Information (PHI) form.



Download the consent form

- Download from [Humana.com/PHI](https://www.humana.com/PHI)
- Print it out, complete and sign
- Fax to **800-633-8188**
- Or, if you prefer, mail your completed form to:
Humana Insurance Company
P.O. Box 14168
Lexington, KY 40512-4168



Call Humana Customer Care

Call **800-733-9064 (TTY: 711)**,
Monday – Friday, 5 a.m. – 6 p.m.,
Pacific time.

*The form needs to be renewed every 2 years.

You have the choice of pharmacies for prescription retail and mail order services, CenterWell Pharmacy™ is one option*

Why choose CenterWell Pharmacy?

Experienced pharmacy team. Pharmacists are available to answer questions about your medication and CenterWell Pharmacy's 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 medication and supplies you need when you need them, CenterWell Pharmacy can remind you when it's time to refill your medication. Just set your preferences when you sign up at **CenterWellPharmacy.com**.

Time-saving mail delivery. Your medication will be shipped safely and securely to the location of your choice. You may be able to order just four times a year† and have more time to do the things you enjoy.

Make CenterWell Pharmacy your one source for:

Maintenance medication(s). Medication(s) you take regularly for conditions like high cholesterol, high blood pressure and asthma.

Specialty medication(s). Specialized therapies to treat chronic or complex illnesses like rheumatoid arthritis and cancer.

CenterWellPharmacy.com

After you become a Humana member, you can sign in with your MyHumana identification number. You can also call them at **800-379-0092 (TTY: 711)**, Mon. – Fri., 5 a.m. – 8 p.m., and Sat., 5 a.m. – 3:30 p.m., Pacific time.

Online

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

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 **CenterWellPharmacy.com/forms** and faxing the prescription to CenterWell Pharmacy at **800-379-7617** or CenterWell Specialty Pharmacy™ at **877-405-7940**.

Mail

Download the "Registration & Prescription Order Form" from **CenterWellPharmacy.com/forms** and mail your paper prescriptions to:
CenterWell Pharmacy
P.O. Box 745099,
Cincinnati, OH 45274-5099

Phone

For maintenance medication(s), call CenterWell Pharmacy at **800-379-0092 (TTY: 711)**, Mon. – Fri., 5 a.m. – 8 p.m., and Sat., 5 a.m. – 3:30 p.m., Pacific time.

For specialty medication(s), call CenterWell Specialty Pharmacy at **800-486-2668 (TTY: 711)**, Mon. – Fri., 5 a.m. – 8 p.m., and Sat., 5 a.m. – 3:30 p.m., Pacific time.

*Other pharmacies are available in the network.

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

Medicare Part D prescription drug tiers



Tier 1 – Generic or preferred generic

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.



Tier 2 – Preferred brand

A medication available to you for less than a nonpreferred

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



Tier 3 – Nonpreferred drug

A more expensive drug than a preferred

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



Tier 4 – Specialty

Drugs for specific uses

Some injectable and other high-cost drugs to treat chronic or complex illnesses like rheumatoid arthritis and cancer.



Understanding your vaccines and diabetes coverage



Where you get your vaccines may determine how it is covered

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 help prevent illness.

Some common vaccines that you should get at your pharmacy, not from your provider, are shingles, Tdap and hepatitis A.

Diabetes coverage

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

Diabetes prescriptions and supplies covered under Part D

Part D typically covers diabetes supplies used to inject or inhale insulin. You must be enrolled in a Medicare drug plan to get the supplies Part D covers.

- 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)

*Available through our preferred durable medical equipment vendors, CCS Medical, 877-531-7959 or Edwards Healthcare, 888-344-3434.

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 medications 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.

Prescription drug 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 **800-555-2546 (TTY: 711)** to speak with our Humana Clinical Pharmacy Review team Monday – Friday, 5 a.m. – 5 p.m., Pacific time.

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



Giving you **support** with **less stress** matters to us, because when your plan gives you **peace of mind**, you're free to **put yourself, and your health, first**.

Comprehensive medication review

As part of your Medicare Part D coverage with Humana, you may be eligible to set up a one-on-one review of your medications with a pharmacist or other healthcare provider trained in medication therapy management (MTM). This review is called a comprehensive medication review (CMR) and is offered at no extra cost to members meeting eligibility requirements. 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 chronic conditions:
 - Mental health-bipolar
 - Hypertension
 - Dyslipidemia (high or low LDL cholesterol)
 - Bone disease (arthritis, osteoporosis)
 - Chronic obstructive pulmonary disease (COPD); and
- Take at least eight chronic/maintenance (Part D) drugs; and
- Likely to have annual Part D medication costs of \$4,935 or more.

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.



What you need for your review

- Your medication bottles (with the pharmacy's label) or a complete list of the medications you take, including any over-the-counter medications or any herbal remedies
- A pen and paper for taking notes
- Your doctors' names

A Humana pharmacist or other trained healthcare provider is available to help you complete your CMR. Please call **888-686-4486 (TTY: 711)**, Monday – Friday, 5 a.m.- 3 p.m., Pacific time, or visit **Humana.com/mtm**.

Your personalized benefits statement

Humana’s SmartSummary provides a comprehensive overview of your Part D benefits and prescription drug spending. **You’ll receive this statement after each month you’ve had a prescription claim processed.** You can also sign-in to MyHumana and see your past SmartSummary statements anytime.

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 prescription details.** A personalized prescription section tells you more about your prescription medications, including information about dosage and the pharmacy provider. This page can be useful to take to your provider appointments or to your pharmacist.

SmartSummary®

Humana.

Your Part D Pharmacy claims processed in January 2022

THIS IS NOT A BILL

This summary is your "Explanation of Benefits" (EOB) and claim payments for your Medicare prescription drug coverage (Part D). Please review this summary and keep it for your records. **This is not a bill.**

OVERVIEW OF YOUR JANUARY CLAIMS

Part D prescription drug claims (see page 5)	
Total cost this month	\$4.50
Other Payments	- \$0.00
Amount Humana Paid	- \$0.00
Your Share	\$4.50

YOU ARE CURRENTLY IN PART D DRUG PAYMENT STAGE: 1 2 3 4

CONTACT US IF YOU HAVE QUESTIONS OR NEED HELP.

Questions
Login to MyHumana at [Humana.com](#) to see your benefits, drug lists, prescriptions and claims.

Call us
Call **1-866-396-8810 (TTY: 711)**
Monday to Friday 8 a.m. - 9 p.m. EST. Calls to these numbers are free.
For large print or another format

JOHN DOE
Member ID: XXXXXXXX
Plan name: Humana Group Medicare PDP
Rx PCN or Rx Group number: 00000000

SmartSummary®

Page 3 of 10
John Doe

STAGE 2

Initial coverage period-
Ends when maximum prescription costs paid by you/your plan/others on your behalf reaches \$4,430.

	Standard Retail Cost Sharing Pharmacy (30 days)	Standard Mail-Order Cost-Sharing Pharmacy (90 days)
You pay:		
Generic or Preferred Generic drugs	\$2.00	\$5.00
Preferred Brand drugs	20%	20%
Non-Preferred Drug drugs	40%	40%
Specialty Tier drugs	25%	N/A
The plan pays:	the rest	the rest
Specialty Tier drugs are limited to a 30 day supply		

STAGE 3

Coverage gap- Ends when amount of year to date costs paid by you (or others on your behalf) reaches \$7,050.

	Standard Retail Cost Sharing Pharmacy (30 days)	Standard Mail-Order Cost-Sharing Pharmacy (90 days)
You pay:		
For all Generic drugs you pay up to	25%	25%
For all Brand drugs you pay up to	25%	25%
Specialty Tier drugs are limited to a 30 day supply		
Certain Home Infusion Drugs could have additional coverage. Please refer to your Evidence of Coverage for additional information.		

SmartSummary®

Page 2 of 10
John Doe

Part D Prescription Drug Coverage

WHICH PART D "DRUG PAYMENT STAGE" ARE YOU IN?

As shown below, your Part D prescription drug coverage has "drug payment stages." How much you pay for a covered Part D prescription depends on which payment stage you are in when you fill it. During the calendar year, whether you move from one payment stage to the next depends on how much is spent for your drugs.

STAGE 1

You are in Stage 1. During this payment stage, you (or others on your behalf) pay the full cost of all your drugs. You begin in this payment stage when you fill your first prescription of the plan year.

Yearly deductible- You generally stay in this stage until you (or others on your behalf) have paid \$100 for your drugs (\$100 is the amount of your deductible).

What happens next?
Once you (or others on your behalf) have paid an additional \$183.80 for

	Standard Retail Cost Sharing Pharmacy (30 days)	Standard Mail-Order Cost-Sharing Pharmacy (90 days)
You pay:	100%	100%
The plan pays:	0%	0%
Specialty Tier drugs are limited to a 30 day supply		

SmartSummary®

Page 4 of 10
John Doe

Your Part D "Out-of-pocket costs" and "Total drug costs" (Amounts and definitions)

This section helps you keep track of your "out-of-pocket costs" and "total drug costs." These costs determine which drug payment stage you are in. As explained in the drug payment stage section, the payment stage you are in determines how much you pay for your prescriptions.

Your "out-of-pocket costs"	January 2022	\$4.50
	Year-to-date since January 2022	\$114.00
Your "total drug costs"	January 2022	\$4.50
	Year-to-date since January 2022	\$261.20

Definitions

"Out of pocket costs" include:

- What you pay when you fill or refill a prescription for a covered Part D drug. (This includes payments for your drugs, if any, that are made by family or friends.)
- Payments made for your drugs by any of the following programs or organizations: "Extra Help" from Medicare; Medicare's Coverage Gap Discount Program; Indian Health Service; AIDS drug assistance programs; most charities; and most State Pharmaceutical Assistance Programs (SPAPs).

"Out of pocket costs" do not include:

- Payments made for: a) plan premiums; b) drugs not covered by our plan; c) non-Part D drugs (such as drugs you receive during a hospital stay); d) drugs obtained at a non-network pharmacy that does not meet our network pharmacy access requirements; e) over-the-counter drugs; f) off-invoice or union health

Frequently asked questions

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. Keep your Medicare ID card in a safe place.

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.

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 **800-MEDICARE (800-633-4227)**, 24 hours a day, seven days a week. If you use a TTY, call **877-486-2048**.

You can also call the Social Security Administration at **800-772-1213**. If you use a TTY, call **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**.

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

To request reimbursement for a charge you paid for a prescription drug, send the provider's itemized receipt and the Prescription Drug Claim Form (available at **Humana.com** or by calling Customer Care) 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. Call Humana Group Medicare Customer Care for more information and assistance.

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 PDP plan enrollment is confirmed.

Pharmacy terms and definitions

Catastrophic coverage

What you pay for covered drugs after reaching \$7,400

Once your out-of-pocket costs reach the \$7,400 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.

Plan discount

A way Humana helps you save money

Amount you are not responsible for due to Humana's negotiated rate with provider.

Know your numbers

Find important numbers anytime you need them*

Humana Group Medicare Customer Care

800-733-9064 (TTY: 711),

Monday – Friday, 5 a.m. – 6 p.m., Pacific time

MyHumana

Sign in to or register for MyHumana to access your personal and secure plan information at **Humana.com**

CenterWell Pharmacy™

800-379-0092 (TTY: 711),

Monday – Friday, 5 a.m. – 8 p.m., and Sat., 5 a.m. – 3:30 p.m., Pacific time

CenterWellPharmacy.com

Caregivers

800-733-9064 (TTY: 711),

Monday – Friday, 5 a.m. – 6 p.m., Pacific time

Humana.com/caregiver

State health insurance program offices

800-633-4227 (TTY: 711), 24 hours a day, 7 days a week

www.cms.gov/apps/contacts/#

*You must be a Humana member to use these services.

Important

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, ancestry, ethnicity, sex, sexual orientation, gender, gender identity, disability, age, marital status, religion, or language in their programs and activities, including in admission or access to, or treatment or employment in, their programs and activities.

- The following department has been designated to handle inquiries regarding Humana's non-discrimination policies: Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618, **800-733-9064 (TTY: 711)**.

Auxiliary aids and services, free of charge, are available to you. **800-733-9064 (TTY: 711)**

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

This information is available for free in other languages. Please call our customer service number at **877-320-1235 (TTY: 711)**. Hours of operation: **8 a.m. – 8 p.m. Eastern time.**

Español (Spanish): Llame al número indicado para recibir servicios gratuitos de asistencia lingüística. **877-320-1235 (TTY: 711)**. Horas de operación: 8 a.m. a 8 p.m. hora del este.

