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

Important plan information

2023 Humana Group Medicare

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

Beyond healthcare

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

Humana®

A more human way
to healthcare™

2023 HUMANA GROUP MEDICARE PREFERRED PROVIDER ORGANIZATION (PPO) PLAN

PPO

Jackson Health System

We're here for you

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

Humana is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal. Call **866-396-8810 (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.

Group Medicare Advantage
Preferred provider organization (PPO) plan guide

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

Inside this guide you'll find:

Plan specific information

- Inflation Reduction Act Flyer
- Medical Summary of Benefits
- Rx Summary of Benefits
- Prescription Drug Guide
- Enrollment Form Checklist
- Enrollment Form
- Business Reply Envelope

Humana®

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

Humana 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...

- You can go to any Medicare-approved provider or hospital, but you may save money using in-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

Humana Group Medicare Advantage PPO plan

Welcome to a more human way to healthcare

Take action to enroll

Dear Group Medicare Beneficiary,

We're excited to let you know that **Jackson Health System** 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 **FBMC Benefits Management, Inc, Service Center** at **855-565-4748 (TTY: 711)**, Monday - Friday, 7 a.m. - 7 p.m. Eastern Time.
- 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.
- Use Humana's Find a doctor tool at **Humana.com/FindaDoctor** for a list of providers.

Enrollment Information
- To begin your Humana coverage, please enroll before your effective date by filling out the enrollment form in the back of this book and mailing it in the enclosed envelope or fax to **877-889-9936**.
- You must complete a separate application for each family member eligible for your plan.
- You also have the option to enroll over the phone by calling our Customer Care number. Be sure to have your Medicare ID on hand.
- Please keep a copy of your application for your records.

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.

- continued on next page

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

  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

What is Medicare?

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

How does it work?

Medicare is divided into parts A, B, C and D. Parts A and B are called Original Medicare. You must be entitled to Medicare Part A and enrolled in Medicare Part B as the Humana Group Medicare PPO plan is a Medicare Advantage plan. You must also continue paying Medicare Part B premiums to remain enrolled in this plan.

Medicare Part A

Hospital insurance

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

Medicare Part B

Medical insurance

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

Medicare Part C

Medicare Advantage plans

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

Medicare Part D

Prescription drug coverage

It helps pay for the medications your provider prescribes and is available in a stand-alone prescription drug plan or included in a Medicare Advantage prescription drug plan. Like Part C Medicare Advantage plans, Part D is only available through private companies, such as Humana. Many Part C Medicare Advantage plans include Medicare Part D prescription drug coverage.

Your health at your fingertips with MyHumana

Get your personalized health information on MyHumana

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

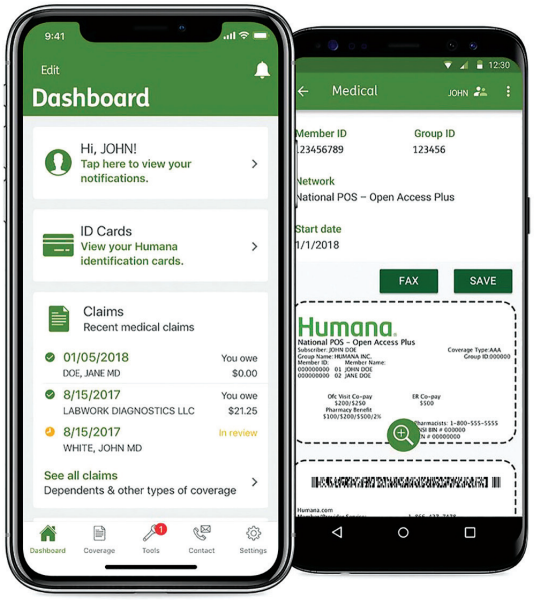
Getting started is easy—just have your Humana member ID card ready and follow these three steps:

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
- Compare drug prices
- View or print your Humana member ID card
- Select your communication preferences

Have questions?

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

Building healthy provider relationships

Having a relationship with your primary care provider (PCP) is important in protecting and managing your health. With the Humana Group Medicare PPO plan, you can use any provider who is part of our network. You also can go to any provider outside of our network who accepts Medicare and agrees to bill Humana, however your member cost share may be higher.

