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

Important plan information

Your journey to better health, for better retirement

Humana Group Medicare

Humana®

Beyond healthcare

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

Humana®

A more human way
to healthcare™

Y0040_GHHL9PNEN_24_C BC24

2024 HUMANA GROUP MEDICARE PREFERRED PROVIDER ORGANIZATION (PPO) PLAN

Steamfitters Local 439
Health & Welfare Fund

We're here for you

Humana Group Medicare Customer Care
800-733-9064 (TTY: 711)
Monday – Friday, 7 a.m. – 8 p.m., Central time

Humana is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal. Call **800-733-9064 (TTY: 711)** for more information.

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

Humana®

UFCW 888

PPO

Y0040_GHHLP4LEN_24_RF_SL439HWF_M

RFMAPDTPPOEDI

This page intentionally left blank.

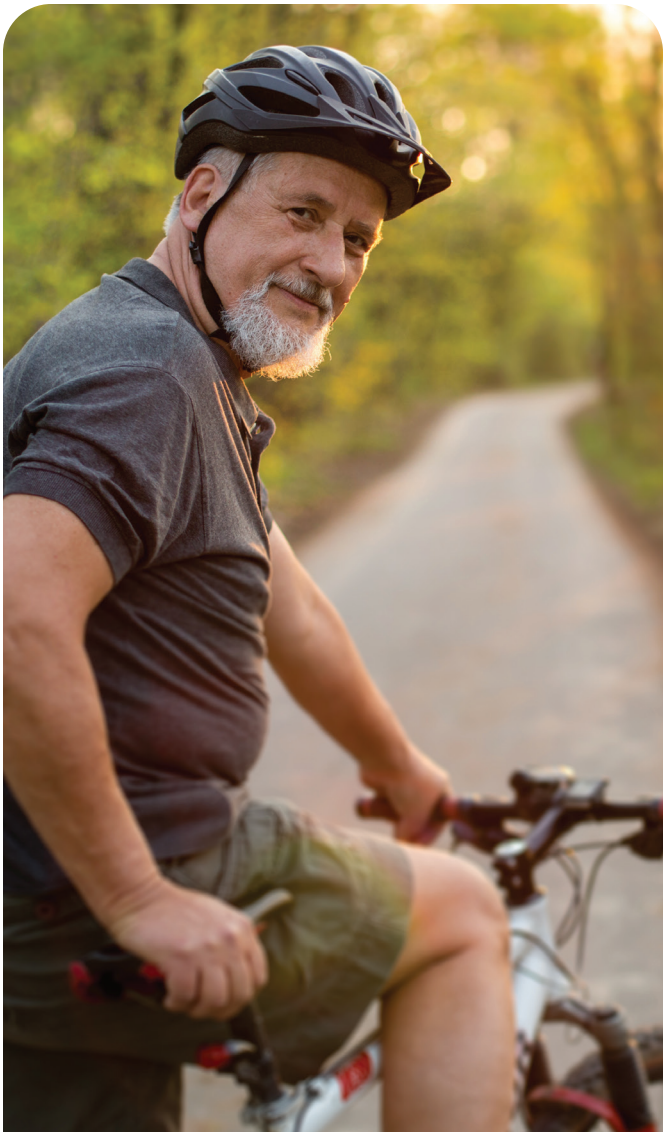
Group Medicare Advantage plan guide

Understanding your Medicare plan and how it works is important. 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.

Inside this guide you'll find:

Plan specific information

- Medical Summary of Benefits
- Dental Benefits
- Hearing Benefits
- Vision Benefits
- Rx Summary of Benefits
- Prescription Drug Guide



Humana®

Get the hassle-free care you deserve

Humana Medicare Advantage PPO with prescription drug plan offers you:

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

A dedicated team and more...

- Your benefit levels are the same for in-network and out-of-network providers
- Large network of providers, specialists and hospitals to pick from
- You don’t need a referral to see any healthcare provider
- Coverage for office visits, including routine physical exams
- Almost no claim forms to fill out or mail—we take care of that for you
- Dedicated Customer Care specialists who serve only our Group Medicare members

Welcome to a more human way to healthcare

You will be automatically enrolled

Dear Group Medicare Beneficiary,

We're excited to let you know that **Steamfitters Local 439 Health & Welfare Fund** has asked Humana to offer you a Medicare Advantage and 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 **RetireeFirst at 855-430-7095 (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.
- Go to **Humana.com**, "Member Resources" and select "Humana Drug List" then scroll to "Required Fields" to find a list of drugs covered by your Humana Group Medicare plan. For **Rx 591** choose **GRP 24**.
- Use Humana's Find a doctor tool at **Humana.com/FindaDoctor** for a list of network providers.

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)**
  You will receive information on how to view or request a copy of an Evidence of Coverage document (also known as a member contract or subscriber agreement). Please read the document to learn about the plan's coverage and services. This will also include your privacy notice.

- continued on next page

- **Take your Medicare Health Assessment**
  CMS requires Humana to ask new members to complete a health survey within their first few months of enrollment.

  It's nine simple questions about your health. Your answers will help us guide you to tools and resources available to help you reach your health goals. The information you provide will not affect your plan premiums or benefits or what you pay for them.

  Once you have received your Humana member ID card or after your plan is effective, you can call our automated voice service anytime to take this survey at **888-445-3389 (TTY: 711)**. When you call, you'll be asked to provide your eight-digit member ID number located on the front of your Humana member ID card, so have your ID card handy.

  You may also take the survey online at **MyHumana.com** after activating your online account.

- **In-home Health and Well-being Assessment (IHWA)**
  This is a yearly detailed health review conducted in the comfort of your home, providing an extra set of eyes and ears for your doctor so you can feel more in control of your health and well-being.

  You may receive a call from one of our IHWA vendors, Signify Health or Matrix Medical Network, to schedule your assessment. If you have questions, you may ask when they call, or contact Humana at the phone number listed on the back of your member ID card.

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

Sincerely,
Group Medicare Operations

Steamfitters Local 439 Health & Welfare Fund is enrolling you in the Humana Group Medicare preferred provider organization (PPO) plan. You do not need to do anything to be automatically enrolled in this Medicare health plan. If you do not want to join this plan, you can follow the instructions included below. You must do this before the date set by your benefit administrator. **Enrollment in this plan will cancel your enrollment in a different Medicare Advantage or a Medicare Prescription Drug (Part D) plan. However, if you are currently enrolled in a Medicare Supplement plan, you will have to take action to cancel your enrollment.**

What do I need to know as a member of the Humana Group Medicare PPO 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 information on how to view or request a copy of an Evidence of Coverage document (also known as a member contract or subscriber agreement) from the Humana Group Medicare PPO plan. Please read the document to learn about the plan's coverage and services. As a member of the Humana Group Medicare PPO plan, you can appeal plan decisions about payment or services if you disagree. Enrollment in this plan is generally for the entire year.

When your Humana Group Medicare PPO plan begins, Humana will cover all medically necessary items and services, even if you get the services out of network. However, your member cost share may be lower if you use in-network providers. "In-network" means that your doctor or provider is on our list of participating providers. "Out-of-network" means that you are using someone who isn't on this list. The exception is for emergency care, out of area dialysis services, or urgently needed services.

You must use network pharmacies to access Humana benefits, except under limited, non-routine circumstances when you can't reasonably use network pharmacies.

You must keep Medicare Parts A and B as the Humana Group Medicare plan is a Medicare Advantage plan. **You must also 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.**

You can enroll in only one Medicare Advantage plan at a time. You must let us know if you think you might be enrolled in a different Medicare Advantage plan or a Medicare prescription drug plan and inform us of any prescription drug coverage that you may get in the future.

What happens if I don't join the Humana Group Medicare PPO plan?
You aren't required to be enrolled in this plan. If you don't want to enroll or have enrollment questions, please contact **RetireeFirst at 855-430-7095 (TTY: 711), Monday – Friday, 8 a.m. – 5 p.m., Central time.**

- continued on next page

If you choose to join a different Medicare plan, you can contact **800-MEDICARE** anytime, 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 PPO 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 **RetireeFirst at 855-430-7095 (TTY: 711), Monday – Friday, 8 a.m. – 5 p.m., Central time.**

What happens if I move?
The Humana Group Medicare PPO plan serves a specific service area. **If you move to another area or state, it may affect your plan.** It's important to contact **RetireeFirst at 855-430-7095 (TTY: 711), Monday – Friday, 8 a.m. – 5 p.m., Central time** to provide your new address and phone number.

If you don't have Medicare prescription drug coverage, or drug coverage that's as good as Medicare's prescription drug coverage, you may have to pay a late enrollment penalty if you sign up for Medicare prescription drug coverage in the future.

Release of Information
By joining this Medicare Advantage plan, you give us permission to share your information with Medicare and other plans when needed for treatment, payment and health care operations. We do this to make sure you get the best treatment and to make sure that it is covered by the plan. Medicare may also use this information for research and other reasons allowed by Federal law.

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, find providers, 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.*

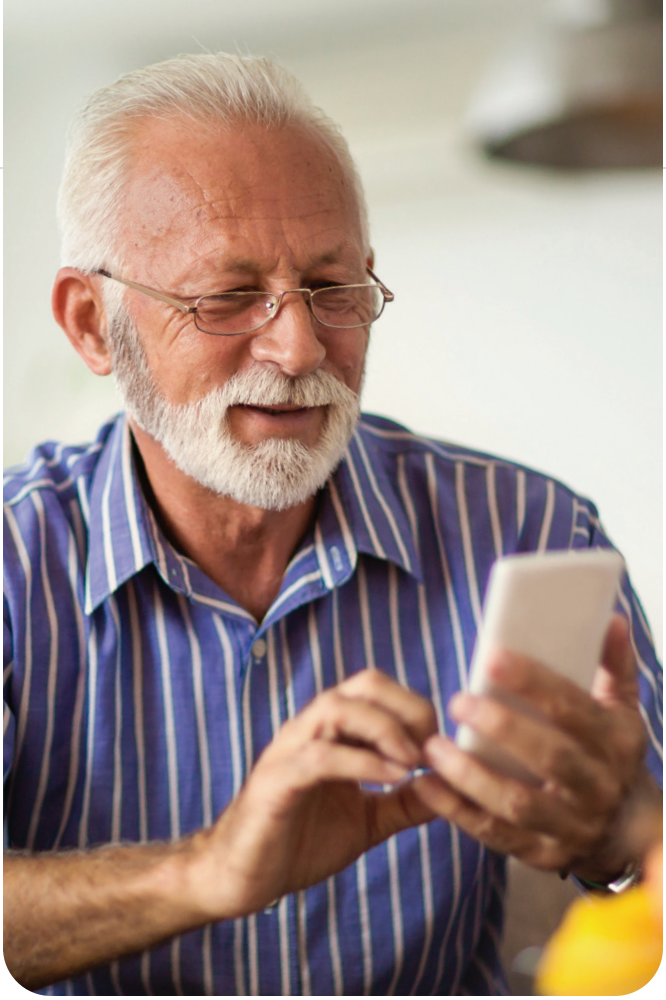
Getting started is easy—just have your Humana member ID card ready and follow these three steps:

1. **Create your account.**
   Visit **Humana.com/registration** 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.

*Standard data rates may apply.



The MyHumana mobile app

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

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

With MyHumana and the MyHumana mobile app, you can:

- Review your plan benefits and claims
- Find pharmacies in your network
- Find providers in your network
- Lookup and compare medication prices
- View or update your medication list
- View or print your Humana member ID card

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.

Building healthy provider relationships

Having a relationship with your primary care provider (PCP) is an important step in protecting and managing your health.

With the Humana Group Medicare PPO plan, you can use any provider who is part of our network, or you can use any provider who accepts Medicare and agrees to bill Humana. Your benefit plan coverage remains the same, even if you receive care from an out-of-network provider. For more information, refer to your Summary of Benefits located in this packet.

Why choose a Humana network provider?