繁體中文 (Chinese): 本資訊也有其他語言版本可供免費索取。請致電客戶服務部：**877-320-1235 (聽障專線：711)**。辦公時間：東部時間上午 8 時至晚上 8 時。

GHHLE7BEN 0822

2023 enhanced vaccine and insulin coverage

At Humana, we strive to help our members achieve total health so that they may live their best lives, which includes efforts to provide our members with access to more affordable prescription drugs. Helping to further support these initiatives, President Biden signed the Inflation Reduction Act into law on August 16, 2022.

This means that this Humana Group Medicare prescription drug plan (PDP) in this booklet may have additional benefits that are not currently described, including reduced out-of-pocket costs for Part D vaccines and Humana covered insulin. Benefits include:



\$0 vaccines

Member cost share of all Part D vaccines listed on the Advisory Committee on Immunization Practices (ACIP) list¹ will be **\$0**.



\$35 insulin copay

Member cost share of this plan's covered insulin products covered under Part D will be **no more than \$35** for every one-month (up to a 30-day) supply.

Additional information on the 2023 benefit enhancements will be provided as soon as possible.

- Please check **Humana.com** frequently for updates on these benefit enhancements.
- If you have questions about these benefit enhancements or general questions about the plan, contact Humana Group Medicare Customer Care.

Humana®

¹For more information regarding the Centers for Disease Control and Prevention's ACIP vaccine recommendations, please go to www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/index.html.

2023

Summary of Benefits

**Humana Group Medicare PDP Plan
PDP 037/355**

Alaska Laborers Local 341 and 942

Humana®

Our service area includes the United States and Puerto Rico.



Let's talk about the **Humana Group Medicare PDP Plan.**

Find out more about the Humana Group Medicare PDP 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 PDP 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 PDP plan

How to reach us:

Members should call toll-free
1-866-850-2323 for questions
(TTY/TDD 711)

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

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



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 **\$4,660**. 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)	\$2 copay	\$2 copay
2 (Preferred Brand)	\$15 copay	\$15 copay
3 (Non-Preferred Drug)	\$35 copay	\$35 copay
4 (Specialty Tier)	\$35 copay	\$35 copay
90-day supply		
1 (Generic or Preferred Generic)	\$6 copay	\$4 copay
2 (Preferred Brand)	\$45 copay	\$30 copay
3 (Non-Preferred Drug)	\$105 copay	\$70 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. To view the most complete and current Drug Guide information online, visit www.humana.com/SearchResources, locate Prescription Drug section, select www.humana.com/MedicareDrugList link; under Printable drug lists, click Printable Drug lists, select future plan year, select Group Medicare under Plan Type and search for GRP26.

Important Message About What You Pay for Vaccines – Our plan covers most Part D vaccines at no cost to you (even if you haven't paid your deductible, if applicable). Call Customer Care for more information.

Important Message About What You Pay for Insulin – You won't pay more than **\$35** for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on (even if you haven't paid your deductible, if applicable).

ADDITIONAL DRUG COVERAGE

Original Medicare excluded drugs

Certain drugs excluded by Original Medicare are covered under this plan. You pay the cost share associated with the tier level for certain Cosmetic, Cough/Cold, Fertility, Vitamins/Minerals, Weight Loss drugs. The amount you pay when you fill a prescription for these drugs does not count towards qualifying you for the Catastrophic Coverage stage. Contact Humana Group Medicare Customer Care at the phone number on the back of your membership card for more details.

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 **\$4,660**.

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 **\$7,400**, you pay the greater of either:

- **\$4.15** for generic (including brand drugs treated as generic) and a **\$10.35** copay for all other drugs,
OR
- **5%** coinsurance
 - **One-month Retail:** **\$2** maximum out-of-pocket per prescription for tier 1 drugs, **\$15** maximum out-of-pocket per prescription for tier 2 drugs, **\$35** maximum out-of-pocket per prescription for tier 3 drugs, and **\$35** maximum out-of-pocket per prescription for tier 4 drugs.
 - **Three-month Mail order:** **\$4** maximum out-of-pocket per prescription for tier 1 drugs, **\$30** maximum out-of-pocket per prescription for tier 2 drugs, and **\$70** maximum out-of-pocket per prescription for tier 3 drugs.

[illegible]

[illegible]

This image shows a blank sheet of white paper designed for handwriting practice. It features a series of horizontal lines. At the very top, there is a dashed line. Below this, there are several pairs of solid lines, creating uniform spaces for writing. The lines are evenly spaced and extend across the entire width of the page. There is no text or other markings on the paper.

Important

At Humana, it is important you are treated fairly.

Humana 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, ethnicity, marital status, religion, or language. 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 **1-877-320-1235** 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.

Auxiliary aids and services, free of charge, are available to you. 1-877-320-1235 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people 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)

Multi-Language Insert

Multi-language Interpreter Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



Find out **more**



You can see your plan's pharmacy directory at **<https://www.humana.com/finder/pharmacy/>** or call us at the number listed at the beginning of this booklet and we will send you one.



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.

Humana is a stand-alone prescription drug 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

SB037355EN23

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.

26

This abridged formulary was updated on 11/02/2022 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 with any questions 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. Our automated phone system is available after hours, weekends, and holidays. Our website is also available 24 hours a day 7 days a week by visiting **Humana.com**.

Important Message About What You Pay for Vaccines – Our plan covers most Part D vaccines at no cost to you, even if your plan has a deductible and you haven't paid it. Call Humana Medicare Employer Plan for more information.

Important Message About What You Pay for Insulin – You won't pay more than \$35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if your plan has a deductible and you haven't paid it.

Instructions for getting information about all covered drugs are inside.

Humana®

Welcome to The 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, 2023. For a complete, updated formulary, please contact us on our website at [Humana.com/PlanDocuments](https://www.humana.com/PlanDocuments) or you can call the number below to request a paper copy. 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](https://www.humana.com/medicaredruglist). The Drug List Search tool lets you search for your drug by name or drug type.

If you are thinking about enrolling in a Humana Medicare Employer Plan and need help or a complete list of covered drugs, please contact Group Medicare Customer Care number listed in your enrollment materials. If you are 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. Our live representatives are available from 8 a.m. to 9 p.m. (EST), Monday through Friday. Our automated phone system is available after hours, weekends, and holidays.

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 titled "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 will 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 titled "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 2023 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2023 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 are affected by a Drug List change?

We will 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, 2023. We will update the printed formularies each month and they will be available on **[Humana.com/medicaredruglist](https://www.humana.com/medicaredruglist)**.

To get updated information about the drugs that Humana covers, please visit **[Humana.com/medicaredruglist](https://www.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 have put the drugs into groups depending on the type of medical conditions that they are 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 are 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 will 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 will need to get approval from the Humana Medicare Employer Plan before you fill your prescriptions. If you do not 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 is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day. 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. (EST).

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](https://www.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 is not on the formulary?

If your drug is not included in this list of covered drugs, visit [Humana.com/medicaredruglist](https://www.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 does not 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 Humana 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 is 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. *You can ask us to cover a formulary drug at a lower cost-sharing level, unless the drug is on the specialty tier.*

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 would not 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 receive 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 does not 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 are a member of the plan.

Here is what we will do for each of your current Part D drugs that are not on the formulary, or if you have limited ability to get your drugs:

- We will 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 have been a member of the plan for less than 90 days, unless a formulary exception has been approved.

If you are a resident of a long-term care facility and you take Part D drugs that are not on the formulary, we will 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 are a member of our plan. We will 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 is not on the formulary *or*
- You have limited ability to get your drugs *and*
- You are 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 are 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 has not been processed by the end of your initial transition period. We will 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.

CenterWell Pharmacy™

You may fill your medicines at any network pharmacy, CenterWell Pharmacy – Humana's mail-delivery pharmacy is one option. To get started or learn more, visit **CenterWellpharmacy.com**. You can also call CenterWell Pharmacy at **1-844-222-2151 (TTY: 711)** Monday – Friday, 8 a.m. to 11 p.m. (EST), and Saturday, 8 a.m. to 6:30 p.m. (EST).

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 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 is not listed in this partial formulary, please visit our website at **Humana.com**.

Your Humana Medicare Employer plan has additional coverage of some drugs. These drugs are not normally covered under Medicare Part D and are not subject to the Medicare appeals process. These drugs are listed separately on page 26.

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 or Utilization Management column, 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.

LA - Limited Access; The health plan has authorized certain pharmacies to dispense this medicine, as it requires extra handling, doctor coordination or patient education. Please call the number on the back of your ID card for additional information.

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-codeine 300-30 mg TABLET DL	1	QL(360 per 30 days)
BELBUCA 150 MCG, 300 MCG, 450 MCG, 600 MCG, 75 MCG, 750 MCG, 900 MCG FILM DL	3	QL(60 per 30 days)
celecoxib 100 mg, 200 mg CAPSULE MO	1	QL(60 per 30 days)
diclofenac sodium 1 % GEL MO	1	QL(1000 per 30 days)
diclofenac sodium 75 mg TABLET, DR/EC MO	1	
hydrocodone-acetaminophen 10-325 mg, 5-325 mg, 7.5-325 mg TABLET DL	1	QL(360 per 30 days)
ibuprofen 600 mg, 800 mg TABLET MO	1	
ketoprofen 200 mg CAPSULE ER PELLETS 24 HR. MO	1	
ketoprofen 25 mg CAPSULE MO	1	ST
meloxicam 15 mg TABLET MO	1	QL(30 per 30 days)
meloxicam 7.5 mg TABLET MO	1	QL(60 per 30 days)
morphine 15 mg TABLET ER DL	1	QL(120 per 30 days)
naproxen 500 mg TABLET MO	1	
oxycodone 10 mg, 15 mg, 5 mg TABLET DL	1	QL(360 per 30 days)
oxycodone-acetaminophen 10-325 mg, 5-325 mg, 7.5-325 mg TABLET DL	1	QL(360 per 30 days)
tramadol 50 mg TABLET DL	1	QL(240 per 30 days)
XTAMPZA ER 13.5 MG, 18 MG, 27 MG, 36 MG, 9 MG CAPSULE ER SPRINKLE 12 HR. DL	2	QL(60 per 30 days)
Anti-addiction/substance Abuse Treatment Agents		
acamprosate 333 mg TABLET, DR/EC MO	1	
VIVITROL 380 MG SUSPENSION, ER, RECON DL	4	QL(1 per 28 days)
ZUBSOLV 0.7-0.18 MG, 1.4-0.36 MG SUBLINGUAL TABLET MO	1	QL(90 per 30 days)
ZUBSOLV 11.4-2.9 MG SUBLINGUAL TABLET MO	1	QL(30 per 30 days)
Antibacterials		
amoxicillin 500 mg CAPSULE MO	1	
amoxicillin 500 mg TABLET MO	1	
amoxicillin-pot clavulanate 875-125 mg TABLET MO	1	
azithromycin 250 mg TABLET MO	1	
cefdinir 300 mg CAPSULE MO	1	
cephalexin 500 mg CAPSULE MO	1	
ciprofloxacin hcl 500 mg TABLET MO	1	
clarithromycin 125 mg/5 ml SUSPENSION FOR RECONSTITUTION MO	1	
clindamycin hcl 300 mg CAPSULE MO	1	
doxycycline hyclate 100 mg CAPSULE MO	1	

Need more information about the indicators displayed by the drug names? Please go to page 9. Need more information about the utilization management requirements? Please go to page 5.