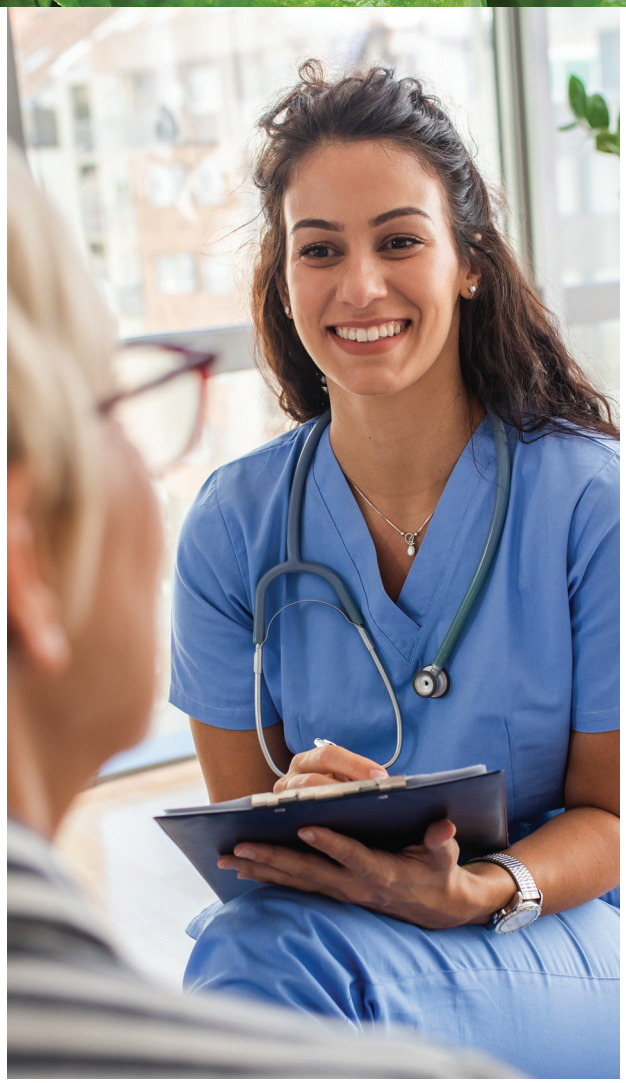
Why choose a Humana network provider?

- 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?

Humana respects your relationship with your provider. We want you to be able to select a provider who's close to home and who can focus on your specific needs. If you need help finding a provider, call our Group Medicare Customer Care team or use our online directory 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.

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

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

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

Options
Select a lookup method from 3 options:

1) Coverage type—choose Medicare or Medicare-Medicaid for the network that represents your plan (this is a required field),
2) Member ID, or
3) Sign in to MyHumana for more accurate results in finding your network.

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 **866-396-8810 (TTY: 711)**,
Monday – Friday, 8 a.m. – 9 p.m., Eastern 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

Use telehealth for minor illnesses and infections, medication refills, lab orders, help managing chronic conditions, and other nonemergency appointments, 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

You have many options for care. One option is Array.

Learn about Array, a national in-network virtual behavioral health provider, by visiting **Arraybc.com/patients/Humana** or call **888-410-0405 (TTY: 711)** to schedule your Array virtual visit.

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.

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

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

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

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

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

Download the consent form

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

Call Humana Customer Care

Call **866-396-8810 (TTY: 711)**, Monday – Friday, 8 a.m. – 9 p.m., Eastern time.

*The form needs to be renewed every 2 years.

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

Why choose CenterWell Pharmacy?

Experienced pharmacy team. Pharmacists are available to answer questions about your medication and CenterWell Pharmacy's services.

Safe and accurate. Two pharmacists check your new prescriptions to make sure they're safe to take with your other medications. The dispensing equipment and heat–sealed bottles with tamper-resistant foil help ensure quality and safety. Plus, your order comes in plain packaging for additional security.

Timely reminders. To help make sure you have the medication and supplies you need when you need them, CenterWell Pharmacy can remind you when it's time to refill your medication. Just set your preferences when you sign up at **CenterWellPharmacy.com**.

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

Make CenterWell Pharmacy your one source for:

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

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

CenterWellPharmacy.com

After you become a Humana member, you can sign in with your MyHumana identification number. You can also call them at **800-379-0092 (TTY: 711)**, Mon. – Fri., 8 a.m. - 11 p.m., and Sat., 8 a.m. - 6:30 p.m., Eastern time.

Online

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

Provider

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

Mail

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

Phone

For maintenance medication(s), call CenterWell Pharmacy at **800-379-0092 (TTY: 711)**, Mon. – Fri., 8 a.m. - 11 p.m., and Sat., 8 a.m. - 6:30 p.m., Eastern time.