- Your PCP will get to know your overall health history and can guide you toward preventive care to help you be healthy and active.
- Your plan doesn't require referrals to see other providers, but your PCP can help guide you when you need specialized care.
- Humana Medicare PPO network providers must take payment from Humana for treating plan members.
- Network providers coordinate with Humana, which makes it easier to share information. Patients may have a better experience when providers share information this way.
- Humana supplies in-network providers with information about services and programs available to patients with chronic conditions.

Is your healthcare provider in Humana's provider network?

If you need help finding a provider, call our Group Medicare Customer Care team or use our online directory at **Humana.com/Findadoctor**. You can also find a complete list of network providers and pharmacies at MyHumana, your personal, secure online account at **MyHumana.com** or on the MyHumana mobile app (standard data rates may apply).

Medical preauthorization

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

Use Humana's Find a Doctor tool to search for a provider near you

Choosing a doctor or healthcare facility is an important decision. You can use Humana's Find a Doctor tool to search for an in-network provider near you.

1. Go to **Humana.com/FindaDoctor**.

2. **Find a doctor or pharmacy**
   Use the tabs to help you search for a doctor or pharmacy.

3. **Location**
   Enter a ZIP code and the distance radius you want to search.

4. **Options**
   Select a lookup method from 3 options:
   1) Coverage type—choose Medicare or Medicare-Medicaid then select the network that represents your plan,
   2) Member ID, or
   3) Sign in to MyHumana for more accurate results in finding your network.

5. **Select the "Search" button for your results**
   Have you found the doctor or facility that you're looking for? If you need to revise your search, you can search again without leaving the results page.

Find a doctor on the MyHumana mobile app

Once you are enrolled with Humana, you can use the MyHumana mobile app to find a provider near you. On the app dashboard, locate the "Find Care" section.

Call our Customer Care team at **800-733-9064 (TTY: 711)**, Monday – Friday, 7 a.m. – 8 p.m., Central time.

Telehealth visits are available through your Humana plan

The doctor is in, even if you can't or don't want to go into an office. Telehealth visits allow you to get nonemergency medical care or behavioral healthcare through your phone,* tablet or computer.†

Virtual care where you're most comfortable

Telehealth could be used for chronic condition management, follow-up care after an in-office visit, medication reviews and refills, and much more—just like an in-office visit.

When should I use it? For a nonemergency issue, instead of going to the emergency room (ER) or an urgent care center.

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

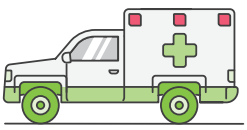
Connect with someone who cares

Use telehealth services to connect with a licensed behavioral health specialist. These providers are available when you may need them to coach you through many of life's challenges. These providers can:

- Discuss healthy ways you can deal with stress, anxiety or sadness
- Listen without judgment as you talk about your life, relationships and feelings
- Help you set and meet behavioral and emotional goals
- Assist you in developing strategies for living a fuller, healthier life

Ask your trusted provider about any virtual behavioral health options they may offer. One option is Array, a national in-network virtual behavioral health provider. Visit **Arraybc.com/patients/Humana** or call **888-410-0405 (TTY: 711)** to learn more.

Delivering the care you need securely, conveniently and on your terms—that's human care.



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

*Depending on the initial consultation, video may be required for telehealth visits.
†Standard data rates may apply.

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

Having a provider you're happy with can play an important role in your health and meeting your needs

If your healthcare provider says they do not accept Humana insurance, give them this flyer.

Once you are a member of the Humana Group Medicare Preferred Provider Organization (PPO) plan, sharing this information can help your provider understand how this plan works.

Don't forget to take your Humana member ID card to your first appointment.

A message for your provider

Humana will provide coverage for this retiree under a Group Medicare PPO plan. The in-network and out-of-network benefits are structured the same for any member of this plan. This means you can provide services to this retiree or any member of this plan if you are a provider who is eligible to participate in Medicare.

Contracted healthcare providers

If you're a Humana Medicare Employer PPO-contracted healthcare provider, you'll receive your contracted rate.

Out-of-network healthcare providers

Humana is dedicated to an easy transition. If you're a provider who is eligible to participate in Medicare, you can treat and receive payment for your Humana-covered patients who have this plan. Humana pays providers according to the Original Medicare fee schedule less any member plan responsibility.

Claims process

If you need more information about our claims processes or about becoming a Humana Medicare Employer PPO-contracted provider, call Provider Relations at **800-626-2741**, Monday – Friday, 8 a.m. – 5 p.m., Central time. **This number is not for patient use.**

Patients, please call the Group Medicare Customer Care number on the back of your Humana member ID card.

Humana®

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

Y0040_GHHHJE5HH_24_C
MTPF24

Medicare Part D prescription medication tiers

Tier 1 – Generic or preferred generic

Essentially the same medications, usually priced differently

Have the same active ingredients as brand-name medications and are prescribed for the same reasons. The Food and Drug Administration (FDA) requires generic medications to have the same quality, strength, purity and stability as brand-name medications. Your cost for generic medications is usually lower than your cost for brand-name medications.

Tier 2 – Preferred brand

A medication available to you for less than a nonpreferred

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

Tier 3 – Nonpreferred medication

A more expensive medication than a preferred

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

Tier 4 – Specialty

Medications for specific uses

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

Important information about your prescription medication coverage

Some medications covered by Humana may have requirements or limits on coverage. These requirements and limits may include prior authorization, quantity limits or step therapy. 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 medications. 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. 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.

Quantity limits

For some medications, the Humana Group Medicare Plan limits the quantity of the medication that is covered. The Humana Group Medicare Plan might limit how many refills you can get or quantity of a medication you can get each time you fill your prescription. Specialty medications are limited to a 30-day supply regardless of tier placement.

One-time transition fill

For certain medications typically requiring prior authorization or step therapy, Humana will cover a one-time, 30-day supply of your Part D covered medication 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 medications do not qualify for a transitional fill, such as medications that require a Part B vs D determination, CMS Excluded medications, or those that require a diagnosis review to determine coverage.

Step therapy

In some cases, the Humana Group Medicare Plan requires that you first try certain medications to treat your medical condition before coverage is available for a more expensive medication prescribed to treat your medical condition.

Next steps for you

1. Visit **Humana.com/Pharmacy** to view your prescription drug guide. The prescription drug guide will provide information on quantity limits, step therapy or if a prior authorization is required. If you have additional questions, please call our Customer Care number on the back of your Humana member ID card.
2. Talk to your provider about your medications if they require prior authorization, have quantity limits or if step therapy is needed.

Next steps for your provider

1. 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.
2. Call **800-555-2546 (TTY: 711)** to speak with our Humana Clinical Pharmacy Review team, Monday – Friday, 7 a.m. – 7 p.m., Central time.

How to find the list of medications covered by your Humana Group Medicare plan

View the most complete and current Drug Guide information online.

Humana's Drug List, also called "formulary," lists the most widely prescribed medications covered by Humana and is updated regularly by doctors and pharmacists in our medical committee. Updates to this year's formulary are posted monthly. New medications are added as needed, and medications that are deemed unsafe by the Food and Drug Administration (FDA) or a drug's manufacturer are immediately removed. We will communicate changes to the Drug List to members based on the Drug List notification requirements established by each state.

If a specific medication you need is not on the list, please call the Customer Care number on the back of your Humana member ID card.

To find a list of drugs, use the GRP# provided within the Welcome Letter.

- Go to **Humana.com**
- Hover over the tab, **"Member Resources"** and then select **"Humana Drug List"**
- Scroll to **"Required Fields"**, from the **"Select plan type"** choose **Group Medicare** in the drop-down menu, select **"plan year"** and then select the **"Find Drug Guide"** button
- Scroll and locate your GRP # within the drug list

You can print out the full list of drugs covered under your Humana plan, called the Prescription Drug Guide. (You must have Adobe Reader to view and print these documents.)

CenterWell Pharmacy

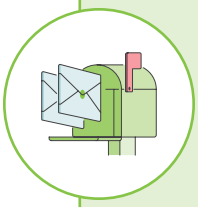
You have the choice of pharmacies for prescription retail and mail order services, CenterWell Pharmacy™ is one option.*

Online

After you become a Humana member, you can sign in to **CenterWellPharmacy.com** with your MyHumana identification number and start a new prescription, order refills or check on an order.

Provider

Your provider can send prescriptions electronically through e-prescribe or by downloading the fax form 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., 7 a.m. - 10 p.m., and Sat., 7 a.m. - 5:30 p.m., Central time.

For specialty medication(s), call CenterWell Specialty Pharmacy at **800-486-2668 (TTY: 711)**, Mon. – Fri., 7 a.m. - 10 p.m., and Sat., 7 a.m. - 5:30 p.m., Central time.

*Other pharmacies are available in the network.

Where you get your vaccines may determine how it is covered

Medicare Part B vaccines

The Medicare Part B portion of your plan covers vaccines administered at your provider's office if the vaccine is directly related to the treatment of an injury or direct exposure to a disease or condition, such as hepatitis B, rabies, and tetanus.

The following Medicare Part B vaccines may be obtained at your provider's office or are readily available at a network pharmacy: influenza (flu), pneumococcal, and COVID-19 vaccine and boosters.

Medicare Part D vaccines

The Medicare Part D portion of your plan covers vaccines that are considered necessary to help prevent illness. Some common vaccines that you should get at your pharmacy, not from your provider, include shingles, Tdap and hepatitis A.

Diabetes coverage

Medicare Part B

Part B covers certain preventive services for people at risk for diabetes. You must have Part B to get the services and supplies it covers, like:

- diabetic testing supplies
- insulin pumps*
- continuous glucose monitors (CGM)*
- insulin administered (or used) in insulin pumps

Medicare Part D

Part D typically covers diabetes supplies used to administer insulin. You must be enrolled in a Medicare drug plan to get the supplies Part D covers, like:

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

Diabetic testing supplies

Your Humana Medicare Advantage Plan helps cover a variety of diabetic glucose testing supplies. The following meters along with their test strips and lancets are covered at $0 through CenterWell Pharmacy™.

- CenterWell TRUE METRIX® AIR by Trividia
- Accu-Chek Guide Me® by Roche
- Accu-Chek Guide® by Roche

To order a meter and supplies from CenterWell Pharmacy, call **888-538-3518 (TTY: 711)**, Monday – Friday, 7 a.m. - 10 p.m., and Sat., 7 a.m. - 5:30 p.m., Central time.

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

You can also request a no-cost meter from the manufacturer by calling Roche at **877-264-7263 (TTY: 711)**, or Trividia Health at **866-788-9618 (TTY: 711)**, Monday – Friday, 7 a.m. – 7 p.m., Central time.

Enhanced vaccine and insulin coverage

Part B

Part B medications: Some Medicare members may see lower out-of-pocket costs for certain Part B medications as determined by CMS.

$35 insulin copay: Members who administer insulin via an insulin pump will pay **no more than $35** for every one-month (up to a 30-day) supply. If your plan has a deductible, the deductible does not apply to Part B insulin.

Part D

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

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

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**.

*CGMs are available through participating retail pharmacies. In addition, CGMs and Insulin pumps are available through our preferred durable medical equipment vendors, CCS Medical, 877-531-7959 or Edwards Healthcare, 888-344-3434.

†For 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.

Your personalized benefits statement

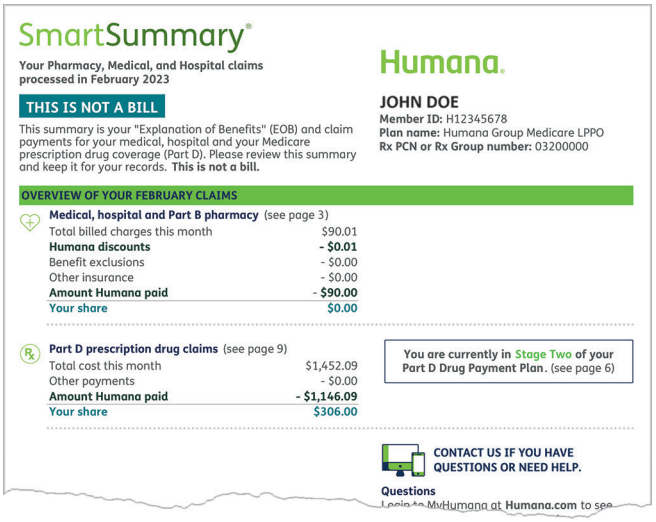
Humana's SmartSummary provides a comprehensive overview of your health benefits and healthcare spending. **You'll receive this statement after each month you've had a claim processed.** You can also sign in to your MyHumana account and see your past SmartSummary statements anytime.