B vs D - Part B vs Part D • MO – Mail Order • PA - Prior Authorization • QL - Quantity Limit • ST - Step Therapy
• DL – Dispensing Limit • LA – Limited Access

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
doxycycline hyclate 100 mg TABLET MO	1	
levofloxacin 500 mg TABLET MO	1	
metronidazole 500 mg TABLET MO	1	
nitrofurantoin monohyd/m-cryst 100 mg CAPSULE MO	1	
NUZYRA 100 MG RECON SOLUTION DL	4	
NUZYRA 150 MG TABLET DL	4	QL(30 per 14 days)
SIVEXTRO 200 MG RECON SOLUTION DL	4	QL(6 per 28 days)
SIVEXTRO 200 MG TABLET DL	4	QL(6 per 28 days)
sulfacetamide sodium 10 % OINTMENT MO	1	
sulfamethoxazole-trimethoprim 800-160 mg TABLET MO	1	
Anticonvulsants		
EPIDIOLEX 100 MG/ML SOLUTION DL	4	PA
gabapentin 100 mg, 300 mg, 400 mg CAPSULE MO	1	QL(270 per 30 days)
gabapentin 600 mg, 800 mg TABLET MO	1	QL(180 per 30 days)
lamotrigine 100 mg, 200 mg TABLET MO	1	
levetiracetam 500 mg TABLET MO	1	
primidone 50 mg TABLET MO	1	
VIMPAT 10 MG/ML SOLUTION DL	4	PA,QL(1395 per 30 days)
VIMPAT 100 MG, 150 MG, 200 MG TABLET DL	4	PA,QL(60 per 30 days)
VIMPAT 50 MG TABLET MO	3	PA,QL(60 per 30 days)
Antidementia Agents		
donepezil 10 mg TABLET MO	1	QL(60 per 30 days)
donepezil 5 mg TABLET MO	1	QL(30 per 30 days)
memantine 10 mg, 5 mg TABLET MO	1	PA,QL(60 per 30 days)
NAMZARIC 14-10 MG, 21-10 MG, 28-10 MG, 7-10 MG CAPSULE ER SPRINKLE 24 HR. MO	2	QL(30 per 30 days)
NAMZARIC 7/14/21/28 MG-10 MG CAPSULE ER SPRINKLE 24 HR. MO	2	QL(28 per 28 days)
Antidepressants		
amitriptyline 25 mg TABLET MO	1	
bupropion hcl 150 mg TABLET, ER 24 HR. MO	1	QL(90 per 30 days)
bupropion hcl 150 mg TABLET, SR 12 HR. MO	1	QL(90 per 30 days)
bupropion hcl 300 mg TABLET, ER 24 HR. MO	1	QL(60 per 30 days)
citalopram 10 mg, 40 mg TABLET MO	1	QL(30 per 30 days)
citalopram 20 mg TABLET MO	1	QL(60 per 30 days)
duloxetine 20 mg, 60 mg CAPSULE, DR/EC MO	1	QL(60 per 30 days)
duloxetine 30 mg CAPSULE, DR/EC MO	1	QL(90 per 30 days)

Need more information about the indicators displayed by the drug names? Please go to page 9. Need more information about the utilization management requirements? Please go to page 5.

B vs D - Part B vs Part D • MO – Mail Order • PA - Prior Authorization • QL - Quantity Limit • ST - Step Therapy
• DL – Dispensing Limit • LA – Limited Access

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
escitalopram oxalate 10 mg TABLET MO	1	QL(45 per 30 days)
escitalopram oxalate 20 mg, 5 mg TABLET MO	1	QL(30 per 30 days)
fluoxetine 20 mg CAPSULE MO	1	QL(120 per 30 days)
fluoxetine 40 mg CAPSULE MO	1	QL(60 per 30 days)
imipramine hcl 10 mg TABLET MO	1	
mirtazapine 15 mg, 30 mg, 7.5 mg TABLET MO	1	
paroxetine hcl 20 mg TABLET MO	1	QL(30 per 30 days)
sertraline 100 mg TABLET MO	1	QL(60 per 30 days)
sertraline 25 mg, 50 mg TABLET MO	1	QL(90 per 30 days)
trazodone 100 mg, 150 mg, 50 mg TABLET MO	1	
TRINTELLIX 10 MG, 20 MG, 5 MG TABLET MO	3	ST,QL(30 per 30 days)
venlafaxine 150 mg CAPSULE, ER 24 HR. MO	1	QL(60 per 30 days)
venlafaxine 75 mg CAPSULE, ER 24 HR. MO	1	QL(90 per 30 days)
Antiemetics		
meclizine 25 mg TABLET MO	1	
ondansetron 4 mg TABLET, DISINTEGRATING MO	1	BvsD,QL(90 per 30 days)
ondansetron hcl 4 mg TABLET MO	1	BvsD,QL(90 per 30 days)
promethazine 25 mg TABLET MO	1	
SANCUSO 3.1 MG/24 HOUR PATCH, WEEKLY DL	4	QL(4 per 30 days)
Antifungals		
clotrimazole-betamethasone 1-0.05 % CREAM MO	1	QL(180 per 30 days)
fluconazole 150 mg TABLET MO	1	
ketoconazole 2 % CREAM MO	1	QL(60 per 30 days)
ketoconazole 2 % SHAMPOO MO	1	QL(120 per 30 days)
Antigout Agents		
allopurinol 100 mg, 300 mg TABLET MO	1	
MITIGARE 0.6 MG CAPSULE MO	2	
Antimigraine Agents		
AIMOVIG AUTOINJECTOR 140 MG/ML AUTO-INJECTOR MO	3	PA,QL(1 per 30 days)
AIMOVIG AUTOINJECTOR 70 MG/ML AUTO-INJECTOR MO	3	PA,QL(2 per 30 days)
EMGALITY PEN 120 MG/ML PEN INJECTOR MO	3	PA,QL(2 per 30 days)
EMGALITY SYRINGE 120 MG/ML SYRINGE MO	3	PA,QL(2 per 30 days)
EMGALITY SYRINGE 300 MG/3 ML (100 MG/ML X 3) SYRINGE MO	3	PA,QL(3 per 30 days)
rizatriptan 5 mg TABLET MO	1	QL(12 per 30 days)
sumatriptan succinate 100 mg TABLET MO	1	QL(9 per 30 days)
topiramate 50 mg TABLET MO	1	QL(120 per 30 days)

Need more information about the indicators displayed by the drug names? Please go to page 9. Need more information about the utilization management requirements? Please go to page 5.

B vs D - Part B vs Part D • MO – Mail Order • PA - Prior Authorization • QL - Quantity Limit • ST - Step Therapy
• DL – Dispensing Limit • LA – Limited Access

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
Antineoplastics		
ALECENSA 150 MG CAPSULE DL	4	PA,QL(240 per 30 days)
ALUNBRIG 180 MG, 90 MG TABLET DL	4	PA,QL(30 per 30 days)
ALUNBRIG 30 MG TABLET DL	4	PA,QL(180 per 30 days)
ALUNBRIG 90 MG (7)- 180 MG (23) TABLET, DOSE PACK DL	4	PA,QL(30 per 30 days)
<i>anastrozole 1 mg TABLET</i> MO	1	QL(30 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)
<i>exemestane 25 mg TABLET</i> MO	1	QL(60 per 30 days)
IBRANCE 100 MG, 125 MG, 75 MG CAPSULE DL	4	PA,QL(21 per 28 days)
IBRANCE 100 MG, 125 MG, 75 MG TABLET DL	4	PA,QL(21 per 28 days)
IMBRUVICA 140 MG CAPSULE DL	4	PA,QL(90 per 30 days)
IMBRUVICA 420 MG, 560 MG TABLET DL	4	PA,QL(28 per 28 days)
IMBRUVICA 70 MG CAPSULE DL	4	PA,QL(28 per 28 days)
NUBEQA 300 MG TABLET DL	4	PA,QL(120 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)
XTANDI 40 MG TABLET DL	4	PA,QL(120 per 30 days)
XTANDI 80 MG TABLET DL	4	PA,QL(60 per 30 days)
Antiparasitics		
<i>hydroxychloroquine 200 mg TABLET</i> MO	1	
<i>nitazoxanide 500 mg TABLET</i> DL	4	QL(40 per 30 days)
Antiparkinson Agents		
<i>carbidopa-levodopa 25-100 mg TABLET</i> MO	1	
KYNMOBI 10 MG, 15 MG, 20 MG, 25 MG, 30 MG FILM DL	4	PA,QL(150 per 30 days)
RYTARY 23.75-95 MG CAPSULE, ER MO	3	ST,QL(360 per 30 days)
Antipsychotics		
ABILIFY 10 MG, 15 MG, 2 MG, 20 MG, 30 MG, 5 MG TABLET DL	4	PA
ABILIFY MAINTENA 300 MG, 400 MG SUSPENSION, ER, RECON DL	4	QL(1 per 28 days)
ABILIFY MAINTENA 300 MG, 400 MG SUSPENSION, ER, SYRINGE DL	4	QL(1 per 28 days)
ABILIFY MYCITE 30 MG TABLET WITH SENSOR AND PATCH DL	4	PA,QL(30 per 30 days)
ABILIFY MYCITE MAINTENANCE KIT 15 MG, 2 MG, 20 MG, 5 MG TABLET WITH SENSOR AND STRIP DL	4	PA,QL(30 per 30 days)
ABILIFY MYCITE STARTER KIT 10 MG TABLET W/SENSOR AND STRIP, POD DL	4	PA,QL(30 per 30 days)
ARISTADA 1,064 MG/3.9 ML SUSPENSION, ER, SYRINGE	4	QL(3.9 per 56 days)

Need more information about the indicators displayed by the drug names? Please go to page 9. Need more information about the utilization management requirements? Please go to page 5.

B vs D - Part B vs Part D • MO – Mail Order • PA - Prior Authorization • QL - Quantity Limit • ST - Step Therapy
 • DL – Dispensing Limit • LA – Limited Access

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
ARISTADA 441 MG/1.6 ML SUSPENSION, ER, SYRINGE DL	4	QL(1.6 per 28 days)
ARISTADA 662 MG/2.4 ML SUSPENSION, ER, SYRINGE DL	4	QL(2.4 per 28 days)
ARISTADA 882 MG/3.2 ML SUSPENSION, ER, SYRINGE DL	4	QL(3.2 per 28 days)
ARISTADA INITIO 675 MG/2.4 ML SUSPENSION, ER, SYRINGE DL	4	QL(2.4 per 42 days)
INVEGA 1.5 MG, 3 MG, 9 MG TABLET, ER 24 HR. DL	4	PA,QL(30 per 30 days)
INVEGA 6 MG TABLET, ER 24 HR. DL	4	PA,QL(60 per 30 days)
INVEGA HAFYERA 1,092 MG/3.5 ML SYRINGE	4	QL(3.5 per 180 days)
INVEGA HAFYERA 1,560 MG/5 ML SYRINGE	4	QL(5 per 180 days)
INVEGA SUSTENNA 117 MG/0.75 ML, 234 MG/1.5 ML, 78 MG/0.5 ML SYRINGE DL	4	QL(1.5 per 28 days)
INVEGA SUSTENNA 156 MG/ML SYRINGE DL	4	QL(1 per 28 days)
INVEGA SUSTENNA 39 MG/0.25 ML SYRINGE MO	3	QL(1.5 per 28 days)
INVEGA TRINZA 273 MG/0.88 ML SYRINGE	4	QL(0.88 per 90 days)
INVEGA TRINZA 410 MG/1.32 ML SYRINGE	4	QL(1.32 per 90 days)
INVEGA TRINZA 546 MG/1.75 ML SYRINGE	4	QL(1.75 per 90 days)
INVEGA TRINZA 819 MG/2.63 ML SYRINGE	4	QL(2.63 per 90 days)
PERSERIS 120 MG, 90 MG SUSPENSION, ER, SYRINGE DL	4	QL(1 per 28 days)
quetiapine 100 mg TABLET MO	1	QL(90 per 30 days)
quetiapine 25 mg, 50 mg TABLET MO	1	QL(120 per 30 days)
RISPERDAL 0.5 MG TABLET MO	3	QL(120 per 30 days)
RISPERDAL 1 MG, 2 MG, 3 MG, 4 MG TABLET DL	4	QL(60 per 30 days)
RISPERDAL 1 MG/ML SOLUTION DL	4	
RISPERDAL CONSTA 12.5 MG/2 ML, 25 MG/2 ML SUSPENSION, ER, RECON MO	3	QL(2 per 28 days)
RISPERDAL CONSTA 37.5 MG/2 ML, 50 MG/2 ML SUSPENSION, ER, RECON DL	4	QL(2 per 28 days)
Antispasticity Agents		
baclofen 10 mg TABLET MO	1	
dantrolene 100 mg, 25 mg, 50 mg CAPSULE MO	1	
tizanidine 2 mg, 4 mg TABLET MO	1	
Antivirals		
acyclovir 400 mg TABLET MO	1	
DESCOVY 200-25 MG TABLET DL	4	QL(30 per 30 days)
EPCLUSA 150-37.5 MG PELLETS IN PACKET DL	4	PA,QL(28 per 28 days)
EPCLUSA 200-50 MG PELLETS IN PACKET DL	4	PA,QL(56 per 28 days)
EPCLUSA 200-50 MG, 400-100 MG TABLET DL	4	PA,QL(28 per 28 days)
GENVOYA 150-150-200-10 MG TABLET DL	4	QL(30 per 30 days)
HARVONI 33.75-150 MG PELLETS IN PACKET DL	4	PA,QL(28 per 28 days)

Need more information about the indicators displayed by the drug names? Please go to page 9. Need more information about the utilization management requirements? Please go to page 5.