SmartSummary helps you:

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

SmartSummary includes:

- **Numbers to watch.** SmartSummary shows your total drug costs for the month and year-to-date. It also shows how much of these costs your plan paid and how much you paid—so you can see the value of your prescription benefits.
- **Personalized messages.** SmartSummary gives you tips on saving money on the prescription drugs you take, information about changes in prescription copayments and how to plan ahead.
- **Your 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.
- **Information relevant for you.** SmartSummary personalizes an informational section with tips on topics that may be helpful for your health.



SmartSummary®

Your Pharmacy, Medical, and Hospital claims processed in February 2023

Humana.

THIS IS NOT A BILL

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

JOHN DOE
Member ID: H12345678
Plan name: Humana Group Medicare LPPO
Rx PCN or Rx Group number: 03200000

OVERVIEW OF YOUR FEBRUARY CLAIMS

Medical, hospital and Part B pharmacy (see page 3)

Total billed charges this month	$90.01
Humana discounts	**- $0.01**
Benefit exclusions	- $0.00
Other insurance	- $0.00
Amount Humana paid	**- $90.00**
Your share	$0.00

Part D prescription drug claims (see page 9)

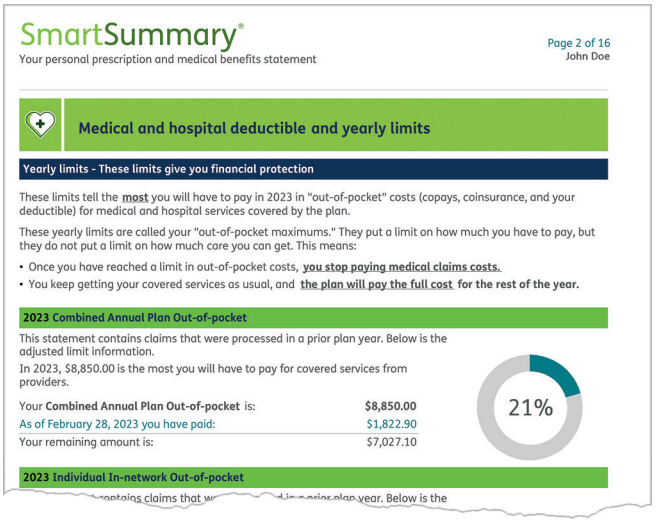
Total cost this month	$1,452.09
Other payments	- $0.00
Amount Humana paid	**- $1,146.09**
Your share	$306.00

You are currently in Stage Two of your Part D Drug Payment Plan. (see page 6)

CONTACT US IF YOU HAVE QUESTIONS OR NEED HELP.

Questions

Login to MyHumana at Humana.com to see



SmartSummary®

Your personal prescription and medical benefits statement

Page 2 of 16
John Doe

Medical and hospital deductible and yearly limits

Yearly limits - These limits give you financial protection

These limits tell the most you will have to pay in 2023 in "out-of-pocket" costs (copays, coinsurance, and your deductible) for medical and hospital services covered by the plan.

These yearly limits are called your "out-of-pocket maximums." They put a limit on how much you have to pay, but they do not put a limit on how much care you can get. This means:

- Once you have reached a limit in out-of-pocket costs, you stop paying medical claims costs.
- You keep getting your covered services as usual, and the plan will pay the full cost for the rest of the year.

2023 Combined Annual Plan Out-of-pocket

This statement contains claims that were processed in a prior plan year. Below is the adjusted limit information.

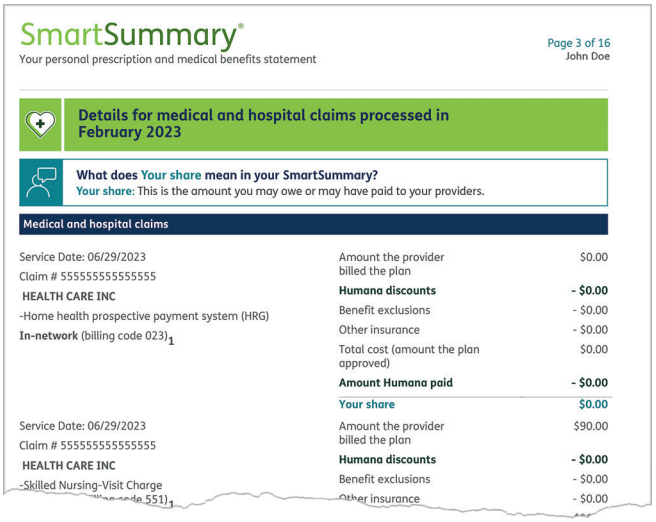
In 2023, $8,850.00 is the most you will have to pay for covered services from providers.

Your **Combined Annual Plan Out-of-pocket** is:	$8,850.00
As of February 28, 2023 you have paid:	$1,822.90
Your remaining amount is:	$7,027.10

21%

2023 Individual In-network Out-of-pocket

contains claims that w... d in a prior plan year. Below is the



SmartSummary®

Your personal prescription and medical benefits statement

Page 3 of 16
John Doe

Details for medical and hospital claims processed in February 2023

What does Your share mean in your SmartSummary?
Your share: This is the amount you may owe or may have paid to your providers.

Medical and hospital claims

Service Date: 06/29/2023
Claim # 555555555555555
HEALTH CARE INC
-Home health prospective payment system (HRG)
In-network (billing code 023)[1]

Amount the provider billed the plan	$0.00
Humana discounts	**- $0.00**
Benefit exclusions	- $0.00
Other insurance	- $0.00
Total cost (amount the plan approved)	$0.00
Amount Humana paid	**- $0.00**
Your share	$0.00

Service Date: 06/29/2023
Claim # 555555555555555
HEALTH CARE INC
-Skilled Nursing-Visit Charge
...ode 551)[1]

Amount the provider billed the plan	$90.00
Humana discounts	**- $0.00**
Benefit exclusions	- $0.00
Other insurance	- $0.00

Extras that may help you improve your overall well-being, at no additional cost

SilverSneakers

SilverSneakers® is a health and fitness program designed for senior adults that offers fun and engaging classes and activities. The program concentrates on improving strength and flexibility so daily living activities become easier. Available at no additional cost through your Humana Medicare Advantage plan, SilverSneakers has online and in-person sessions at any pace—sit, stand, walk or run. Visit **SilverSneakers.com/StartHere** to get your SilverSneakers ID number and find a location near you, or call SilverSneakers at **888-423-4632 (TTY: 711)**.

Go365

Go365 by Humana® is a wellness program that rewards you for completing eligible healthy activities like working out or getting your Annual Wellness Visit. You can earn rewards to redeem for gift cards in the Go365 Mall.

If you have a MyHumana account, you can use the same information to log in to **Go365.com**. If not, activate your profile at **MyHumana.com**. Once you log into Go365, you'll see eligible activities you can complete to earn rewards and details on how to track your actions.

Humana Care Management

Humana care management programs support qualifying members to help them remain independent at home, by providing education about chronic conditions and medication adherence, help with discharge instructions, accessing community resources, finding social support and more, all included in the plan at no additional cost. For more information, please contact the number on the back of your Humana member ID card or visit **Humana.com/home-care**.

Humana Well Dine® meal program

After your overnight inpatient stay in a hospital or nursing facility, you're eligible to receive up to 28 nutritious meals (2 meals per day for 14 days). The meals will be delivered to your door at no additional cost to you. For more information, please contact the number on the back of your Humana member ID card or visit **Humana.com/home-care/well-dine**.

Advance care planning with MyDirectives

MyDirectives®, an online advance care plan platform, helps you ensure your wishes are met in case unexpected medical emergencies happen or as illnesses progress. With MyDirectives, you can make your exact wishes known and identify the people you trust to speak for you as well. Sign in to **MyHumana.com**, go to MyHealth tab, in the drop down select MyHealth Overview and then select MyDirectives under Resources.

Humana Health Coaching

Available to all Humana Group Medicare members, our health coaching program provides guidance to help you develop a plan of action that supports your health and well-being goals. A health coach works with you to create a personal vision for your health and well-being, brings clarity to your goals and priorities and provides accountability and support. Get started by calling **877-567-6450 (TTY: 711)**.

Humana Neighborhood Center

Humana Neighborhood Centers offer a variety of classes in-person and online. Watch daily online classes like cooking demos, crafts, and meditation. To see a full list of virtual activities and to RSVP for classes and other events, visit **HumanaNeighborhoodCenter.com.** To find a Humana Neighborhood Center near you, visit **Humana.com/Humana-neighborhood-centers.**

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 that will take its place. Keep your Medicare ID card in a safe place—or use it only when it's needed for discounts and other offers from retailers.

What should I do if I move or have a temporary address change?
If you move to another area or state, it may affect your plan. It's important to contact your group benefits administrator for details and call to notify Humana of the move.

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

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

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

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

What if my provider says they will not accept my plan?
If your provider says they will not accept your PPO plan, you can give your provider the "Group Medicare Provider Information" flyer on page 11. It explains how your PPO plan works. You can also call Customer Care and have a Humana representative contact your provider and explain how your PPO plan works.

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**.

Medical insurance terms

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

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

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

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

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

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

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

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

Pharmacy terms

Catastrophic coverage
What you pay for covered drugs after reaching $8,000
Once your out-of-pocket costs reach the $8,000 maximum, you pay $0 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 medication 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 medications before the plan pays
The amount you pay for Part D prescription medications 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
Medications covered under your plan
A list of medications 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.

Know your numbers

Find important numbers anytime you need them*

Humana Group Medicare Customer Care
800-733-9064 (TTY: 711),
Monday – Friday, 7 a.m. – 8 p.m., Central time

Medicare Health Assessment
888-445-3389 (TTY: 711), daily

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

MyHumana mobile app
Humana.com/mobile-apps

Doctors in your network
Humana.com/FindaDoctor

Telehealth
Please contact your local provider to ask about virtual visit opportunities, or access nationwide Humana in-network telehealth options by using the "Find a doctor" tool on **Humana.com** or call the number on the back of your member ID card to get connected with a provider that offers this service.

Array behavioral health
888-410-0405 (TTY: 711)
Arraybc.com/patients/Humana

CenterWell Pharmacy™
800-379-0092 (TTY: 711),
Mon. – Fri., 7 a.m. - 10 p.m., and
Sat., 7 a.m. - 5:30 p.m., Central time
CenterWellPharmacy.com

CenterWell Specialty Pharmacy™
800-486-2668 (TTY: 711),
Mon. – Fri., 7 a.m. - 10 p.m., and
Sat., 7 a.m. - 5:30 p.m., Central time
CenterWellSpecialtyPharmacy.com

Humana Clinical Pharmacy Review Team
800-555-2546 (TTY: 711),
Monday – Friday, 7 a.m. – 7 p.m., Central time

SilverSneakers®
888-423-4632 (TTY: 711),
Monday – Friday, 7 a.m. – 7 p.m., Central time
SilverSneakers.com

Go365 by Humana™
Go365.com

Humana Care Management
800-733-9064 (TTY: 711),
Monday – Friday, 7 a.m. – 8 p.m., Central time
Humana.com/home-care

Humana Well Dine®
800-733-9064 (TTY: 711),
Monday – Friday, 7 a.m. – 8 p.m., Central time
Humana.com/home-care/well-dine

Humana Health Coaching
877-567-6450 (TTY: 711)

Humana Neighborhood Centers
Humana.com/Humana-neighborhood-centers

State health insurance program offices
800-633-4227 (TTY: 711), daily
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

Humana® A more human way to healthcare™

2024

Summary of Benefits

Humana Group Medicare Advantage PPO Plan
PPO 079/727

Steamfitters Local 439 Health & Welfare Fund

Humana®

Our service area includes specific counties within the United States, Puerto Rico and all other major US Territories.

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

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

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

To be eligible

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

Plan name:

Humana Group Medicare Advantage PPO plan

How to reach us:

Members should call toll-free **1-800-733-9064** for questions **(TTY/TDD 711)**

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

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

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

A healthy partnership

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

Monthly Premium, Deductible and Limits

	IN-NETWORK	OUT-OF-NETWORK
PLAN COSTS		
Monthly premium You must keep paying your Medicare Part B premium.	For information concerning the actual premiums you will pay, please contact your employer group benefits plan administrator.	
Medical deductible	This plan does not have a deductible.	
Maximum out-of-pocket responsibility The most you pay for copays, coinsurance and other costs for medical services for the year.	**In-Network Maximum Out-of-Pocket** **$0** out-of-pocket limit for Medicare-covered services. The following services do not apply to the maximum out-of-pocket: Part D Pharmacy; Acupuncture; Chiropractic Services (Routine); Dental Services (Routine); Fitness Program; Health Education Services; Hearing Services (Routine); Meal Benefit; Podiatry Services (Routine); Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Private Duty Nursing; Smoking Cessation (Additional); Vision Services (Routine) and the Plan Premium. If you reach the limit on out-of-pocket costs, we will pay the full cost for the rest of the year on covered hospital and medical services.	**Combined In and Out-of-Network Maximum Out-of-Pocket** **$0** out-of-pocket limit for Medicare-covered services. In-Network Exclusions: Part D Pharmacy; Acupuncture; Chiropractic Services (Routine); Dental Services (Routine); Fitness Program; Health Education Services; Hearing Services (Routine); Meal Benefit; Podiatry Services (Routine); Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Private Duty Nursing; Smoking Cessation (Additional); Vision Services (Routine) and the Plan Premium do not apply to the combined maximum out-of-pocket. Out-of-Network Exclusions: Part D Pharmacy; Acupuncture; Chiropractic Services (Routine); Dental Services (Routine); Hearing Services (Routine); Podiatry Services (Routine); Private Duty Nursing; Vision Services (Routine); Worldwide Coverage and the Plan Premium do not apply to the combined maximum out-of-pocket. Your limit for services received from in-network providers will count toward this limit. If you reach the limit on

Note: *A cost share range may display, depending on the service and where the service is provided. Some services require prior authorization.*

Monthly Premium, Deductible and Limits

	IN-NETWORK	OUT-OF-NETWORK
		out-of-pocket costs, we will pay the full cost for the rest of the year on covered hospital and medical services.

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
ACUTE INPATIENT HOSPITAL CARE		
Our plan covers an unlimited number of days for an inpatient hospital stay. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	**$0** per admit	**$0** per admit
OUTPATIENT HOSPITAL COVERAGE		
Outpatient hospital visits	**$0** copay	**$0** copay
Ambulatory surgical center	**$0** copay	**$0** copay
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	**$0** copay	**$0** copay
Specialists	**$0** copay	**$0** copay
PREVENTIVE CARE		
Including: Annual Wellness Visit, flu vaccine, colorectal cancer and breast cancer screenings. Any additional preventive services approved by Medicare during the contract year will be covered.	**Covered at no cost**	**Covered at no cost**
EMERGENCY CARE		
Emergency room	**$0** copay for Medicare-covered emergency room visit(s)	**$0** copay for Medicare-covered emergency room visit(s)
Urgently needed services Urgently needed services are care provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	**$0** copay	**$0** copay
DIAGNOSTIC SERVICES, LABS AND IMAGING		
Diagnostic radiology	**$0** copay	**$0** copay
Lab services	**$0** copay	**$0** copay

Note: *A cost share range may display, depending on the service and where the service is provided. Some services require prior authorization.*

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
Diagnostic tests and procedures	**$0** copay	**$0** copay
Outpatient X-rays	**$0** copay	**$0** copay
Radiation therapy	**$0** copay	**$0** copay
HEARING SERVICES		
Medicare-covered hearing	**$0** copay	**$0** copay
Routine hearing TruHearing Provider must be used. Contact Customer Service to locate a provider.	**$0** copay for routine hearing exams up to 1 per year. **$500** maximum benefit coverage amount for hearing aid(s) (all types) up to 2 every 3 years. Note: Includes 80 batteries per aid and 3 year warranty.	
DENTAL SERVICES		
Medicare-covered dental	**$0** copay (services include surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments or neoplastic disease)	**$0** copay (services include surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments or neoplastic disease)
Routine dental	**0%** of the cost for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. **0%** of the cost for panoramic film or diagnostic x-rays up to 1 every 5 years. **0%** of the cost for bitewing x-rays up to 1 set(s) per year. **0%** of the cost for emergency diagnostic exam, intraoral x-rays up to 1 per year. **0%** of the cost for fluoride treatment, periodic oral exam, prophylaxis (cleaning) up to 2 per year. **0%** of the cost for periodontal maintenance up to 4 per year. **0%** of the cost for general anesthesia (nitrous oxide, anxiolysis, intravenous-conscious-sedation/analgesia) up to unlimited per year. **20%** of the cost for amalgam and/or composite filling,	**0%** of the cost for comprehensive oral evaluation or periodontal exam up to 1 every 3 years. **0%** of the cost for panoramic film or diagnostic x-rays up to 1 every 5 years. **0%** of the cost for bitewing x-rays up to 1 set(s) per year. **0%** of the cost for emergency diagnostic exam, intraoral x-rays up to 1 per year. **0%** of the cost for fluoride treatment, periodic oral exam, prophylaxis (cleaning) up to 2 per year. **0%** of the cost for periodontal maintenance up to 4 per year. **0%** of the cost for general anesthesia (nitrous oxide, anxiolysis, intravenous-conscious-sedation/analgesia) up to unlimited per year. **20%** of the cost for amalgam and/or composite filling,

Note: *A cost share range may display, depending on the service and where the service is provided. Some services require prior authorization.*

	IN-NETWORK	OUT-OF-NETWORK
	emergency treatment for pain up to 2 per year. **20%** of the cost for simple or surgical extraction up to unlimited per year. **50%** of the cost for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. **50%** of the cost for occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years. **50%** of the cost for complete dentures, partial dentures up to 1 set(s) every 5 years. **50%** of the cost for adjustments to dentures, denture rebase, denture reline, denture repair, root canal or retreatment, tissue conditioning up to 1 per year. **50%** of the cost for crown, oral surgery up to 2 per year. **$2,000** combined maximum benefit coverage amount per year for all preventive and comprehensive benefits.	emergency treatment for pain up to 2 per year. **20%** of the cost for simple or surgical extraction up to unlimited per year. **50%** of the cost for scaling and root planing (deep cleaning) up to 1 per quadrant every 3 years. **50%** of the cost for occlusal adjustment, scaling for moderate inflammation up to 1 every 3 years. **50%** of the cost for complete dentures, partial dentures up to 1 set(s) every 5 years. **50%** of the cost for adjustments to dentures, denture rebase, denture reline, denture repair, root canal or retreatment, tissue conditioning up to 1 per year. **50%** of the cost for crown, oral surgery up to 2 per year. **$2,000** combined maximum benefit coverage amount per year for all preventive and comprehensive benefits. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

Limitations and exclusions may apply. Submitted claims are subject to a review process which may include a clinical review and dental history to approve coverage. Dental benefits under this plan may not cover all ADA procedure codes. Any services received that are not listed will not be covered by the plan and will be the member's responsibility. The member is responsible for any amount above the dental coverage limit. Benefits are offered on a calendar year basis. Any amount unused at the end of the year will expire. Information regarding each plan is available at **Humana.com/sb**.

In-network dentists have agreed to provide covered services at contracted rates (per the in-network fee schedules, or INFS). If a member visits a participating network dentist, the member cannot be billed for charges that exceed the negotiated fee schedule (but coinsurance payment still applies).

Out-of-network dentists have not agreed to provide services at contracted fees. Benefits received out-of-network are subject to any in-network benefit maximums, limitations and/or exclusions. Members may be billed by the out-of-network provider for any amount greater than the payment made by Humana to the provider. Please see below for provider locator instructions. Network providers agree to bill us directly. If a provider who is not in our network is not willing to bill us directly, you may have to pay upfront

Note: *A cost share range may display, depending on the service and where the service is provided. Some services require prior authorization.*

	IN-NETWORK	OUT-OF-NETWORK

and submit a request for reimbursement. The coinsurance level will apply to the average negotiated in-network fee schedule (INFS) in your area. See Chapter 2 Payment Requests Contact Information or visit Humana.com for information on requesting reimbursement.

When visiting an out-of-network provider there could be a difference between Humana's reimbursement and the dentist's charges. Members are responsible for this difference when visiting an out-of-network provider; this is known as balanced billing.

The Mandatory Supplemental Dental benefits are provided through the Humana Dental Medicare Network. The provider locator can be found at **Humana.com > Find a doctor > Select the Dentist icon from the menu > From the Distance drop down select the preferred distance > Enter Zip code > From the look up method select All Dental Networks > Then select HumanaDental Medicare**.

VISION SERVICES		
Medicare-covered vision services	**$0** copay (services include diagnosis and treatment of diseases and injuries of the eye)	**$0** copay (services include diagnosis and treatment of diseases and injuries of the eye)
Medicare-covered diabetic eye exam	**$0** copay	**$0** copay
Medicare-covered glaucoma screening	**$0** copay	**$0** copay
Medicare-covered eyewear (post-cataract)	**$0** copay	**$0** copay
Routine vision EyeMed is the In-Network provider for the routine vision benefit. Contact Customer Service to locate a provider.	**$0** copay for routine exam (includes refraction) up to 1 per year.	**$175** combined maximum benefit coverage amount per year for routine exam (includes refraction). **$0** copay for routine exam (includes refraction) up to 1 per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

Note: *A cost share range may display, depending on the service and where the service is provided. Some services require prior authorization.*

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
MENTAL HEALTH SERVICES		
Inpatient The inpatient hospital care limit applies to inpatient mental services provided in a general hospital. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. 190 day lifetime limit in a psychiatric facility.	**$0** per admit	**$0** per admit
Outpatient group and individual therapy visits	**Outpatient therapy visit:** **$0** copay **Partial Hospitalization:** **$0** copay	**Outpatient therapy visit:** **$0** copay **Partial Hospitalization:** **$0** copay
SKILLED NURSING FACILITY		
Our plan covers up to 100 days in a SNF. No 3-day hospital stay is required. Plan pays $0 after 100 days.	**$0** copay per day for days 1-100	**$0** copay per day for days 1-100
PHYSICAL THERAPY		
	$0 copay	**$0** copay
AMBULANCE		
Per date of service regardless of the number of trips. Limited to Medicare-covered transportation.	**$0** copay	**$0** copay
PART B PRESCRIPTION DRUGS		
	$0 copay or **0%** of the cost	**$0** copay or **0%** of the cost

Note: *A cost share range may display, depending on the service and where the service is provided. Some services require prior authorization.*

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
ACUPUNCTURE SERVICES		
Medicare-covered acupuncture visit(s) for chronic low back pain Your plan allows services to be received by a provider licensed to perform acupuncture or by providers meeting the Original Medicare provider requirements.	**$0** copay for acupuncture for chronic low back pain visits up to 20 combined in and out of network visit(s) per year.	**$0** copay for acupuncture for chronic low back pain visits up to 20 combined in and out of network visit(s) per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
Routine acupuncture	**$0** copay for acupuncture visits up to 12 combined in and out of network visit(s) per year.	**$0** copay for acupuncture visits up to 12 combined in and out of network visit(s) per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
ALLERGY		
Allergy shots & serum	**$0** copay	**$0** copay
CHIROPRACTIC SERVICES		
Medicare-covered chiropractic visit(s)	**$0** copay	**$0** copay
Routine chiropractic visit(s)	**$0** copay for routine chiropractic visits up to 12 combined in and out of network visit(s) per year.	**$0** copay for routine chiropractic visits up to 12 combined in and out of network visit(s) per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
DIABETES MANAGEMENT TRAINING		
	$0 copay	**$0** copay
FOOT CARE (PODIATRY)		
Medicare-covered foot care	**$0** copay	**$0** copay
Routine foot care	**$0** copay for routine podiatry visits up to 6 combined in and out of network visit(s) per year.	**$0** copay for routine podiatry visits up to 6 combined in and out of network visit(s) per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