B vs D - Part B vs Part D • MO – Mail Order • PA - Prior Authorization • QL - Quantity Limit • ST - Step Therapy
• DL – Dispensing Limit • LA – Limited Access

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
HARVONI 45-200 MG PELLETS IN PACKET DL	4	PA,QL(56 per 28 days)
HARVONI 90-400 MG TABLET DL	4	PA,QL(28 per 28 days)
ISENTRESS HD 600 MG TABLET DL	4	QL(60 per 30 days)
ledipasvir-sofosbuvir 90-400 mg TABLET DL	4	PA,QL(28 per 28 days)
ODEFSEY 200-25-25 MG TABLET DL	4	QL(30 per 30 days)
valacyclovir 1 gram, 500 mg TABLET MO	1	
VOSEVI 400-100-100 MG TABLET DL	4	PA,QL(28 per 28 days)
XOFLUZA 40 MG TABLET MO	3	QL(10 per 365 days)
XOFLUZA 80 MG TABLET MO	3	QL(5 per 365 days)
Anxiolytics		
alprazolam 0.25 mg, 0.5 mg, 1 mg TABLET DL	1	QL(120 per 30 days)
buspirone 10 mg, 15 mg, 5 mg TABLET MO	1	
clonazepam 0.5 mg, 1 mg TABLET DL	1	
diazepam 10 mg TABLET DL	1	QL(120 per 30 days)
diazepam 5 mg TABLET DL	1	QL(90 per 30 days)
hydroxyzine hcl 25 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 SPRAY, NON-AEROSOL MO	2	
BYDUREON BCISE 2 MG/0.85 ML AUTO-INJECTOR MO	3	QL(3.4 per 28 days)
FARXIGA 10 MG TABLET MO	3	QL(30 per 30 days)
FIASP FLEXTouch U-100 INSULIN 100 UNIT/ML (3 ML) INSULIN PEN MO	2	
FIASP PENFILL U-100 INSULIN 100 UNIT/ML (3 ML) CARTRIDGE MO	2	
FIASP U-100 INSULIN 100 UNIT/ML SOLUTION MO	2	
glimepiride 2 mg, 4 mg TABLET MO	1	
glipizide 10 mg TABLET, ER 24 HR. MO	1	
glipizide 10 mg, 5 mg TABLET MO	1	
GLYXAMBI 10-5 MG, 25-5 MG TABLET MO	2	QL(30 per 30 days)
GVOKE 1 MG/0.2 ML SOLUTION MO	2	
GVOKE HYPOPEN 2-PACK 0.5 MG/0.1 ML, 1 MG/0.2 ML AUTO-INJECTOR MO	2	
GVOKE PFS 1-PACK SYRINGE 0.5 MG/0.1 ML, 1 MG/0.2 ML SYRINGE MO	2	
INSULIN ASP PRT-INSULIN ASPART 100 UNIT/ML (70-30) INSULIN PEN MO	2	
INSULIN ASP PRT-INSULIN ASPART 100 UNIT/ML (70-30) SOLUTION MO	2	
INSULIN ASPART U-100 100 UNIT/ML (3 ML) INSULIN PEN MO	2	
INSULIN ASPART U-100 100 UNIT/ML CARTRIDGE MO	2	
INSULIN ASPART U-100 100 UNIT/ML SOLUTION MO	2	

Need more information about the indicators displayed by the drug names? Please go to page 9. Need more information about the utilization management requirements? Please go to page 5.

B vs D - Part B vs Part D • MO – Mail Order • PA - Prior Authorization • QL - Quantity Limit • ST - Step Therapy
• DL – Dispensing Limit • LA – Limited Access

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
INVOKAMET 150-1,000 MG, 150-500 MG, 50-1,000 MG, 50-500 MG TABLET MO	2	QL(60 per 30 days)
INVOKAMET XR 150-1,000 MG, 150-500 MG, 50-1,000 MG, 50-500 MG TABLET, IR/ER 24 HR., BIPHASIC MO	2	QL(60 per 30 days)
INVOKANA 100 MG, 300 MG TABLET MO	2	QL(30 per 30 days)
JANUMET 50-1,000 MG TABLET MO	2	QL(60 per 30 days)
JANUMET XR 100-1,000 MG TABLET, ER 24 HR., MULTIPHASE MO	2	QL(30 per 30 days)
JANUMET XR 50-1,000 MG TABLET, ER 24 HR., MULTIPHASE 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 2.5-1,000 MG, 2.5-500 MG, 2.5-850 MG TABLET MO	2	QL(60 per 30 days)
JENTADUETO XR 2.5-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC MO	2	QL(60 per 30 days)
JENTADUETO XR 5-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC MO	2	QL(30 per 30 days)
KOMBIGLYZE XR 2.5-1,000 MG TABLET, ER 24 HR., MULTIPHASE MO	3	QL(60 per 30 days)
KOMBIGLYZE XR 5-1,000 MG TABLET, ER 24 HR., MULTIPHASE MO	3	QL(30 per 30 days)
LANTUS SOLOSTAR U-100 INSULIN 100 UNIT/ML (3 ML) INSULIN PEN MO	2	
LANTUS U-100 INSULIN 100 UNIT/ML SOLUTION MO	2	
LEVEMIR FLEXTouch U-100 INSULIN 100 UNIT/ML (3 ML) INSULIN PEN MO	2	
LEVEMIR U-100 INSULIN 100 UNIT/ML SOLUTION MO	2	
metformin 1,000 mg, 500 mg TABLET MO	1	
metformin 500 mg TABLET, ER 24 HR. MO	1	QL(120 per 30 days)
NOVOLIN 70-30 FLEXPEN U-100 100 UNIT/ML (70-30) INSULIN PEN MO	2	
NOVOLIN 70/30 U-100 INSULIN 100 UNIT/ML (70-30) SUSPENSION MO	2	
NOVOLIN N FLEXPEN 100 UNIT/ML (3 ML) INSULIN PEN MO	2	
NOVOLIN N NPH U-100 INSULIN 100 UNIT/ML SUSPENSION MO	2	
NOVOLOG FLEXPEN U-100 INSULIN 100 UNIT/ML (3 ML) INSULIN PEN MO	2	
NOVOLOG MIX 70-30 U-100 INSULIN 100 UNIT/ML (70-30) SOLUTION MO	2	
NOVOLOG MIX 70-30FLEXPEN U-100 100 UNIT/ML (70-30) INSULIN PEN MO	2	
NOVOLOG PENFILL U-100 INSULIN 100 UNIT/ML CARTRIDGE MO	2	
NOVOLOG U-100 INSULIN ASPART 100 UNIT/ML 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) PEN INJECTOR MO	2	QL(1.5 per 28 days)
OZEMPIC 1 MG/DOSE (4 MG/3 ML), 2 MG/DOSE (8 MG/3 ML) PEN INJECTOR MO	2	QL(3 per 28 days)
pioglitazone 15 mg, 30 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 INSULIN PEN MO	2	QL(15 per 24 days)

Need more information about the indicators displayed by the drug names? Please go to page 9. Need more information about the utilization management requirements? Please go to page 5.

B vs D - Part B vs Part D • MO – Mail Order • PA - Prior Authorization • QL - Quantity Limit • ST - Step Therapy
• DL – Dispensing Limit • LA – Limited Access

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
SYNJARDY 12.5-1,000 MG, 12.5-500 MG, 5-1,000 MG, 5-500 MG TABLET MO	2	QL(60 per 30 days)
SYNJARDY XR 10-1,000 MG, 25-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC MO	2	QL(30 per 30 days)
SYNJARDY XR 12.5-1,000 MG, 5-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC MO	2	QL(60 per 30 days)
TOUJEO MAX U-300 SOLOSTAR 300 UNIT/ML (3 ML) INSULIN PEN MO	2	
TOUJEO SOLOSTAR U-300 INSULIN 300 UNIT/ML (1.5 ML) INSULIN PEN MO	2	
TRADJENTA 5 MG TABLET MO	2	QL(30 per 30 days)
TRESIBA FLEXTOUCH U-100 100 UNIT/ML (3 ML) INSULIN PEN MO	2	
TRESIBA U-100 INSULIN 100 UNIT/ML SOLUTION MO	2	
TRIJARDY XR 10-5-1,000 MG, 25-5-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC MO	2	QL(30 per 30 days)
TRIJARDY XR 12.5-2.5-1,000 MG, 5-2.5-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC MO	2	QL(60 per 30 days)
TRULICITY 0.75 MG/0.5 ML, 1.5 MG/0.5 ML, 3 MG/0.5 ML, 4.5 MG/0.5 ML PEN INJECTOR MO	2	QL(2 per 28 days)
VICTOZA 3-PAK 0.6 MG/0.1 ML (18 MG/3 ML) PEN INJECTOR MO	2	QL(9 per 30 days)
XIGDUO XR 10-1,000 MG, 10-500 MG TABLET, IR/ER 24 HR., BIPHASIC MO	3	QL(30 per 30 days)
XULTOPHY 100/3.6 100 UNIT-3.6 MG /ML (3 ML) INSULIN PEN MO	2	QL(15 per 30 days)
ZEGALOGUE AUTOINJECTOR 0.6 MG/0.6 ML AUTO-INJECTOR MO	2	
ZEGALOGUE SYRINGE 0.6 MG/0.6 ML SYRINGE MO	2	
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 TREAT 30D START 5 MG (74 TABS) TABLET, DOSE PACK MO	2	QL(74 per 30 days)
NIVESTYM 300 MCG/0.5 ML SYRINGE DL	4	PA,QL(7 per 30 days)
NIVESTYM 300 MCG/ML SOLUTION DL	4	PA,QL(14 per 30 days)
NIVESTYM 480 MCG/0.8 ML SYRINGE DL	4	PA,QL(11.2 per 30 days)
NIVESTYM 480 MCG/1.6 ML SOLUTION DL	4	PA,QL(22.4 per 30 days)
PROCRIT 10,000 UNIT/ML SOLUTION MO	3	PA,QL(14 per 30 days)
RETACRIT 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML, 40,000 UNIT/ML SOLUTION MO	3	PA,QL(14 per 30 days)
UDENYCA 6 MG/0.6 ML SYRINGE DL	4	PA,QL(1.2 per 28 days)
warfarin 5 mg TABLET MO	1	
XARELTO 1 MG/ML SUSPENSION FOR RECONSTITUTION MO	2	ST,QL(600 per 30 days)
XARELTO 10 MG, 20 MG TABLET MO	2	QL(30 per 30 days)

Need more information about the indicators displayed by the drug names? Please go to page 9. Need more information about the utilization management requirements? Please go to page 5.