Note: *A cost share range may display, depending on the service and where the service is provided. Some services require prior authorization.*

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
HOME HEALTH CARE		
	$0 copay	**$0** copay
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment (like wheelchairs or oxygen)	**0%** of the cost	**0%** of the cost
Medical supplies	**0%** of the cost	**0%** of the cost
Prosthetics (artificial limbs or braces)	**0%** of the cost	**0%** of the cost
Diabetes monitoring supplies	**$0** copay	**$0** copay
OUTPATIENT SUBSTANCE ABUSE		
Outpatient group and individual substance abuse treatment visits	**Outpatient therapy visit:** **$0** copay **Partial Hospitalization:** **$0** copay	**Outpatient therapy visit**: **$0** copay **Partial Hospitalization:** **$0** copay
PRIVATE DUTY NURSING		
$5,000 combined In & Out-of-Network maximum benefit coverage amount per year	**$0** copay	**$0** copay
REHABILITATION SERVICES		
Occupational and speech therapy	**$0** copay	**$0** copay
Cardiac rehabilitation	**$0** copay	**$0** copay
Pulmonary rehabilitation	**$0** copay	**$0** copay
RENAL DIALYSIS		
Renal dialysis	**$0** copay	**$0** copay
Kidney disease education services	**$0** copay	**$0** copay
TELEHEALTH SERVICES (in addition to Original Medicare)		
Primary care provider (PCP)	**$0** copay	Not Covered
Specialist	**$0** copay	Not Covered
Urgent care services	**$0** copay	Not Covered
Substance abuse or behavioral health services	**$0** copay	Not Covered

Note: *A cost share range may display, depending on the service and where the service is provided. Some services require prior authorization.*

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
FITNESS AND WELLNESS		
	SilverSneakers® is a total health and physical activity program that provides access to exercise equipment, group fitness classes, and social events.	
HEALTH EDUCATION SERVICES		
	Personal Health Coaching is an interactive inbound and outreach on-line and telephonic wellness coaching for Medicare participants who elect to participate, for wellness improvement, including weight management, nutrition, exercise, back care, blood pressure management, and blood sugar management.	
MEAL BENEFIT		
	After a member's overnight inpatient stay in a hospital or skilled nursing facility, members are eligible for nutritious meals delivered to their door at no cost.	
POST-DISCHARGE PERSONAL HOME CARE		
	After a member's overnight inpatient stay in a hospital or skilled nursing facility, members may receive assistance performing activities of daily living within the home. Types of assistance include bathing, dressing, toileting, walking, eating and preparing meals.	
POST-DISCHARGE TRANSPORTATION SERVICES		
	After a member's overnight inpatient stay in a hospital or skilled nursing facility, members are provided transportation to plan approved locations by car, van or wheelchair accessible vehicle at no cost.	
SMOKING CESSATION (ADDITIONAL)		
	A comprehensive smoking cessation program available online, email and phone. Personal coaches assist via establishing goals and providing articles and resources to aid in the effort to quit smoking.	
HOSPICE You must get care from a Medicare-certified hospice. You must consult with your plan before you select hospice.		

Note: *A cost share range may display, depending on the service and where the service is provided. Some services require prior authorization.*

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 **1-877-320-1235** 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.

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（听障专线：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（聽障專線：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 quí vị cần thông dịch viên xin gọi 1-877-320-1235 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí 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 답해 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 بخطتنا الصحية أو خطة الأدوية الموصوفة 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.

Portuguese: 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：当社の健康保険と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をご用意しています。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 provider directory at **Humana.com** or call us at the number listed at the beginning of this booklet and we will send you one.

Humana is a Medicare Advantage PPO 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

SB079727EN24

2024 DEN415

HumanaDental® Medicare Network

The following provides an all-inclusive list of dental services covered under this plan. Limitations and exclusions may apply. Submitted claims are subject to a review process which may include a clinical review and dental history to approve coverage. Any services received that are not listed will not be covered by the plan and will be the member's responsibility. The member is responsible for any amount above the dental coverage limit. Benefits are offered on a calendar year basis. Any amount unused at the end of the year will expire.

Contact Information

Members: For information about your dental benefits, call Humana Dental Customer Service at **800-457-4708 (TTY: 711)**, Monday – Friday, 8 a.m. – 6 p.m., in your time zone. Refer to **MyHumana.com** for a full listing of the dental limitations and exclusions available in the Evidence of Coverage (EOC) for your plan. For a copy of this document and other plan resources, please visit **Humana.com/sb**.

Providers: For information about dental benefits, call Humana Dental Provider Customer Service at **800-833-2223**, Monday – Friday, 8 a.m. – 8 p.m., Eastern time.

Additional Plan Details

- In-network dental providers have agreed to provide covered services at contracted rates per the in-network fee schedules (INFS). If a member visits a participating network dental provider, the member cannot be billed for charges that exceed the negotiated fee schedule (but coinsurance payment still applies).
- Out-of-network dental providers have not agreed to provide services at contracted fees. Benefits received out-of-network are subject to any in-network benefit maximums, limitations and/or exclusions. Members may be billed by the out-of-network provider for any amount greater than the payment made by Humana to the provider. Network providers agree to bill us directly. If a provider who is not in our network is not willing to bill us directly, the member may have to pay upfront and submit a request for reimbursement. The coinsurance level will apply to the average negotiated in-network fee schedule (INFS) in the member's area.
- **When visiting an out-of-network dental provider there could be a difference between Humana's reimbursement and the dentist's charges. Members are responsible for this difference when visiting an out-of-network provider; this is known as balanced billing.**
- Humana is a Medicare Advantage preferred provider organization (PPO) with a Medicare contract. Enrollment in any Humana plan depends on contract renewal. Dental benefits on this plan use a PPO dental network.

Humana®

2024 DEN415

HumanaDental® Medicare Network

Deductible	$0
Annual maximum	$2,000
Waiting periods	None

ADA code	Description of benefits	Frequency/limitations	In-network coverage	Out-of-network coverage
Exam				
D0120	Periodic oral evaluation – established patient	Two procedure codes per calendar year	100%	100%
Emergency diagnostic exam				
D0140	Limited oral evaluation – problem focused	One procedure code per calendar year	100%	100%
Additional exams				
D0150	Comprehensive oral evaluation – new or established patient	One procedure code from this group every three calendar years	100%	100%
D0180	Comprehensive periodontal evaluation – new or established patient		100%	100%
Full mouth and panoramic X-rays				
D0210	Intraoral – comprehensive series of radiographic images	One procedure code from this group every five calendar years	100%	100%
D0330	Panoramic radiographic image		100%	100%
Intraoral X-rays (inside the mouth)				
D0220	Intraoral – periapical first radiographic image	One procedure code from this group per calendar year	100%	100%
D0230	Intraoral – periapical each additional radiographic image		100%	100%
D0240	Intraoral – occlusal radiographic image		100%	100%
Bitewing X-rays				
D0270	Bitewing – single radiographic image	One procedure code from this group per calendar year	100%	100%
D0272	Bitewings – two radiographic images		100%	100%
D0273	Bitewings – three radiographic images		100%	100%
D0274	Bitewings – four radiographic images		100%	100%
Prophylaxis (cleaning)				
D1110	Prophylaxis adult (Removal of plaque, calculus and stains from the tooth structures and implants in the permanent and transitional dentition. It is intended to control local irritational factors.)	Two procedure codes per calendar year	100%	100%

ADA code	Description of benefits	Frequency/limitations	In-network coverage	Out-of-network coverage
Fluoride				
D1206	Topical application of fluoride varnish	Two procedure codes from this group per calendar year	100%	100%
D1208	Topical application of fluoride – excluding varnish		100%	100%
Anesthesia				
D9222	Deep sedation/general anesthesia – first 15 minutes	As needed with covered codes	100%	100%
D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment		100%	100%
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis		100%	100%
D9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes		100%	100%
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment		100%	100%
D9910	Application of desensitizing medicament		100%	100%
Restorations (fillings)				
D2140	Amalgam – one surface, primary or permanent	Two procedure codes from this group per calendar year	80%	80%
D2150	Amalgam – two surfaces, primary or permanent		80%	80%
D2160	Amalgam – three surfaces, primary or permanent		80%	80%
D2161	Amalgam – four or more surfaces, primary or permanent		80%	80%
D2330	Resin-based composite – one surface, anterior (front)		80%	80%
D2331	Resin-based composite – two surfaces, anterior (front)		80%	80%
D2332	Resin-based composite – three surfaces, anterior (front)		80%	80%
D2335	Resin-based composite – four or more surfaces (anterior)		80%	80%
D2391	Resin-based composite – one surface, posterior (back)		80%	80%
D2392	Resin-based composite – two surfaces, posterior (back)		80%	80%
D2393	Resin-based composite – three surfaces, posterior (back)		80%	80%
D2394	Resin-based composite – four or more surfaces, posterior (back)		80%	80%

ADA code	Description of benefits	Frequency/limitations	In-network coverage	Out-of-network coverage
Re-cement of crown				
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	One procedure code from this group every five calendar years	80%	80%
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core		80%	80%
D2920	Re-cement or re-bond crown		80%	80%
Re-cement of bridge				
D6930	Re-cement or re-bond fixed partial denture	One procedure code every five calendar years	80%	80%
Extractions				
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	Unlimited	80%	80%
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated		80%	80%
Pain management				
D9110	Palliative treatment of dental pain – per visit	Two procedure codes per calendar year	80%	80%
Crowns				
D2510	Inlay – metallic – one surface (alternate benefit only)	Two procedure codes from this group per calendar year	50%	50%
D2520	Inlay – metallic – two surfaces (alternate benefit only)		50%	50%
D2530	Inlay – metallic – three or more surfaces (alternate benefit only)		50%	50%
D2542	Onlay – metallic – two surfaces		50%	50%
D2543	Onlay – metallic – three surfaces		50%	50%
D2544	Onlay – metallic – four or more surfaces		50%	50%
D2610	Inlay – porcelain/ceramic – one surface (alternate benefit only)		50%	50%
D2620	Inlay – porcelain/ceramic – two surfaces (alternate benefit only)		50%	50%
D2630	Inlay – porcelain/ceramic – three or more surfaces (alternate benefit only)		50%	50%
D2642	Onlay – porcelain/ceramic – two surfaces		50%	50%
D2643	Onlay – porcelain/ceramic – three surfaces		50%	50%
D2644	Onlay – porcelain/ceramic – four or more surfaces		50%	50%
D2650	Inlay – resin-based composite – one surface (alternate benefit only)		50%	50%

ADA code	Description of benefits	Frequency/limitations	In-network coverage	Out-of-network coverage
Crowns (continued)				
D2651	Inlay – resin-based composite – two surfaces (alternate benefit only)	Two procedure codes from this group per calendar year	50%	50%
D2652	Inlay – resin-based composite – three or more surfaces (alternate benefit only)		50%	50%
D2662	Onlay – resin-based composite – two surfaces		50%	50%
D2663	Onlay – resin-based composite – three surfaces		50%	50%
D2664	Onlay – resin-based composite – four or more surfaces		50%	50%
D2710	Crown – resin-based composite (indirect)		50%	50%
D2712	Crown – 3/4 resin-based composite (indirect)		50%	50%
D2720	Crown – resin with high noble metal		50%	50%
D2721	Crown – resin with predominantly base metal		50%	50%
D2722	Crown – resin with noble metal		50%	50%
D2740	Crown – porcelain/ceramic		50%	50%
D2750	Crown – porcelain fused to high noble metal		50%	50%
D2751	Crown – porcelain fused to predominantly base metal		50%	50%
D2752	Crown – porcelain fused to noble metal		50%	50%
D2753	Crown – porcelain fused to titanium and titanium alloys		50%	50%
D2780	Crown – 3/4 cast high noble metal		50%	50%
D2781	Crown – 3/4 cast predominantly base metal		50%	50%
D2782	Crown – 3/4 cast noble metal		50%	50%
D2783	Crown – 3/4 porcelain/ceramic		50%	50%
D2790	Crown – full cast high noble metal		50%	50%
D2791	Crown – full cast predominantly base metal		50%	50%
D2792	Crown – full cast noble metal		50%	50%
D2794	Crown – titanium and titanium alloys		50%	50%
Restorative (other services) core buildup or prefabricated post and core				
D2950	Core buildup, including any pins when required	One per tooth per lifetime	50%	50%
D2952	Post and core in addition to crown, indirectly fabricated		50%	50%
D2953	Each additional indirectly fabricated post – same tooth		50%	50%

ADA code	Description of benefits	Frequency/limitations	In-network coverage	Out-of-network coverage
Restorative (other services) core buildup or prefabricated post and core (continued)				
D2954	Prefabricated post and core in addition to crown	One per tooth per lifetime	50%	50%
D2957	Each additional prefabricated post – same tooth		50%	50%
Endodontic services				
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	One procedure code from this group per calendar year	50%	50%
D3320	Endodontic therapy, premolar tooth (excluding final restoration)		50%	50%
D3330	Endodontic therapy, molar tooth (excluding final restoration)		50%	50%
D3346	Retreatment of previous root canal therapy – anterior		50%	50%
D3347	Retreatment of previous root canal therapy – premolar		50%	50%
D3348	Retreatment of previous root canal therapy – molar		50%	50%
Periodontal scaling and root planing				
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	One procedure code per quadrant from this group every three calendar years	50%	50%
D4342	Periodontal scaling and root planing – one to three teeth per quadrant		50%	50%
Scaling – moderate gingival inflammation				
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	One procedure code every three calendar years	50%	50%
Periodontal maintenance				
D4910	Periodontal maintenance	Four procedure codes per calendar year	100%	100%
Complete dentures (including routine post-delivery care)				
D5110	Complete denture – maxillary	One upper and lower complete denture every five calendar years	50%	50%
D5120	Complete denture – mandibular		50%	50%
D5130	Immediate denture – maxillary		50%	50%
D5140	Immediate denture – mandibular		50%	50%
Removable partial dentures (including routine post-delivery care)				
D5211	Maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth)	One upper and lower partial denture every five calendar years	50%	50%
D5212	Mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth)		50%	50%

ADA code	Description of benefits	Frequency/limitations	In-network coverage	Out-of-network coverage
Removable partial dentures (including routine post-delivery care) (continued)				
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	One upper and lower partial denture every five calendar years	50%	50%
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)		50%	50%
D5221	Immediate maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth)		50%	50%
D5222	Immediate mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth)		50%	50%
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)		50%	50%
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)		50%	50%
D5225	Maxillary partial denture – flexible base (including retentive/clasping materials, rests and teeth)		50%	50%
D5226	Mandibular partial denture – flexible base (including retentive/clasping materials, rests and teeth)		50%	50%
D5227	Immediate Maxillary partial denture – flexible base (including retentive/clasping materials, rests and teeth)		50%	50%
D5228	Immediate Mandibular partial denture – flexible base (including retentive/clasping materials, rests and teeth)		50%	50%
D5282	Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests and teeth), maxillary		50%	50%
D5283	Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests and teeth), mandibular		50%	50%

ADA code	Description of benefits	Frequency/limitations	In-network coverage	Out-of-network coverage
Other removable partial dentures (including routine post-delivery care)				
D5284	Removable unilateral partial denture – one piece flexible base (including retentive/clasping materials, rests and teeth) – per quadrant	One procedure code per quadrant from this group every five calendar years	50%	50%
D5286	Removable unilateral partial denture – one piece resin (including retentive/clasping materials, rests and teeth) – per quadrant		50%	50%
Denture adjustments (not covered if within six months of initial placement)				
D5410	Adjust complete denture – maxillary	One procedure code from this group per calendar year	50%	50%
D5411	Adjust complete denture – mandibular		50%	50%
D5421	Adjust partial denture – maxillary		50%	50%
D5422	Adjust partial denture – mandibular		50%	50%
Repairs to dentures				
D5511	Repair broken complete denture base, mandibular	One procedure code from this group per calendar year	50%	50%
D5512	Repair broken complete denture base, maxillary		50%	50%
D5520	Replace missing or broken teeth – complete denture (each tooth)		50%	50%
D5611	Repair resin partial denture base, mandibular		50%	50%
D5612	Repair resin partial denture base, maxillary		50%	50%
D5621	Repair cast partial framework, mandibular		50%	50%
D5622	Repair cast partial framework, maxillary		50%	50%
D5630	Repair or replace broken retentive/clasping materials – per tooth		50%	50%
D5640	Replace broken teeth – per tooth		50%	50%
D5650	Add tooth to existing partial denture		50%	50%
D5660	Add clasp to existing partial denture – per tooth		50%	50%
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)		50%	50%
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)		50%	50%
Dentures rebase (not covered if within six months of initial placement)				
D5710	Rebase complete maxillary denture	One procedure code from this group per calendar year	50%	50%
D5711	Rebase complete mandibular denture		50%	50%
D5720	Rebase maxillary partial denture		50%	50%
D5721	Rebase mandibular partial denture		50%	50%
D5725	Rebase hybrid prosthesis		50%	50%

ADA code	Description of benefits	Frequency/limitations	In-network coverage	Out-of-network coverage
Denture reline (not allowed on spare dentures or if within six months of initial placement)				
D5730	Reline complete maxillary denture (direct)	One procedure code from this group per calendar year	50%	50%
D5731	Reline complete mandibular denture (direct)		50%	50%
D5740	Reline maxillary partial denture (direct)		50%	50%
D5741	Reline mandibular partial denture (direct)		50%	50%
D5750	Reline complete maxillary denture (indirect)		50%	50%
D5751	Reline complete mandibular denture (indirect)		50%	50%
D5760	Reline maxillary partial denture (indirect)		50%	50%
D5761	Reline mandibular partial denture (indirect)		50%	50%
D5765	Soft liner for complete or partial removable denture (indirect)		50%	50%
Tissue conditioning (not covered if within six months of initial placement)				
D5850	Tissue conditioning, maxillary	One procedure code from this group per calendar year	50%	50%
D5851	Tissue conditioning, mandibular		50%	50%
Oral surgery				
D7220	Removal of impacted tooth – soft tissue	Two procedure codes from this group per calendar year	50%	50%
D7230	Removal of impacted tooth – partially bony		50%	50%
D7240	Removal of impacted tooth – completely bony		50%	50%
D7250	Removal of residual tooth roots (cutting procedure)		50%	50%
D7270	Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth		50%	50%
D7280	Exposure of an unerupted tooth		50%	50%
D7284	Excisional biopsy of minor salivary glands		50%	50%
D7285	Incisional biopsy of oral tissue – hard (bone, tooth)		50%	50%
D7286	Incisional biopsy of oral tissue – soft		50%	50%
D7287	Exfoliative cytological sample collection		50%	50%
D7288	Brush biopsy – transepithelial sample collection		50%	50%
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant		50%	50%

ADA code	Description of benefits	Frequency/limitations	In-network coverage	Out-of-network coverage
Oral surgery (continued)				
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	Two procedure codes from this group per calendar year	50%	50%
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant		50%	50%
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant		50%	50%
D7410	Excision of benign lesion up to 1.25 cm		50%	50%
D7411	Excision of benign lesion greater than 1.25 cm		50%	50%
D7412	Excision of benign lesion, complicated		50%	50%
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm		50%	50%
D7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm		50%	50%
D7460	Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm		50%	50%
D7461	Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm		50%	50%
D7509	Marsupialization of odontogenic cyst		50%	50%
D7510	Incision and drainage of abscess – intraoral soft tissue		50%	50%
D7961	Buccal/labial frenectomy (frenulectomy)		50%	50%
D7962	Lingual frenectomy (frenulectomy)		50%	50%
D7963	Frenuloplasty		50%	50%
D7970	Excision of hyperplastic tissue – per arch		50%	50%
D7971	Excision of pericoronal gingiva		50%	50%
D7972	Surgical reduction of fibrous tuberosity		50%	50%
Occlusal adjustments (not covered if within six months of initial placement)				
D9951	Occlusal adjustment – limited	One procedure code from this group every three calendar years	50%	50%
D9952	Occlusal adjustment – complete		50%	50%

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 **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, **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: **800-927-HELP (4357)**, to file a grievance.

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

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。
Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .
Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.
Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.
Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.
Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.
Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.
Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.
Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.
Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
日本語 **(Japanese)**: 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。
فارسی (Farsi)
برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.
Diné Bizaad (Navajo): Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę niká'adoowoł.
العربية (Arabic)
الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

GCHJV5REN 0721

Routine Hearing

TruHearing® (Choice)

$0 exam / $500 allowance

Routine hearing services offered through TruHearing® includes a fully-managed network of provider locations across the U.S. There are hearing aid styles to meet all members' hearing needs with the lowest pricing amongst industry-leading technology.

All plans include a full 3 year manufacturer warranty on every device, 80 free batteries per hearing aid and unlimited follow-up provider visits during the first year following a TruHearing® hearing aid purchase.

Routine Hearing Benefit Summary

Hearing services	In-network	Out-of-network
Routine hearing exam	$0 copayment for routine hearing exams up to 1 per year.	N/A
Benefit coverage	$500 maximum benefit coverage amount for hearing aid(s) (all types) up to 2 every 3 years.	N/A

Humana®

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 **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, **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: **800-927-HELP (4357)**, to file a grievance.

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

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。
Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .
Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.
Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.
Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.
Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.
Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.
Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.
Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.
Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
日本語 **(Japanese)**: 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。
فارسی (Farsi)
برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.
Diné Bizaad (Navajo): Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę niká'adoowoł.
العربية (Arabic)
الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

2024 VIS204

Humana Medicare Insight Network

When patients receive necessary routine vision services, they will be covered according to the following schedule.

Vision care services	In-network patient cost	Out-of-network reimbursement
Exam (One per calendar year) Routine eye exam (includes refraction)	$0 copay	Up to $175
Eyewear benefit Benefit toward the purchase of eyeglasses and pair of lenses or contact lenses (conventional or disposable)	Not covered	Not covered

Additional plan details:

Benefit allowance is applied toward the retail price. Member is responsible for any costs above the plan-approved amount.

The benefit can only be used one time. Any remaining benefit dollars do not "roll over" to a future purchase.

Eyeglass lens options may be available with the maximum benefit coverage amount up to one pair per year. Maximum benefit coverage amount is limited to one-time use per year.

Lost or broken materials are not covered.

Benefits are offered on a calendar basis. If benefits are changed or eliminated next year and were not used this year, the member is no longer eligible for them.

Humana®

Additional discounts:

Member may receive a 20% discount on items not covered by the plan at in-network locations. Discount does not apply to provider's professional services or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see our online provider locator to determine which participating providers have agreed to the discounted rate. Discounts on vision materials may not be applicable to certain manufacturers' products. The Plan reserves the right to make changes to the products on each tier and the member out-of-pocket costs. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Service and amounts listed above are subject to change at any time.

Members may receive a 40% discount off complete-pair eyeglass purchases and may receive a 15% discount off conventional contact lenses once the funded benefit has been used.

Member may receive a 15% discount off the retail price or may receive 5% off any promotional price of Lasik or photorefractive keratectomy (PRK) laser vision correction procedures. Lasik or PRK correction procedures are provided by the U.S. Laser Network, owned by LCA-Vision. Please note that since Lasik and PRK vision correction are elective procedures, performed by specially trained providers, this discount may not always be available from a provider in your immediate location, so members should first call **844-608-2020** for the nearest facility and to receive authorization for the discount.

Humana is a Medicare Advantage preferred provider organization (PPO) with a Medicare contract. Enrollment in any Humana plan depends on contract renewal.

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 **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, **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: **800-927-HELP (4357)**, to file a grievance.