B vs D - Part B vs Part D • MO – Mail Order • PA - Prior Authorization • QL - Quantity Limit • ST - Step Therapy
• DL – Dispensing Limit • LA – Limited Access

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
XARELTO 15 MG, 2.5 MG TABLET MO	2	QL(60 per 30 days)
XARELTO DVT-PE TREAT 30D START 15 MG (42)- 20 MG (9) TABLET, DOSE PACK MO	2	QL(51 per 30 days)
ZARXIO 300 MCG/0.5 ML SYRINGE DL	4	PA,QL(7 per 30 days)
ZARXIO 480 MCG/0.8 ML SYRINGE DL	4	PA,QL(11.2 per 30 days)
Cardiovascular Agents		
amiodarone 200 mg TABLET MO	1	
amlodipine 10 mg, 2.5 mg, 5 mg TABLET MO	1	
atenolol 25 mg, 50 mg TABLET MO	1	
atorvastatin 10 mg, 20 mg, 40 mg, 80 mg TABLET MO	1	
bumetanide 1 mg TABLET MO	1	
carvedilol 12.5 mg, 25 mg, 3.125 mg, 6.25 mg TABLET MO	1	
chlorthalidone 25 mg TABLET MO	1	
clonidine hcl 0.1 mg TABLET MO	1	
CORLANOR 5 MG, 7.5 MG TABLET MO	3	PA,QL(60 per 30 days)
CORLANOR 5 MG/5 ML SOLUTION MO	3	PA,QL(560 per 28 days)
digoxin 125 mcg (0.125 mg) TABLET MO	1	QL(30 per 30 days)
diltiazem hcl 120 mg, 180 mg, 240 mg CAPSULE, ER 24 HR. MO	1	QL(60 per 30 days)
ENTRESTO 24-26 MG, 49-51 MG, 97-103 MG TABLET MO	2	QL(60 per 30 days)
ezetimibe 10 mg TABLET MO	1	QL(30 per 30 days)
fenofibrate 160 mg TABLET MO	1	QL(30 per 30 days)
fenofibrate nanocrystallized 145 mg TABLET MO	1	QL(30 per 30 days)
furosemide 20 mg, 40 mg TABLET MO	1	
guanfacine 1 mg TABLET MO	1	
hydralazine 25 mg, 50 mg TABLET MO	1	
hydrochlorothiazide 12.5 mg CAPSULE MO	1	
hydrochlorothiazide 12.5 mg, 25 mg TABLET MO	1	
irbesartan 300 mg TABLET MO	1	QL(30 per 30 days)
isosorbide mononitrate 30 mg, 60 mg TABLET, ER 24 HR. MO	1	
lisinopril 10 mg, 2.5 mg, 20 mg, 40 mg, 5 mg TABLET MO	1	
lisinopril-hydrochlorothiazide 10-12.5 mg, 20-12.5 mg, 20-25 mg TABLET MO	1	
losartan 100 mg, 25 mg, 50 mg TABLET MO	1	QL(60 per 30 days)
losartan-hydrochlorothiazide 100-12.5 mg, 100-25 mg, 50-12.5 mg TABLET MO	1	QL(60 per 30 days)
lovastatin 20 mg, 40 mg TABLET MO	1	
metoprolol succinate 100 mg, 50 mg TABLET, ER 24 HR. MO	1	QL(60 per 30 days)
metoprolol succinate 25 mg TABLET, ER 24 HR. MO	1	QL(90 per 30 days)

Need more information about the indicators displayed by the drug names? Please go to page 9. Need more information about the utilization management requirements? Please go to page 5.

B vs D - Part B vs Part D • MO – Mail Order • PA - Prior Authorization • QL - Quantity Limit • ST - Step Therapy
• DL – Dispensing Limit • LA – Limited Access

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
metoprolol tartrate 100 mg, 25 mg, 50 mg TABLET MO	1	
MULTAQ 400 MG TABLET MO	2	QL(60 per 30 days)
NEXLETOL 180 MG TABLET MO	2	PA,QL(30 per 30 days)
NEXLIZET 180-10 MG TABLET MO	2	PA,QL(30 per 30 days)
nitroglycerin 0.4 mg SUBLINGUAL TABLET MO	1	
olmesartan 40 mg TABLET MO	1	QL(30 per 30 days)
pravastatin 10 mg, 20 mg, 40 mg, 80 mg TABLET MO	1	
REPATHA PUSHTRONEX 420 MG/3.5 ML WEARABLE INJECTOR MO	2	PA,QL(3.5 per 28 days)
REPATHA SURECLICK 140 MG/ML PEN INJECTOR MO	2	PA,QL(3 per 28 days)
REPATHA SYRINGE 140 MG/ML SYRINGE MO	2	PA,QL(3 per 28 days)
rosuvastatin 10 mg, 20 mg, 40 mg, 5 mg TABLET MO	1	
simvastatin 10 mg, 20 mg, 40 mg TABLET MO	1	
spironolactone 25 mg, 50 mg TABLET MO	1	
toremide 20 mg TABLET MO	1	
triamterene-hydrochlorothiazid 37.5-25 mg TABLET MO	1	
valsartan 160 mg TABLET MO	1	QL(60 per 30 days)
VASCEPA 0.5 GRAM CAPSULE MO	2	QL(240 per 30 days)
VASCEPA 1 GRAM CAPSULE MO	2	QL(120 per 30 days)
ZYPITAMAG 2 MG, 4 MG TABLET MO	2	ST,QL(30 per 30 days)
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 KIT DL	4	PA,QL(15 per 30 days)
COPAXONE 20 MG/ML SYRINGE DL	4	PA,QL(30 per 30 days)
GILENYA 0.5 MG CAPSULE DL	4	PA,QL(30 per 30 days)
KESIMPTA PEN 20 MG/0.4 ML PEN INJECTOR DL	4	PA,QL(1.2 per 28 days)
pregabalin 100 mg, 150 mg, 50 mg, 75 mg CAPSULE MO	1	QL(90 per 30 days)
SAVELLA 100 MG, 12.5 MG, 25 MG, 50 MG TABLET MO	2	QL(60 per 30 days)
SAVELLA 12.5 MG (5)-25 MG(8)-50 MG(42) TABLET, DOSE PACK MO	2	QL(55 per 28 days)
VUMERITY 231 MG CAPSULE, DR/EC DL	4	PA,QL(120 per 30 days)
Dental & Oral Agents		
chlorhexidine gluconate 0.12 % MOUTHWASH MO	1	
triamcinolone acetonide 0.1 % PASTE MO	1	
Dermatological Agents		
ENSTILAR 0.005-0.064 % FOAM MO	3	QL(120 per 30 days)
erythromycin with ethanol 2 % SOLUTION MO	1	QL(120 per 30 days)

Need more information about the indicators displayed by the drug names? Please go to page 9. Need more information about the utilization management requirements? Please go to page 5.

B vs D - Part B vs Part D • MO – Mail Order • PA - Prior Authorization • QL - Quantity Limit • ST - Step Therapy
• DL – Dispensing Limit • LA – Limited Access

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
<i>mupirocin 2 % OINTMENT</i> MO	1	
OTEZLA 30 MG TABLET DL	4	PA,QL(60 per 30 days)
OTEZLA STARTER 10 MG (4)-20 MG (4)-30 MG (47) TABLET, DOSE PACK DL	4	PA,QL(55 per 28 days)
REGRANEX 0.01 % GEL DL	4	PA
Electrolytes/minerals/metals/vitamins		
<i>calcium acetate(phosphat bind) 667 mg CAPSULE</i> MO	1	
ISOLYTE S PH 7.4 PARENTERAL SOLUTION MO	3	
PLASMA-LYTE 148 PARENTERAL SOLUTION MO	3	
PLASMA-LYTE A PARENTERAL SOLUTION MO	3	
<i>potassium chloride 10 meq CAPSULE, ER</i> MO	1	
<i>potassium chloride 10 meq, 20 meq TABLET ER</i> MO	1	
<i>potassium chloride 10 meq, 20 meq TABLET, ER PARTICLES/CRYSTALS</i> MO	1	
VELPHORO 500 MG CHEWABLE TABLET DL	4	ST
VELTASSA 16.8 GRAM, 25.2 GRAM, 8.4 GRAM POWDER IN PACKET MO	2	QL(30 per 30 days)
Gastrointestinal Agents		
CLENPIQ 10 MG-3.5 GRAM -12 GRAM/160 ML SOLUTION MO	2	
<i>dicyclomine 10 mg CAPSULE</i> MO	1	
<i>dicyclomine 20 mg TABLET</i> MO	1	
<i>esomeprazole magnesium 40 mg CAPSULE, DR/EC</i> MO	1	QL(60 per 30 days)
<i>famotidine 20 mg, 40 mg TABLET</i> MO	1	
<i>lactulose 10 gram/15 ml SOLUTION</i> MO	1	
LINZESS 145 MCG, 290 MCG, 72 MCG CAPSULE MO	2	QL(30 per 30 days)
<i>misoprostol 200 mcg TABLET</i> MO	1	
MOVANTIK 12.5 MG, 25 MG TABLET MO	2	QL(30 per 30 days)
<i>omeprazole 20 mg, 40 mg CAPSULE, DR/EC</i> MO	1	QL(60 per 30 days)
<i>pantoprazole 20 mg, 40 mg TABLET, DR/EC</i> MO	1	QL(60 per 30 days)
PYLERA 140-125-125 MG CAPSULE MO	3	QL(120 per 30 days)
<i>sucralfate 1 gram TABLET</i> MO	1	
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
CREON 24,000-76,000 -120,000 UNIT CAPSULE, DR/EC MO	2	
PROLASTIN-C 1,000 MG RECON SOLUTION DL	4	PA
ZENPEP 25,000-79,000- 105,000 UNIT CAPSULE, DR/EC MO	3	

Need more information about the indicators displayed by the drug names? Please go to page 9. Need more information about the utilization management requirements? Please go to page 5.

B vs D - Part B vs Part D • MO – Mail Order • PA - Prior Authorization • QL - Quantity Limit • ST - Step Therapy
• DL – Dispensing Limit • LA – Limited Access

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
Genitourinary Agents		
finasteride 5 mg TABLET MO	1	QL(30 per 30 days)
GEMTESA 75 MG TABLET MO	3	QL(30 per 30 days)
MYRBETRIQ 25 MG, 50 MG TABLET, ER 24 HR. MO	2	QL(30 per 30 days)
MYRBETRIQ 8 MG/ML SUSPENSION, ER, RECON MO	2	QL(300 per 30 days)
oxybutynin chloride 10 mg, 5 mg TABLET, ER 24 HR. MO	1	QL(60 per 30 days)
oxybutynin chloride 5 mg TABLET MO	1	
tamsulosin 0.4 mg CAPSULE MO	1	
Hormonal Agents, Stimulant/replacement/modifying (adrenal)		
ACTHAR 80 UNIT/ML GEL DL	4	PA,QL(30 per 30 days)
methylprednisolone 4 mg TABLET, DOSE PACK MO	1	
prednisone 10 mg, 20 mg, 5 mg TABLET MO	1	BvsD
triamcinolone acetonide 0.1 % CREAM MO	1	
Hormonal Agents, Stimulant/replacement/modifying (pituitary)		
OMNITROPE 10 MG/1.5 ML (6.7 MG/ML), 5 MG/1.5 ML (3.3 MG/ML) CARTRIDGE DL	4	PA
OMNITROPE 5.8 MG RECON SOLUTION DL	4	PA
Hormonal Agents, Stimulant/replacement/modifying (sex Hormones/modifiers)		
DUAVEE 0.45-20 MG TABLET MO	3	PA,QL(30 per 30 days)
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 CREAM MO	2	
Hormonal Agents, Stimulant/replacement/modifying (thyroid)		
levothyroxine 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 25 mcg, 50 mcg, 75 mcg, 88 mcg TABLET MO	1	
liothyronine 25 mcg, 5 mcg, 50 mcg TABLET MO	1	
Hormonal Agents, Suppressant (pituitary)		
LUPRON DEPOT-PED 11.25 MG KIT DL	4	PA,QL(1 per 28 days)
ORGOVYX 120 MG TABLET DL	4	PA,QL(32 per 30 days)
Immunological Agents		
COSENTYX 75 MG/0.5 ML SYRINGE DL	4	PA,QL(2 per 28 days)
COSENTYX (2 SYRINGES) 150 MG/ML SYRINGE DL	4	PA,QL(8 per 28 days)
COSENTYX PEN (2 PENS) 150 MG/ML PEN INJECTOR DL	4	PA,QL(8 per 28 days)
DUPIXENT PEN 200 MG/1.14 ML PEN INJECTOR DL	4	PA,QL(3.42 per 28 days)
DUPIXENT PEN 300 MG/2 ML PEN INJECTOR DL	4	PA,QL(8 per 28 days)
DUPIXENT SYRINGE 100 MG/0.67 ML SYRINGE DL	4	PA,QL(1.34 per 28 days)

Need more information about the indicators displayed by the drug names? Please go to page 9. Need more information about the utilization management requirements? Please go to page 5.

B vs D - Part B vs Part D • MO – Mail Order • PA - Prior Authorization • QL - Quantity Limit • ST - Step Therapy
• DL – Dispensing Limit • LA – Limited Access

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
DUPIXENT SYRINGE 200 MG/1.14 ML SYRINGE DL	4	PA,QL(3.42 per 28 days)
DUPIXENT SYRINGE 300 MG/2 ML SYRINGE DL	4	PA,QL(8 per 28 days)
ENBREL 25 MG (1 ML) RECON SOLUTION DL	4	PA,QL(8 per 28 days)
ENBREL 25 MG/0.5 ML (0.5), 50 MG/ML (1 ML) SYRINGE DL	4	PA,QL(8 per 28 days)
ENBREL 25 MG/0.5 ML SOLUTION DL	4	PA,QL(8 per 28 days)
ENBREL MINI 50 MG/ML (1 ML) CARTRIDGE DL	4	PA,QL(8 per 28 days)
ENBREL SURECLICK 50 MG/ML (1 ML) PEN INJECTOR DL	4	PA,QL(8 per 28 days)
ENVARUSUS XR 0.75 MG, 1 MG TABLET, ER 24 HR. MO	3	PA
GAMUNEX-C 1 GRAM/10 ML (10 %) SOLUTION DL	4	PA
HUMIRA 40 MG/0.8 ML SYRINGE KIT DL	4	PA,QL(6 per 28 days)
HUMIRA PEN 40 MG/0.8 ML PEN INJECTOR KIT DL	4	PA,QL(6 per 28 days)
HUMIRA PEN CROHNS-UC-HS START 40 MG/0.8 ML PEN INJECTOR KIT DL	4	PA,QL(6 per 28 days)
HUMIRA PEN PSOR-UVEITS-ADOL HS 40 MG/0.8 ML PEN INJECTOR KIT DL	4	PA,QL(6 per 28 days)
HUMIRA(CF) 10 MG/0.1 ML SYRINGE KIT DL	4	PA,QL(2 per 28 days)
HUMIRA(CF) 20 MG/0.2 ML, 40 MG/0.4 ML SYRINGE KIT DL	4	PA,QL(6 per 28 days)
HUMIRA(CF) PEDI CROHNS STARTER 80 MG/0.8 ML, 80 MG/0.8 ML-40 MG/0.4 ML SYRINGE KIT DL	4	PA,QL(6 per 28 days)
HUMIRA(CF) PEN 40 MG/0.4 ML, 80 MG/0.8 ML PEN INJECTOR KIT DL	4	PA,QL(6 per 28 days)
HUMIRA(CF) PEN CROHNS-UC-HS 80 MG/0.8 ML PEN INJECTOR KIT DL	4	PA,QL(6 per 28 days)
HUMIRA(CF) PEN PEDIATRIC UC 80 MG/0.8 ML PEN INJECTOR KIT DL	4	PA,QL(6 per 28 days)
HUMIRA(CF) PEN PSOR-UV-ADOL HS 80 MG/0.8 ML-40 MG/0.4 ML PEN INJECTOR KIT DL	4	PA,QL(6 per 28 days)
KEVZARA 150 MG/1.14 ML, 200 MG/1.14 ML PEN INJECTOR DL	4	PA,QL(2.28 per 28 days)
KEVZARA 150 MG/1.14 ML, 200 MG/1.14 ML SYRINGE DL	4	PA,QL(2.28 per 28 days)
<i>methotrexate sodium</i> 2.5 mg TABLET MO	1	BvsD
RINVOQ 15 MG, 30 MG TABLET, ER 24 HR. DL	4	PA,QL(30 per 30 days)
RINVOQ 45 MG TABLET, ER 24 HR. DL	4	PA,QL(56 per 365 days)
SHINGRIX (PF) 50 MCG/0.5 ML SUSPENSION FOR RECONSTITUTION DL	1	
SKYRIZI 150 MG/ML PEN INJECTOR	4	PA,QL(6 per 365 days)
SKYRIZI 150 MG/ML SYRINGE	4	PA,QL(6 per 365 days)
SKYRIZI 150MG/1.66ML(75 MG/0.83 ML X2) SYRINGE KIT	4	PA,QL(6 per 365 days)
STELARA 45 MG/0.5 ML SOLUTION DL	4	PA,QL(1.5 per 84 days)
STELARA 45 MG/0.5 ML SYRINGE DL	4	PA,QL(1.5 per 84 days)
STELARA 90 MG/ML SYRINGE DL	4	PA,QL(3 per 84 days)
TDVAX 2-2 LF UNIT/0.5 ML SUSPENSION DL	1	

Need more information about the indicators displayed by the drug names? Please go to page 9. Need more information about the utilization management requirements? Please go to page 5.

B vs D - Part B vs Part D • MO – Mail Order • PA - Prior Authorization • QL - Quantity Limit • ST - Step Therapy
• DL – Dispensing Limit • LA – Limited Access

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
Metabolic Bone Disease Agents		
alendronate 70 mg TABLET MO	1	QL(4 per 28 days)
FORTEO 20 MCG/DOSE (600MCG/2.4ML) PEN INJECTOR DL	4	PA,QL(2.4 per 28 days)
PROLIA 60 MG/ML SYRINGE MO	3	QL(1 per 180 days)
RAYALDEE 30 MCG CAPSULE, ER 24 HR. DL	4	QL(60 per 30 days)
TYMLOS 80 MCG (3,120 MCG/1.56 ML) PEN INJECTOR DL	4	PA,QL(1.56 per 30 days)
Miscellaneous Therapeutic Agents		
BD ALCOHOL SWABS PADS, MEDICATED MO	1	
butalbital-acetaminophen-caff 50-325-40 mg TABLET MO	1	QL(180 per 30 days)
RECTIV 0.4 % (W/W) OINTMENT MO	3	QL(30 per 30 days)
Ophthalmic Agents		
ALPHAGAN P 0.1 % DROPS MO	2	
azelastine 0.05 % DROPS MO	1	
brimonidine 0.2 % DROPS MO	1	
COMBIGAN 0.2-0.5 % DROPS MO	2	QL(5 per 25 days)
dorzolamide-timolol 22.3-6.8 mg/ml DROPS MO	1	
DUREZOL 0.05 % DROPS MO	2	
erythromycin 5 mg/gram (0.5 %) OINTMENT MO	1	QL(3.5 per 28 days)
EYSUVIS 0.25 % DROPS, SUSPENSION MO	2	QL(16.6 per 30 days)
ILEVRO 0.3 % DROPS, SUSPENSION MO	2	QL(3 per 30 days)
ketorolac 0.5 % DROPS MO	1	QL(10 per 30 days)
latanoprost 0.005 % DROPS MO	1	QL(5 per 25 days)
levobunolol 0.5 % DROPS MO	1	
LOTEMAX 0.5 % DROPS, GEL MO	3	ST
LOTEMAX 0.5 % OINTMENT MO	3	ST
LOTEMAX SM 0.38 % DROPS, GEL MO	3	
LUMIGAN 0.01 % DROPS MO	2	QL(2.5 per 25 days)
moxifloxacin 0.5 % DROPS MO	1	
prednisolone acetate 1 % DROPS, SUSPENSION MO	1	
RESTASIS 0.05 % DROPPERETTE MO	2	QL(60 per 30 days)
RESTASIS MULTIDOSE 0.05 % DROPS MO	2	QL(5.5 per 25 days)
RHOPRESSA 0.02 % DROPS MO	2	ST,QL(2.5 per 25 days)
ROCKLATAN 0.02-0.005 % DROPS MO	2	ST,QL(2.5 per 25 days)
timolol maleate 0.5 % DROPS MO	1	
VYZULTA 0.024 % DROPS MO	3	QL(5 per 30 days)
ZERVIAE 0.24 % DROPPERETTE MO	3	QL(60 per 30 days)

Need more information about the indicators displayed by the drug names? Please go to page 9. Need more information about the utilization management requirements? Please go to page 5.

B vs D - Part B vs Part D • MO – Mail Order • PA - Prior Authorization • QL - Quantity Limit • ST - Step Therapy
• DL – Dispensing Limit • LA – Limited Access

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
Respiratory Tract/pulmonary Agents		
ADEMPAS 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG TABLET DL,LA	4	PA,QL(90 per 30 days)
ADVAIR DISKUS 100-50 MCG/DOSE, 250-50 MCG/DOSE, 500-50 MCG/DOSE BLISTER WITH DEVICE MO	2	QL(60 per 30 days)
ADVAIR HFA 115-21 MCG/ACTUATION, 230-21 MCG/ACTUATION, 45-21 MCG/ACTUATION HFA AEROSOL INHALER MO	2	QL(12 per 30 days)
<i>albuterol sulfate</i> 90 mcg/actuation HFA AEROSOL INHALER MO	1	QL(36 per 30 days)
ARNUITY ELLIPTA 100 MCG/ACTUATION, 200 MCG/ACTUATION, 50 MCG/ACTUATION BLISTER WITH DEVICE MO	2	QL(30 per 30 days)
<i>azelastine</i> 137 mcg (0.1 %) AEROSOL SPRAY MO	1	QL(30 per 25 days)
BEVESPI AEROSPHERE 9-4.8 MCG HFA AEROSOL INHALER MO	3	QL(10.7 per 30 days)
BREO ELLIPTA 100-25 MCG/DOSE, 200-25 MCG/DOSE BLISTER WITH DEVICE MO	2	QL(60 per 30 days)
BREZTRI AEROSPHERE 160-9-4.8 MCG/ACTUATION HFA AEROSOL INHALER MO	2	QL(10.7 per 30 days)
COMBIVENT RESPIMAT 20-100 MCG/ACTUATION MIST MO	3	QL(4 per 20 days)
FASENRA 30 MG/ML SYRINGE DL	4	PA,QL(1 per 28 days)
FASENRA PEN 30 MG/ML AUTO-INJECTOR DL	4	PA,QL(1 per 28 days)
FLOVENT DISKUS 250 MCG/ACTUATION, 50 MCG/ACTUATION BLISTER WITH DEVICE MO	2	QL(60 per 30 days)
FLOVENT HFA 220 MCG/ACTUATION HFA AEROSOL INHALER MO	2	QL(24 per 30 days)
FLOVENT HFA 44 MCG/ACTUATION HFA AEROSOL INHALER MO	2	QL(10.6 per 30 days)
<i>fluticasone propion-salmeterol</i> 250-50 mcg/dose BLISTER WITH DEVICE MO	1	QL(60 per 30 days)
<i>fluticasone propionate</i> 50 mcg/actuation SPRAY, SUSPENSION MO	1	QL(16 per 30 days)
<i>hydroxyzine pamoate</i> 25 mg CAPSULE MO	1	
<i>levocetirizine</i> 5 mg TABLET MO	1	QL(30 per 30 days)
<i>montelukast</i> 10 mg TABLET MO	1	QL(30 per 30 days)
NUCALA 100 MG RECON SOLUTION DL	4	PA,QL(3 per 28 days)
NUCALA 100 MG/ML AUTO-INJECTOR DL	4	PA,QL(3 per 28 days)
NUCALA 100 MG/ML SYRINGE DL	4	PA,QL(3 per 28 days)
OFEV 100 MG, 150 MG CAPSULE DL,LA	4	PA,QL(60 per 30 days)
OPSUMIT 10 MG TABLET DL,LA	4	PA,QL(30 per 30 days)
SPIRIVA RESPIMAT 1.25 MCG/ACTUATION, 2.5 MCG/ACTUATION MIST MO	2	QL(4 per 28 days)
SPIRIVA WITH HANDIHALER 18 MCG CAPSULE, W/INHALATION DEVICE MO	2	QL(30 per 30 days)
STIOLTO RESPIMAT 2.5-2.5 MCG/ACTUATION MIST MO	2	QL(4 per 28 days)
STRIVERDI RESPIMAT 2.5 MCG/ACTUATION MIST MO	2	QL(4 per 30 days)

Need more information about the indicators displayed by the drug names? Please go to page 9. Need more information about the utilization management requirements? Please go to page 5.

B vs D - Part B vs Part D • MO – Mail Order • PA - Prior Authorization • QL - Quantity Limit • ST - Step Therapy
• DL – Dispensing Limit • LA – Limited Access

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
SYMBICORT 160-4.5 MCG/ACTUATION, 80-4.5 MCG/ACTUATION HFA AEROSOL INHALER MO	2	QL(10.2 per 30 days)
TRELEGY ELLIPTA 100-62.5-25 MCG, 200-62.5-25 MCG BLISTER WITH DEVICE MO	2	QL(60 per 30 days)
VENTOLIN HFA 90 MCG/ACTUATION HFA AEROSOL INHALER MO	2	QL(36 per 30 days)
zafirlukast 20 mg TABLET MO	1	QL(60 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, 30 mg CAPSULE DL	1	QL(30 per 30 days)
zolpidem 10 mg, 5 mg TABLET MO	1	QL(30 per 30 days)

Need more information about the indicators displayed by the drug names? Please go to page 9. Need more information about the utilization management requirements? Please go to page 5.