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

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。
Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .
Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.
Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.
Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.
Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.
Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.
Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.
Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.
Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
日本語 **(Japanese)**: 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。
فارسی (Farsi)
برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.
Diné Bizaad (Navajo): Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę niká'adoowoł.
العربية (Arabic)
الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

GCHJV5REN 0721

2024

Prescription Drug Summary of Benefits

Humana Group Medicare Advantage Plan
Rx 591

Steamfitters Local 439 Health & Welfare Fund

Humana®

This page is left intentionally blank.

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

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

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

Deductible

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

Prescription Drug Benefits

Initial coverage (after you pay your deductible, if applicable)
You pay the following until your total yearly drug costs reach **$5,030**. 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)	**25%** of the cost (**$100** copay maximum per prescription)	**25%** of the cost (**$100** copay maximum per prescription)
2 (Preferred Brand)	**25%** of the cost (**$100** copay maximum per prescription)	**25%** of the cost (**$100** copay maximum per prescription)
3 (Non-Preferred Drug)	**25%** of the cost (**$100** copay maximum per prescription)	**25%** of the cost (**$100** copay maximum per prescription)
4 (Specialty Tier)	**25%** of the cost (**$100** copay maximum per prescription)	**25%** of the cost (**$100** copay maximum per prescription)
90-day supply		
1 (Generic or Preferred Generic)	**25%** of the cost (**$200** copay maximum per prescription)	**25%** of the cost (**$100** copay maximum per prescription)
2 (Preferred Brand)	**25%** of the cost (**$200** copay maximum per prescription)	**25%** of the cost (**$100** copay maximum per prescription)
3 (Non-Preferred Drug)	**25%** of the cost (**$200** copay maximum per prescription)	**25%** of the cost (**$100** copay maximum per prescription)
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 GRP**24**.

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.

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, Erectile Dysfunction, 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 **$5,030**.
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 **$8,000**, you have a **$0** copayment.

Notes

Notes

Notes

Important

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, 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.

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（听障专线：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（聽障專線：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 quí vị cần thông dịch viên xin gọi 1-877-320-1235 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí 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 답해 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 بخطتنا الصحية أو خطة الأدوية الموصوفة 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.

Portuguese: 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：当社の健康保険と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をご用意しています。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®

Humana.com

RX591EN24

2024

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.

24

This abridged formulary was updated on 10/11/2023 and is not a complete list of drugs covered by our plan. For a complete listing, or other questions, please contact the 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**.

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, 2024. For a complete, updated formulary, please contact us on our website at **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**.

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 Monday through Friday from 8 a.m. - 9 p.m., Eastern time. 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 Humana 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 Humana formulary?"

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2024 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2024 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, 2024. We will update the printed formularies each month and they will be available on **Humana.com/medicaredruglist**.

To get updated information about the drugs that Humana covers, please visit **Humana.com/medicaredruglist.**

How do I use the formulary?

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

Medical condition

The formulary starts on page 11. 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 11. Then look under the category name for your drug. The formulary also lists the Tier and Utilization Management Requirements for each drug (see page 6 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 36. 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 11.

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

You can ask the Humana Medicare Employer Plan to make an exception to these restrictions or limits. See the section "**How do I request an exception to the Humana formulary?**" on page 7 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** 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 them 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 36.

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 30.

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.
CI – Covered insulin products; Part D insulin products covered by your plan. For more information on cost sharing for your covered insulin products, please refer to your Evidence of Coverage.
AV – Advisory Committee on Immunization Practices (ACIP) Covered Part D vaccines; Part D vaccines recommended by ACIP for adults that may be available at no cost to you; additional restrictions may apply. For more information, please refer to your Evidence of Coverage.
PDS – Preferred Diabetic Supplies; BD and HTL- Droplet are the preferred diabetic syringe and pen needle brands for the plan.

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 6 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	
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	

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • B vs D - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
clindamycin hcl 300 mg CAPSULE **MO**	1	
daptomycin 500 mg RECON SOLUTION **DL**	4	
doxycycline hyclate 100 mg CAPSULE **MO**	1	
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)
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)
XCOPRI 100 MG, 50 MG TABLET **DL**	4	QL(30 per 30 days)
XCOPRI 150 MG, 200 MG TABLET **DL**	4	QL(60 per 30 days)
XCOPRI MAINTENANCE PACK 250MG/DAY(150 MG X1-100MG X1), 350 MG/DAY (200 MG X1-150MG X1) TABLET **DL**	4	QL(56 per 28 days)
XCOPRI TITRATION PACK 12.5 MG (14)- 25 MG (14) TABLET, DOSE PACK **MO**	3	QL(28 per 28 days)
XCOPRI TITRATION PACK 150 MG (14)- 200 MG (14), 50 MG (14)- 100 MG (14) TABLET, DOSE PACK **DL**	4	QL(28 per 28 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)

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • B vs D - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
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 CAPSULE, DR/EC **MO**	1	QL(120 per 30 days)
duloxetine 30 mg CAPSULE, DR/EC **MO**	1	QL(90 per 30 days)
duloxetine 60 mg CAPSULE, DR/EC **MO**	1	QL(60 per 30 days)
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
ondansetron hcl 4 mg TABLET **MO**	1	BvsD
promethazine 25 mg TABLET **MO**	1	
SANCUSO 3.1 MG/24 HOUR PATCH, WEEKLY **DL**	4	QL(4 per 30 days)

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • B vs D - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
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)
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)
anastrozole 1 mg TABLET **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)
exemestane 25 mg TABLET **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(120 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)

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • B vs D - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
RUXIENCE 10 MG/ML SOLUTION **DL**	4	PA
TRAZIMERA 150 MG, 420 MG RECON SOLUTION **DL**	4	PA
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)
ZIRABEV 25 MG/ML SOLUTION **DL**	4	PA
ANTIPARASITICS		
hydroxychloroquine 200 mg TABLET **MO**	1	
nitazoxanide 500 mg TABLET **DL**	4	
ANTIPARKINSON AGENTS		
carbidopa-levodopa 25-100 mg TABLET **MO**	1	
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 **MO**	3	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)
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)

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • B vs D - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
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 TABLET **MO**	3	QL(60 per 30 days)
RISPERDAL 1 MG/ML SOLUTION **DL**	4	
RISPERDAL 3 MG, 4 MG TABLET **DL**	4	QL(60 per 30 days)
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)
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)
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)

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • B vs D - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
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 **CI,MO**	2	
FIASP PENFILL U-100 INSULIN 100 UNIT/ML (3 ML) CARTRIDGE **CI,MO**	2	
FIASP U-100 INSULIN 100 UNIT/ML SOLUTION **CI,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	
HUMALOG KWIKPEN INSULIN 100 UNIT/ML, 200 UNIT/ML (3 ML) INSULIN PEN **CI,MO**	2	
HUMALOG MIX 50-50 INSULN U-100 100 UNIT/ML (50-50) SUSPENSION **CI,MO**	2	
HUMALOG MIX 50-50 KWIKPEN 100 UNIT/ML (50-50) INSULIN PEN **CI,MO**	2	
HUMALOG MIX 75-25 KWIKPEN 100 UNIT/ML (75-25) INSULIN PEN **CI,MO**	2	
HUMALOG MIX 75-25(U-100)INSULN 100 UNIT/ML (75-25) SUSPENSION **CI,MO**	2	
HUMALOG U-100 INSULIN 100 UNIT/ML CARTRIDGE **CI,MO**	2	
HUMALOG U-100 INSULIN 100 UNIT/ML SOLUTION **CI,MO**	2	
HUMULIN 70/30 U-100 INSULIN 100 UNIT/ML (70-30) SUSPENSION **CI,MO**	2	

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • B vs D - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
HUMULIN 70/30 U-100 KWIKPEN 100 UNIT/ML (70-30) INSULIN PEN **CI,MO**	2	
HUMULIN N NPH INSULIN KWIKPEN 100 UNIT/ML (3 ML) INSULIN PEN **CI,MO**	2	
HUMULIN N NPH U-100 INSULIN 100 UNIT/ML SUSPENSION **CI,MO**	2	
HUMULIN R REGULAR U-100 INSULN 100 UNIT/ML SOLUTION **CI,MO**	2	
HUMULIN R U-500 (CONC) INSULIN 500 UNIT/ML SOLUTION **CI,DL**	4	
HUMULIN R U-500 (CONC) KWIKPEN 500 UNIT/ML (3 ML) INSULIN PEN **CI,DL**	4	
INSULIN ASP PRT-INSULIN ASPART 100 UNIT/ML (70-30) INSULIN PEN **CI,MO**	2	
INSULIN ASP PRT-INSULIN ASPART 100 UNIT/ML (70-30) SOLUTION **CI,MO**	2	
INSULIN ASPART U-100 100 UNIT/ML (3 ML) INSULIN PEN **CI,MO**	2	
INSULIN ASPART U-100 100 UNIT/ML CARTRIDGE **CI,MO**	2	
INSULIN ASPART U-100 100 UNIT/ML SOLUTION **CI,MO**	2	
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)
LANTUS SOLOSTAR U-100 INSULIN 100 UNIT/ML (3 ML) INSULIN PEN **CI,MO**	2	
LANTUS U-100 INSULIN 100 UNIT/ML SOLUTION **CI,MO**	2	
LEVEMIR FLEXTOUCH U100 INSULIN 100 UNIT/ML (3 ML) INSULIN PEN **CI,MO**	3	PA
LEVEMIR U-100 INSULIN 100 UNIT/ML SOLUTION **CI,MO**	3	PA
metformin 1,000 mg, 500 mg TABLET **MO**	1	
metformin 500 mg TABLET, ER 24 HR. **MO**	1	QL(120 per 30 days)
MOUNJARO 10 MG/0.5 ML, 12.5 MG/0.5 ML, 15 MG/0.5 ML, 2.5 MG/0.5 ML, 5 MG/0.5 ML, 7.5 MG/0.5 ML PEN INJECTOR **MO**	2	QL(2 per 28 days)
NOVOLIN 70-30 FLEXPEN U-100 100 UNIT/ML (70-30) INSULIN PEN **CI,MO**	2	
NOVOLIN 70/30 U-100 INSULIN 100 UNIT/ML (70-30) SUSPENSION **CI,MO**	2	

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • B vs D - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
NOVOLIN N FLEXPEN 100 UNIT/ML (3 ML) INSULIN PEN **CI,MO**	2	
NOVOLIN N NPH U-100 INSULIN 100 UNIT/ML SUSPENSION **CI,MO**	2	
NOVOLOG FLEXPEN U-100 INSULIN 100 UNIT/ML (3 ML) INSULIN PEN **CI,MO**	2	
NOVOLOG MIX 70-30 U-100 INSULN 100 UNIT/ML (70-30) SOLUTION **CI,MO**	2	
NOVOLOG MIX 70-30FLEXPEN U-100 100 UNIT/ML (70-30) INSULIN PEN **CI,MO**	2	
NOVOLOG PENFILL U-100 INSULIN 100 UNIT/ML CARTRIDGE **CI,MO**	2	
NOVOLOG U-100 INSULIN ASPART 100 UNIT/ML SOLUTION **CI,MO**	2	
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 **CI,MO**	2	QL(15 per 24 days)
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 **CI,MO**	2	
TOUJEO SOLOSTAR U-300 INSULIN 300 UNIT/ML (1.5 ML) INSULIN PEN **CI,MO**	2	
TRADJENTA 5 MG TABLET **MO**	2	QL(30 per 30 days)
TRESIBA FLEXTOUCH U-100 100 UNIT/ML (3 ML) INSULIN PEN **CI,MO**	2	
TRESIBA U-100 INSULIN 100 UNIT/ML SOLUTION **CI,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 **CI,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	

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • B vs D - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
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)
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)

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • B vs D - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
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, 25 mg, 50 mg TABLET, ER 24 HR. **MO**	1	
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	
torsemide 20 mg TABLET **MO**	1	

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • B vs D - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
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)
mupirocin 2 % OINTMENT **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)
ELECTROLYTES/MINERALS/METALS/VITAMINS		
calcium acetate(phosphat bind) 667 mg CAPSULE **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	
potassium chloride 10 meq CAPSULE, ER **MO**	1	
potassium chloride 10 meq, 20 meq TABLET ER **MO**	1	
potassium chloride 10 meq, 20 meq TABLET, ER PARTICLES/CRYSTALS **MO**	1	