B vs D - Part B vs Part D • MO – Mail Order • PA - Prior Authorization • QL - Quantity Limit • ST - Step Therapy
• DL – Dispensing Limit • LA – Limited Access

Humana Medicare Employer Plan Coverage of Additional Prescription Drugs		
DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
Cosmetics - Mail Order Available		
<i>bimatoprost 0.03 % DROPS</i>	1	
<i>blanche 4 % CREAM</i>	1	
<i>finasteride 1 mg TABLET</i>	1	
<i>hydroquinone 4 % CREAM</i>	1	
LATISSE 0.03 % DROPS	3	
<i>obagi elastiderm 4 % CREAM</i>	1	
<i>obagi nu-derm blender 4 % CREAM</i>	1	
<i>obagi nu-derm clear 4 % CREAM</i>	1	
PROPECIA 1 MG TABLET	3	
<i>refissa 0.05 % CREAM</i>	1	
RENOVA 0.02 % CREAM	3	
<i>tretinoin (emollient) 0.05 % CREAM</i>	1	
TRI-LUMA 0.01-4-0.05 % CREAM	3	
VANIQA 13.9 % CREAM	3	
Cough/Cold - Mail Order Available		
<i>benzonatate 100 mg, 150 mg, 200 mg CAPSULE</i>	1	
<i>bromfed dm 2-30-10 mg/5 ml SYRUP</i>	1	
<i>brompheniramine-pseudoeph-dm 2-30-10 mg/5 ml SYRUP</i>	1	
HYCODAN 5-1.5 MG/5 ML (5 ML) SYRUP	1	
HYCODAN (WITH HOMATROPINE) 5-1.5 MG TABLET	1	
HYCODAN (WITH HOMATROPINE) 5-1.5 MG/5 ML SYRUP	1	
<i>hydrocodone-chlorpheniramine 10-8 mg/5 ml SUSPENSION, ER 12 HR.</i>	1	
<i>hydrocodone-homatropine 5-1.5 mg TABLET</i>	1	
<i>hydrocodone-homatropine 5-1.5 mg/5 ml, 5-1.5 mg/5 ml (5 ml) SYRUP</i>	1	
<i>hydromet 5-1.5 mg/5 ml SYRUP</i>	1	

Your Humana Medicare Employer plan has additional coverage of some drugs. These drugs are not normally covered under Medicare Part D. These drugs are not subject to the Medicare appeals process. The amount you pay when you fill a prescription for these drugs does not count toward your total drug costs (in other words, the amount you pay does not help you qualify for catastrophic coverage).

B vs D - Part B vs Part D • MO – Mail Order • PA - Prior Authorization • QL - Quantity Limit • ST - Step Therapy
 • DL – Dispensing Limit • LA – Limited Access

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
Cough/Cold - Mail Order Available		
OBREDON 2.5-200 MG/5 ML SOLUTION	3	
<i>promethazine vc-codeine 6.25-5-10 mg/5 ml SYRUP</i>	1	
<i>promethazine-codeine 6.25-10 mg/5 ml SYRUP</i>	1	
<i>promethazine-dm 6.25-15 mg/5 ml SYRUP</i>	1	
<i>promethazine-phenyleph-codeine 6.25-5-10 mg/5 ml SYRUP</i>	1	
RESPA-AR 8-90-0.24 MG TABLET, ER 12 HR.	3	
TESSALON PERLES 100 MG CAPSULE	3	
TUSSICAPS 10-8 MG CAPSULE, ER 12 HR.	1	
TUXARIN ER 8-54.3 MG TABLET, ER 12 HR.	3	
TUZISTRA XR 14.7-2.8 MG/5 ML SUSPENSION, ER 12 HR.	3	
Fertility - Mail Order Available		
<i>cetrorelix 0.25 mg KIT</i>	1	
CETROTIDE 0.25 MG KIT	3	
<i>clomid 50 mg TABLET</i>	1	
<i>clomiphene citrate 50 mg TABLET</i>	1	
FOLLISTIM AQ 300 UNIT/0.36 ML, 600 UNIT/0.72 ML, 900 UNIT/1.08 ML CARTRIDGE	3	
<i>fyremadel 250 mcg/0.5 ml SYRINGE</i>	1	
GANIRELIX 250 MCG/0.5 ML SYRINGE	3	
<i>ganirelix 250 mcg/0.5 ml SYRINGE</i>	3	
GONAL-F 1,050 UNIT, 450 UNIT RECON SOLUTION	3	
GONAL-F RFF 75 UNIT RECON SOLUTION	3	
GONAL-F RFF REDI-JECT 300/0.5 UNIT/ML, 450/0.75 UNIT/ML, 900/1.5 UNIT/ML PEN INJECTOR	3	
MENOPUR 75 UNIT RECON SOLUTION	3	
OVIDREL 250 MCG/0.5 ML SYRINGE	3	

Your Humana Medicare Employer plan has additional coverage of some drugs. These drugs are not normally covered under Medicare Part D. These drugs are not subject to the Medicare appeals process. The amount you pay when you fill a prescription for these drugs does not count toward your total drug costs (in other words, the amount you pay does not help you qualify for catastrophic coverage).

B vs D - Part B vs Part D • MO – Mail Order • PA - Prior Authorization • QL - Quantity Limit • ST - Step Therapy
• DL – Dispensing Limit • LA – Limited Access

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
Vitamins/Minerals - Mail Order Available		
ascorbic acid (vitamin c) 500 mg/ml SOLUTION	1	
b complex 100 100-2-100-2-2 mg/ml SOLUTION	1	
b-complex injection 100-2-100-2-2 mg/ml SOLUTION	1	
cyanocobalamin (vitamin b-12) 1,000 mcg/ml SOLUTION	1	
dodex 1,000 mcg/ml SOLUTION	1	
DRISDOL 1,250 MCG (50,000 UNIT) CAPSULE	3	
ergocalciferol (vitamin d2) 1,250 mcg (50,000 unit) CAPSULE	1	
folic acid 1 mg TABLET	1	
folic acid 5 mg/ml SOLUTION	1	
hydroxocobalamin 1,000 mcg/ml SOLUTION	1	
INFUVITE ADULT 3,300 UNIT- 150 MCG/10 ML SOLUTION	3	
INFUVITE PEDIATRIC 80 MG-400 UNIT- 200 MCG/5 ML SOLUTION	3	
M.V.I. ADULT 3,300 UNIT- 150 MCG/10 ML SOLUTION	3	
M.V.I. PEDIATRIC 80-400-200 MG-UNIT-MCG RECON SOLUTION	3	
M.V.I.-12 (WITHOUT VITAMIN K) 3,300 UNIT-200 UNIT/10 ML SOLUTION	3	
MEPHYTON 5 MG TABLET	3	
NASCOBAL 500 MCG/SPRAY SPRAY, NON-AEROSOL	3	
phytonadione (vitamin k1) 1 mg/0.5 ml SYRINGE	1	
phytonadione (vitamin k1) 1 mg/0.5 ml, 10 mg/ml SOLUTION	1	
phytonadione (vitamin k1) 5 mg TABLET	1	
POTABA 500 MG CAPSULE	3	
pyridoxine (vitamin b6) 100 mg/ml SOLUTION	1	
thiamine hcl (vitamin b1) 100 mg/ml SOLUTION	1	
vitamin d2 1,250 mcg (50,000 unit) CAPSULE	1	
vitamin k 1 mg/0.5 ml SOLUTION	1	

Your Humana Medicare Employer plan has additional coverage of some drugs. These drugs are not normally covered under Medicare Part D. These drugs are not subject to the Medicare appeals process. The amount you pay when you fill a prescription for these drugs does not count toward your total drug costs (in other words, the amount you pay does not help you qualify for catastrophic coverage).

B vs D - Part B vs Part D • MO – Mail Order • PA - Prior Authorization • QL - Quantity Limit • ST - Step Therapy
• DL – Dispensing Limit • LA – Limited Access

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
Vitamins/Minerals - Mail Order Available		
vitamin k1 10 mg/ml SOLUTION	1	
zingiber 1.2 mg-40 mg- 124.1 mg-100 mg TABLET	1	
Weight Loss - Mail Order Available		
adipex-p 37.5 mg CAPSULE	1	
ADIPEX-P 37.5 MG TABLET	1	
benzphetamine 50 mg TABLET	1	
CONTRAVE 8-90 MG TABLET ER	3	QL(120 per 30 days)
diethylpropion 25 mg TABLET	1	
diethylpropion 75 mg TABLET ER	1	
lomaira 8 mg TABLET	1	
phendimetrazine tartrate 105 mg CAPSULE, ER	3	
phendimetrazine tartrate 35 mg TABLET	1	
phentermine 15 mg, 30 mg, 37.5 mg CAPSULE	1	
phentermine 37.5 mg TABLET	1	
PLENITY 0.75 GRAM CAPSULE	3	
PLENITY (WELCOME KIT) 0.75 GRAM CAPSULE	3	
QSYMIA 11.25-69 MG, 15-92 MG, 3.75-23 MG, 7.5-46 MG CAPSULE ER MULTIPHASE 24 HR.	3	QL(30 per 30 days)
SAXENDA 3 MG/0.5 ML (18 MG/3 ML) PEN INJECTOR	3	
WEGOVY 0.25 MG/0.5 ML, 0.5 MG/0.5 ML, 1 MG/0.5 ML, 1.7 MG/0.75 ML, 2.4 MG/0.75 ML PEN INJECTOR	3	

Your Humana Medicare Employer plan has additional coverage of some drugs. These drugs are not normally covered under Medicare Part D. These drugs are not subject to the Medicare appeals process. The amount you pay when you fill a prescription for these drugs does not count toward your total drug costs (in other words, the amount you pay does not help you qualify for catastrophic coverage).

B vs D - Part B vs Part D • MO – Mail Order • PA - Prior Authorization • QL - Quantity Limit • ST - Step Therapy
• DL – Dispensing Limit • LA – Limited Access

Index

A

ABILIFY MAINTENA... 13
 ABILIFY MYCITE MAINTENANCE KIT... 13
 ABILIFY MYCITE STARTER KIT... 13
 ABILIFY MYCITE... 13
 ABILIFY... 13
 acamprosate... 10
 acetaminophen-codeine... 10
 ACTHAR... 21
 acyclovir... 14
 ADEMPAS... 24
 adipex-p... 29
 ADVAIR DISKUS... 24
 ADVAIR HFA... 24
 AIMOVIG AUTOINJECTOR... 12
 albuterol sulfate... 24
 ALECENSA... 13
 alendronate... 23
 allopurinol... 12
 ALPHAGAN P... 23
 alprazolam... 15
 ALUNBRIG... 13
 amiodarone... 18
 amitriptyline... 11
 amlodipine... 18
 amoxicillin... 10
 amoxicillin-pot clavulanate... 10
 anastrozole... 13
 ARISTADA INITIO... 14
 ARISTADA... 13, 14

ARNUITY ELLIPTA... 24
 ascorbic acid (vitamin c)... 28
 atenolol... 18
 atorvastatin... 18
 AUSTEDO... 19
 azelastine... 23, 24
 azithromycin... 10

B

b complex 100... 28
 b-complex injection... 28
 baclofen... 14
 BAQSIMI... 15
 BD ALCOHOL SWABS... 23
 BELBUCA... 10
 BELSOMRA... 25
 benzonatate... 26
 benzphetamine... 29
 BETASERON... 19
 BEVESPI AEROSPHERE... 24
 bimatoprost... 26
 blanche... 26
 BREO ELLIPTA... 24
 BREZTRI AEROSPHERE... 24
 BRILINTA... 17
 brimonidine... 23
 bromfed dm... 26
 brompheniramine-pseudoeph-dm... 26
 bumetanide... 18
 bupropion hcl... 11
 buspirone... 15

butalbital-acetaminophen-caff... 23
 BYDUREON BCISE... 15

C

CABOMETYX... 13
 calcium acetate(phosphat bind)... 20
 carbidopa-levodopa... 13
 carvedilol... 18
 cefdinir... 10
 celecoxib... 10
 cephalexin... 10
 CERDELGA... 20
 cetorelix... 27
 CETROTIDE... 27
 chlorhexidine gluconate... 19
 chlorthalidone... 18
 ciprofloxacin hcl... 10
 citalopram... 11
 clarithromycin... 10
 CLENPIQ... 20
 clindamycin hcl... 10
 clomid... 27
 clomiphene citrate... 27
 clonazepam... 15
 clonidine hcl... 18
 clopidogrel... 17
 clotrimazole-betamethasone... 12
 COMBIGAN... 23
 COMBIVENT RESPIMAT... 24
 CONTRAVE... 29
 COPAXONE... 19