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • B vs D - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
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	
dicyclomine 10 mg CAPSULE MO	1	
dicyclomine 20 mg TABLET MO	1	
esomeprazole magnesium 40 mg CAPSULE, DR/EC MO	1	QL(60 per 30 days)
famotidine 20 mg, 40 mg TABLET MO	1	
lactulose 10 gram/15 ml SOLUTION MO	1	
LINZESS 145 MCG, 290 MCG, 72 MCG CAPSULE MO	2	QL(30 per 30 days)
misoprostol 200 mcg TABLET MO	1	
MOVANTIK 12.5 MG, 25 MG TABLET MO	2	QL(30 per 30 days)
omeprazole 20 mg, 40 mg CAPSULE, DR/EC MO	1	QL(60 per 30 days)
pantoprazole 20 mg, 40 mg TABLET, DR/EC MO	1	QL(60 per 30 days)
sucralfate 1 gram TABLET MO	1	
XIFAXAN 200 MG TABLET MO	3	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		
AMVUTTRA 25 MG/0.5 ML SYRINGE DL	4	PA,QL(0.5 per 90 days)
CERDELGA 84 MG CAPSULE DL	4	PA
CREON 24,000-76,000 -120,000 UNIT CAPSULE, DR/EC MO	2	
ELELYSO 200 UNIT RECON SOLUTION DL	4	PA
ONPATTRO 2 MG/ML SOLUTION DL	4	PA
ZENPEP 25,000-79,000- 105,000 UNIT CAPSULE, DR/EC MO	3	
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	

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • B vs D - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
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)		
desmopressin 0.1 mg, 0.2 mg TABLET **MO**	1	
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)
SOMATULINE DEPOT 120 MG/0.5 ML SYRINGE **DL**	4	PA,QL(0.5 per 28 days)
SOMATULINE DEPOT 60 MG/0.2 ML SYRINGE **DL**	4	PA,QL(0.2 per 28 days)
SOMATULINE DEPOT 90 MG/0.3 ML SYRINGE **DL**	4	PA,QL(0.3 per 28 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)
DUPIXENT SYRINGE 200 MG/1.14 ML SYRINGE **DL**	4	PA,QL(3.42 per 28 days)

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • B vs D - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
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)
ENVARSUS 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)
methotrexate sodium 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(168 per 365 days)
SHINGRIX (PF) 50 MCG/0.5 ML SUSPENSION FOR RECONSTITUTION **AV,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)
SOLIRIS 300 MG/30 ML SOLUTION **DL**	4	PA
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)

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • B vs D - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
STELARA 90 MG/ML SYRINGE **DL**	4	PA,QL(3 per 84 days)
TDVAX 2-2 LF UNIT/0.5 ML SUSPENSION **AV,DL**	1	
ULTOMIRIS 100 MG/ML SOLUTION	4	PA
VYVGART 20 MG/ML SOLUTION **DL**	4	PA
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	
BD INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 5/16" SYRINGE **PDS,MO**	1	
BD INSULIN SYRINGE U-500 1/2 ML 31 GAUGE X 15/64" SYRINGE **PDS,MO**	1	
BD INSULIN SYRINGE ULTRA-FINE 0.3 ML 30 GAUGE X 1/2", 0.3 ML 31 GAUGE X 5/16", 0.5 ML 30 GAUGE X 1/2", 0.5 ML 31 GAUGE X 5/16", 1 ML 30 GAUGE X 1/2", 1 ML 31 GAUGE X 5/16 SYRINGE **PDS,MO**	1	
BD NANO 2ND GEN PEN NEEDLE 32 GAUGE X 5/32" NEEDLE **PDS,MO**	1	
BD ULTRA-FINE MICRO PEN NEEDLE 32 GAUGE X 1/4" NEEDLE **PDS,MO**	1	
BD ULTRA-FINE MINI PEN NEEDLE 31 GAUGE X 3/16" NEEDLE **PDS,MO**	1	
BD ULTRA-FINE NANO PEN NEEDLE 32 GAUGE X 5/32" NEEDLE **PDS,MO**	1	
BD ULTRA-FINE ORIG PEN NEEDLE 29 GAUGE X 1/2" NEEDLE **PDS,MO**	1	
BD ULTRA-FINE SHORT PEN NEEDLE 31 GAUGE X 5/16" NEEDLE **PDS,MO**	1	
BD VEO INSULIN SYR (HALF UNIT) 0.3 ML 31 GAUGE X 15/64" SYRINGE **PDS,MO**	1	
BD VEO INSULIN SYRINGE UF 0.3 ML 31 GAUGE X 15/64", 1 ML 31 GAUGE X 15/64", 1/2 ML 31 GAUGE X 15/64" SYRINGE **PDS,MO**	1	
butalbital-acetaminophen-caff 50-325-40 mg TABLET **MO**	1	QL(180 per 30 days)
DROPLET INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 1/2", 0.3 ML 30 GAUGE X 15/64", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 15/64", 0.3 ML 31 GAUGE X 5/16", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 15/64", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 15/64", 1 ML 31 GAUGE X 5/16 SYRINGE **PDS,MO**	1	

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • B vs D - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
DROPLET PEN NEEDLE 29 GAUGE X 1/2", 29 GAUGE X 3/8", 30 GAUGE X 5/16", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 3/16", 32 GAUGE X 5/16", 32 GAUGE X 5/32" NEEDLE **PDS,MO**	1	
GIVLAARI 189 MG/ML SOLUTION **DL**	4	PA
OMNIPOD 5 G6 PODS (GEN 5) CARTRIDGE **MO**	2	
OXLUMO 94.5 MG/0.5 ML SOLUTION	4	PA
PAXLOVID 150-100 MG TABLET, DOSE PACK **MO**	2	QL(40 per 10 days)
PAXLOVID 300 MG (150 MG X 2)-100 MG TABLET, DOSE PACK **MO**	2	QL(60 per 10 days)
RECTIV 0.4 % (W/W) OINTMENT **MO**	3	QL(30 per 30 days)
V-GO 20 DEVICE **MO**	2	
V-GO 30 DEVICE **MO**	2	
V-GO 40 DEVICE **MO**	2	
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	
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)

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • B vs D - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
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(2.5 per 25 days)
ZERVIATE 0.24 % DROPPERETTE **MO**	3	QL(60 per 30 days)
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**	3	ST,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)
albuterol sulfate 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)
azelastine 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)
fluticasone propion-salmeterol 250-50 mcg/dose BLISTER WITH DEVICE **MO**	1	QL(60 per 30 days)
fluticasone propionate 50 mcg/actuation SPRAY, SUSPENSION **MO**	1	QL(16 per 30 days)
hydroxyzine pamoate 25 mg CAPSULE **MO**	1	
levocetirizine 5 mg TABLET **MO**	1	QL(30 per 30 days)
montelukast 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)

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • B vs D - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
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)
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 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • B vs D - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

Humana Medicare Employer Plan Coverage of Additional Prescription Drugs

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
Cosmetics - Mail Order Available		
bimatoprost 0.03 % DROPS WITH APPLICATOR	1	
blanche 4 % CREAM	1	
finasteride 1 mg TABLET	1	
hydrocortisone-pramoxine 2.5-1 % CREAM	1	
hydroquinone 4 % CREAM	1	
LATISSE 0.03 % DROPS WITH APPLICATOR	3	
obagi elastiderm 4 % CREAM	1	
obagi nu-derm blender 4 % CREAM	1	
obagi nu-derm clear 4 % CREAM	1	
PROPECIA 1 MG TABLET	3	
refissa 0.05 % CREAM	1	
RENOVA 0.02 % CREAM	3	
sulfacetamide sodium 10 % CLEANSER	1	
sulfacetamide sodium-sulfur 10-5 % (w/w) CREAM	1	
tretinoin (emollient) 0.05 % CREAM	1	
TRI-LUMA 0.01-4-0.05 % CREAM	3	
VANIQA 13.9 % CREAM	3	
Cough/Cold - Mail Order Available		
benzonatate 100 mg, 150 mg, 200 mg CAPSULE	1	
bromfed dm 2-30-10 mg/5 ml SYRUP	1	
brompheniramine-pseudoeph-dm 2-30-10 mg/5 ml SYRUP	1	

Your Humana Medicare Employer Plan has additional coverage for 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).

AV - ACIP Covered Part D vaccines • B vs D - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
Cough/Cold - Mail Order Available		
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	
hydrocodone-chlorpheniramine 10-8 mg/5 ml SUSPENSION, ER 12 HR.	1	
hydrocodone-homatropine 5-1.5 mg TABLET	1	
hydrocodone-homatropine 5-1.5 mg/5 ml, 5-1.5 mg/5 ml (5 ml) SYRUP	1	
hydromet 5-1.5 mg/5 ml SYRUP	1	
OBREDON 2.5-200 MG/5 ML SOLUTION	3	
promethazine vc-codeine 6.25-5-10 mg/5 ml SYRUP	1	
promethazine-codeine 6.25-10 mg/5 ml SYRUP	1	
promethazine-dm 6.25-15 mg/5 ml SYRUP	1	
promethazine-phenyleph-codeine 6.25-5-10 mg/5 ml SYRUP	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	
Erectile Dysfunction - Mail Order Available		
ADDYI 100 MG TABLET	3	
CIALIS 10 MG, 20 MG TABLET	3	QL(6 per 30 days)
sildenafil 100 mg, 25 mg, 50 mg TABLET	1	QL(6 per 30 days)

Your Humana Medicare Employer Plan has additional coverage for 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).

AV - ACIP Covered Part D vaccines • B vs D - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
Erectile Dysfunction - Mail Order Available		
STENDRA 100 MG, 200 MG, 50 MG TABLET	3	QL(6 per 30 days)
tadalafil 10 mg, 20 mg TABLET	1	QL(6 per 30 days)
vardenafil 10 mg TABLET, DISINTEGRATING	1	QL(6 per 30 days)
vardenafil 10 mg, 2.5 mg, 20 mg, 5 mg TABLET	1	QL(6 per 30 days)
VIAGRA 100 MG, 25 MG, 50 MG TABLET	3	QL(6 per 30 days)
VYLEESI 1.75 MG/0.3 ML AUTO-INJECTOR	3	
Fertility - Mail Order Available		
cetrorelix 0.25 mg KIT	1	
CETROTIDE 0.25 MG KIT	3	
clomid 50 mg TABLET	1	
clomiphene citrate 50 mg TABLET	1	
FOLLISTIM AQ 300 UNIT/0.36 ML, 600 UNIT/0.72 ML, 900 UNIT/1.08 ML CARTRIDGE	3	
fyremadel 250 mcg/0.5 ml SYRINGE	1	
GANIRELIX 250 MCG/0.5 ML SYRINGE	3	
ganirelix 250 mcg/0.5 ml SYRINGE	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 for 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).

AV - ACIP Covered Part D vaccines • B vs D - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

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	

Your Humana Medicare Employer Plan has additional coverage for 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).

AV - ACIP Covered Part D vaccines • B vs D - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
Vitamins/Minerals - Mail Order Available		
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	
vitamin k1 10 mg/ml SOLUTION	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)

Your Humana Medicare Employer Plan has additional coverage for 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).

AV - ACIP Covered Part D vaccines • B vs D - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
Weight Loss - Mail Order Available		
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 for 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).

AV - ACIP Covered Part D vaccines • B vs D - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

Index

C

D

E

N

O

P

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 (听障专线 : 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 (聽障專線 : 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 quí vị cần thông dịch viên xin gọi 1-877-320-1235 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí 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 답해 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 بخطتنا الصحية أو خطة الأدوية الموصوفة 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.

Portuguese: 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：当社の健康保険と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をご用意しています。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。日本語を話す者が支援いたします。これは無料のサービスです。

Notes

This abridged formulary was updated on 10/11/2023 and is not a complete list of drugs covered by our plan. For a complete listing, or other questions, please contact the 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**.

GRP024PDG2480024_v1

Humana®

Humana.com