CORLANOR... 18	ENBREL SURECLICK... 22	fluticasone propion-salmeterol... 24
COSENTYX (2 SYRINGES)... 21	ENBREL... 22	fluticasone propionate... 24
COSENTYX PEN (2 PENS)... 21	ENSTILAR... 19	folic acid... 28
COSENTYX... 21	ENTRESTO... 18	FOLLISTIM AQ... 27
CREON... 20	ENVARUS XR... 22	FORTEO... 23
cyanocobalamin (vitamin b-12)... 28	EPCLUSA... 14	furosemide... 18
cyclobenzaprine... 25	EPIDIOLEX... 11	fyremadel... 27
D	ergocalciferol (vitamin d2)... 28	G
dantrolene... 14	ERIVEDGE... 13	gabapentin... 11
DESCOVY... 14	ERLEADA... 13	GAMUNEX-C... 22
diazepam... 15	erythromycin with ethanol... 19	GANIRELIX... 27
diclofenac sodium... 10	erythromycin... 23	GEMTESA... 21
dicyclomine... 20	escitalopram oxalate... 12	GENVOYA... 14
diethylpropion... 29	esomeprazole magnesium... 20	GILENYA... 19
digoxin... 18	exemestane... 13	glimepiride... 15
diltiazem hcl... 18	EYSUVIS... 23	glipizide... 15
dodex... 28	ezetimibe... 18	GLYXAMBI... 15
donepezil... 11	F	GONAL-F RFF REDI-JECT... 27
dorzolamide-timolol... 23	famotidine... 20	GONAL-F RFF... 27
doxycycline hyclate... 10, 11	FARXIGA... 15	GONAL-F... 27
DRISDOL... 28	FASENRA PEN... 24	guanfacine... 18
DUAVEE... 21	FASENRA... 24	GVOKE HYPOPEN 2-PACK... 15
duloxetine... 11	fenofibrate nanocrystallized... 18	GVOKE PFS 1-PACK SYRINGE... 15
DUPIXENT PEN... 21	fenofibrate... 18	GVOKE... 15
DUPIXENT SYRINGE... 21, 22	FIASP FLEXTOUCH U-100 INSULIN... 15	H
DUREZOL... 23	FIASP PENFILL U-100 INSULIN... 15	HARVONI... 14, 15
E	FIASP U-100 INSULIN... 15	HUMIRA PEN CROHNS-UC-HS START... 22
ELIQUIS DVT-PE TREAT 30D START... 17	finasteride... 21, 26	HUMIRA PEN PSOR-UEVITS-ADOL HS... 22
ELIQUIS... 17	FLOVENT DISKUS... 24	HUMIRA PEN... 22
EMGALITY PEN... 12	FLOVENT HFA... 24	HUMIRA... 22
EMGALITY SYRINGE... 12	fluconazole... 12	HUMIRA(CF) PEDI CROHNS STARTER... 22
ENBREL MINI... 22	fluoxetine... 12	

HUMIRA(CF) PEN CROHNS-UC-HS... 22
 HUMIRA(CF) PEN PEDIATRIC UC... 22
 HUMIRA(CF) PEN PSOR-UV-ADOL HS... 22
 HUMIRA(CF) PEN... 22
 HUMIRA(CF)... 22
 HYCODAN (WITH HOMATROPINE)... 26
 HYCODAN... 26
 hydralazine... 18
 hydrochlorothiazide... 18
 hydrocodone-acetaminophen... 10
 hydrocodone-chlorpheniramine... 26
 hydrocodone-homatropine... 26
 hydromet... 26
 hydroquinone... 26
 hydroxocobalamin... 28
 hydroxychloroquine... 13
 hydroxyzine hcl... 15
 hydroxyzine pamoate... 24

I

IBRANCE... 13
 ibuprofen... 10
 ILEVRO... 23
 IMBRUVICA... 13
 imipramine hcl... 12
 INFUVITE ADULT... 28
 INFUVITE PEDIATRIC... 28
 INSULIN ASP PRT-INSULIN ASPART... 15
 INSULIN ASPART U-100... 15
 INVEGA HAFYERA... 14
 INVEGA SUSTENNA... 14

INVEGA TRINZA... 14
 INVEGA... 14
 INVOKAMET XR... 16
 INVOKAMET... 16
 INVOKANA... 16
 irbesartan... 18
 ISENTRESS HD... 15
 ISOLYTE S PH 7.4... 20
 isosorbide mononitrate... 18

J

JANUMET XR... 16
 JANUMET... 16
 JANUVIA... 16
 JARDIANCE... 16
 JENTADUETO XR... 16
 JENTADUETO... 16

K

KESIMPTA PEN... 19
 ketoconazole... 12
 ketoprofen... 10
 ketorolac... 23
 KEVZARA... 22
 KOMBIGLYZE XR... 16
 KYNMOBI... 13

L

lactulose... 20
 lamotrigine... 11
 LANTUS SOLOSTAR U-100 INSULIN... 16
 LANTUS U-100 INSULIN... 16
 latanoprost... 23
 LATISSE... 26
 ledipasvir-sofosbuvir... 15

LEVEMIR FLEXTOUCH U-100 INSULN... 16
 LEVEMIR U-100 INSULIN... 16
 levetiracetam... 11
 levobunolol... 23
 levocetirizine... 24
 levofloxacin... 11
 levothyroxine... 21
 LINZESS... 20
 liothyronine... 21
 lisinopril... 18
 lisinopril-hydrochlorothiazide... 18
 lomaira... 29
 lorazepam... 15
 losartan... 18
 losartan-hydrochlorothiazide... 18
 LOTEMAX SM... 23
 LOTEMAX... 23
 lovastatin... 18
 LUMIGAN... 23
 LUPRON DEPOT-PED... 21

M

M.V.I. ADULT... 28
 M.V.I. PEDIATRIC... 28
 M.V.I.-12 (WITHOUT VITAMIN K)... 28
 meclizine... 12
 meloxicam... 10
 memantine... 11
 MENOPUR... 27
 MEPHYTON... 28
 metformin... 16
 methocarbamol... 25

methotrexate sodium... 22

methylprednisolone... 21

metoprolol succinate... 18

metoprolol tartrate... 19

metronidazole... 11

mirtazapine... 12

misoprostol... 20

MITIGARE... 12

montelukast... 24

morphine... 10

MOVANTIK... 20

moxifloxacin... 23

MULTAQ... 19

mupirocin... 20

MYRBETRIQ... 21

N

NAMZARIC... 11

naproxen... 10

NASCOBAL... 28

NEXLETOL... 19

NEXLIZET... 19

nitazoxanide... 13

nitrofurantoin monohyd/m-cryst...
11

nitroglycerin... 19

NIVESTYM... 17

NOVOLIN N FLEXPEN... 16

NOVOLIN N NPH U-100 INSULIN...
16

NOVOLIN 70-30 FLEXPEN U-100...
16

NOVOLIN 70/30 U-100 INSULIN...
16

NOVOLOG FLEXPEN U-100
INSULIN... 16

NOVOLOG MIX 70-30 U-100

INSULN... 16

NOVOLOG MIX 70-30FLEXPEN
U-100... 16

NOVOLOG PENFILL U-100 INSULIN...
16

NOVOLOG U-100 INSULIN ASPART...
16

NUBEQA... 13

NUCALA... 24

NUZYRA... 11

O

obagi elastiderm... 26

obagi nu-derm blender... 26

obagi nu-derm clear... 26

OBREDON... 27

ODEFSEY... 15

OFEV... 24

olmesartan... 19

omeprazole... 20

OMNITROPE... 21

ondansetron hcl... 12

ondansetron... 12

ONGLYZA... 16

OPSUMIT... 24

ORGOVYX... 21

OSPHERA... 21

OTEZLA STARTER... 20

OTEZLA... 20

OVIDREL... 27

oxybutynin chloride... 21

oxycodone... 10

oxycodone-acetaminophen... 10

OZEMPIC... 16

P

pantoprazole... 20

paroxetine hcl... 12

PERSERIS... 14

phendimetrazine tartrate... 29

phentermine... 29

phytonadione (vitamin k1)... 28

pioglitazone... 16

PLASMA-LYTE A... 20

PLASMA-LYTE 148... 20

PLENITY (WELCOME KIT)... 29

PLENITY... 29

POTABA... 28

potassium chloride... 20

pravastatin... 19

prednisolone acetate... 23

prednisone... 21

pregabalin... 19

PREMARIN... 21

primidone... 11

PROCRT... 17

PROLASTIN-C... 20

PROLIA... 23

promethazine vc-codeine... 27

promethazine... 12

promethazine-codeine... 27

promethazine-dm... 27

promethazine-phenyleph-codeine...
27

PROPECIA... 26

PYLERA... 20

pyridoxine (vitamin b6)... 28

Q

QSYMIA... 29
quetiapine... 14

R

RAYALDEE... 23
RECTIV... 23
refissa... 26
REGRANEX... 20
RENOVA... 26
REPATHA PUSHTRONEX... 19
REPATHA SURECLICK... 19
REPATHA SYRINGE... 19
RESPA-AR... 27
RESTASIS MULTIDOSE... 23
RESTASIS... 23
RETACRIT... 17
RHOPRESSA... 23
RINVOQ... 22
RISPERDAL CONSTA... 14
RISPERDAL... 14
rizatriptan... 12
ROCKLATAN... 23
rosuvastatin... 19
RYBELSUS... 16
RYTARY... 13

S

SANCUSO... 12
SAVELLA... 19
SAXENDA... 29
sertraline... 12
SHINGRIX (PF)... 22
simvastatin... 19
SIVEXTRO... 11
SKYRIZI... 22

SOLQUA 100/33... 16
SPIRIVA RESPIMAT... 24
SPIRIVA WITH HANDIHALER... 24
spironolactone... 19
STELARA... 22
STIOLTO RESPIMAT... 24
STRIVERDI RESPIMAT... 24
sucralfate... 20
sulfacetamide sodium... 11
sulfamethoxazole-trimethoprim... 11
sumatriptan succinate... 12
SYMBICORT... 25
SYNJARDY XR... 17
SYNJARDY... 17

T

tamsulosin... 21
TDVAX... 22
temazepam... 25
TESSALON PERLES... 27
thiamine hcl (vitamin b1)... 28
timolol maleate... 23
tizanidine... 14
topiramate... 12
torsemide... 19
TOUJEO MAX U-300 SOLOSTAR... 17
TOUJEO SOLOSTAR U-300 INSULIN... 17
TRADJENTA... 17
tramadol... 10
trazodone... 12
TRELEGY ELLIPTA... 25
TRESIBA FLEXTOUCH U-100... 17

TRESIBA U-100 INSULIN... 17
tretinoin (emollient)... 26
TRI-LUMA... 26
triamcinolone acetonide... 19, 21
triamterene-hydrochlorothiazid... 19
TRIJARDY XR... 17
TRINTELLIX... 12
TRULICITY... 17
TUSSICAPS... 27
TUXARIN ER... 27
TUZISTRA XR... 27
TYMLOS... 23

U

UDENYCA... 17

V

valacyclovir... 15
valsartan... 19
VANIQA... 26
VASCEPA... 19
VELPHORO... 20
VELTASSA... 20
venlafaxine... 12
VENTOLIN HFA... 25
VERZENIO... 13
VICTOZA 3-PAK... 17
VIMPAT... 11
vitamin d2... 28
vitamin k... 28
vitamin k1... 29
VIVITROL... 10
VOSEVI... 15
VUMERITY... 19

VYZULTA... 23

W

warfarin... 17

WEGOVY... 29

X

XARELTO DVT-PE TREAT 30D START...
18

XARELTO... 17, 18

XIFAXAN... 20

XIGDUO XR... 17

XOFLUZA... 15

XTAMPZA ER... 10

XTANDI... 13

XULTOPHY 100/3.6... 17

Z

zafirlukast... 25

ZARXIO... 18

ZEGALOGUE AUTOINJECTOR... 17

ZEGALOGUE SYRINGE... 17

ZENPEP... 20

ZERVIAE... 23

zingiber... 29

zolpidem... 25

ZUBSOLV... 10

ZYPITAMAG... 19

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, ethnicity, marital status, religion, or language. 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 the Office for Civil Rights 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)**.
- **California residents:** You may also call the California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

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

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

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

Multi-Language Insert

Multi-language Interpreter Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



This abridged formulary was updated on 11/02/2022 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 with any questions 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. Our automated phone system is available after hours, weekends, and holidays. Our website is also available 24 hours a day 7 days a week by visiting **Humana.com**.



Humana.com

Humana Group Medicare
Humana Inc.
P.O. Box 669
Louisville, KY 40201-0669

Important plan information



A more human way to healthcare™