For specialty medication(s), call CenterWell Specialty Pharmacy at **800-486-2668 (TTY: 711)**, Mon. – Fri., 8 a.m. - 11 p.m., and Sat., 8 a.m. - 6:30 p.m., Eastern time.

*Other pharmacies are available in the network.
† Some prescriptions are only available in a 30-day supply.

Medicare Part D prescription drug tiers

Tier 1 – Generic or preferred generic

Essentially the same drugs, usually priced differently

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

Tier 2 – Preferred brand

A medication available to you for less than a nonpreferred

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

Tier 3 – Nonpreferred drug

A more expensive drug than a preferred

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

Tier 4 – Specialty

Drugs for specific uses

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

Important information about your prescription drug coverage

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

Prior authorization

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

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

Step therapy

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

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

Quantity limits

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

One-time transition fill

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

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

Next steps for you

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

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

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

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

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

Comprehensive medication review

As part of your Medicare Part D coverage with Humana, you may be eligible to set up a one-on-one review of your medications with a pharmacist or other healthcare provider trained in medication therapy management (MTM). This review is called a comprehensive medication review (CMR) and is offered at no extra cost to members meeting eligibility requirements. MTM may help you to:

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

Who's eligible?

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

- Have three of the five chronic conditions:
  - Mental health-bipolar
  - Hypertension
  - Dyslipidemia (high or low LDL cholesterol)
  - Bone disease (arthritis, osteoporosis)
  - Chronic obstructive pulmonary disease (COPD); and
- Take at least eight chronic/maintenance (Part D) drugs; and
- Likely to have annual Part D medication costs of $4,935 or more.

Scheduling a consultation

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

What you need for your review

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

A Humana pharmacist or other trained healthcare provider is available to help you complete your CMR. Please call **888-686-4486 (TTY: 711)**, Monday – Friday, 8 a.m. - 7 p.m., Eastern time, or visit **Humana.com/mtm**.

Where you get your vaccines may determine how it is covered

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

Vaccines at your provider's office

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

Vaccines at a network pharmacy

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

Diabetes coverage

Diabetes prescriptions and supplies

Medicare Part B

Generally, Part B covers the services that may affect people with diabetes. Part B also covers certain preventive services for people at risk for diabetes. You must have Part B to get the services and supplies it covers.

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

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

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 RocheDiabetes
- Accu-Chek Guide® by RocheDiabetes

To order a meter and supplies from CenterWell Pharmacy, call **888-538-3518 (TTY: 711)**, Monday – Friday, 8 a.m. - 11 p.m., and Sat., 8 a.m. - 6:30 p.m., Eastern time.

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

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

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

Your personalized benefits statement

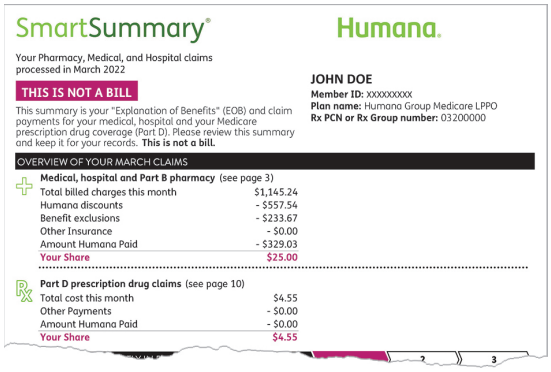
Humana's SmartSummary provides a comprehensive overview of your health benefits and healthcare spending. **You'll receive this statement after each month you've had a claim processed.** You can also sign in to your MyHumana account and see your past SmartSummary statements anytime.

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®

Humana.

Your Pharmacy, Medical, and Hospital claims processed in March 2022

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: XXXXXXXXX
Plan name: Humana Group Medicare LPPO
Rx PCN or Rx Group number: 03200000

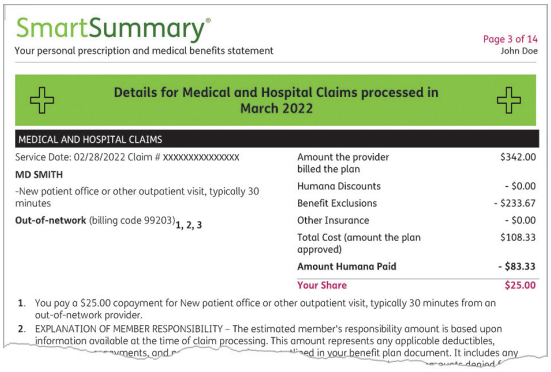
OVERVIEW OF YOUR MARCH CLAIMS

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

Total billed charges this month	$1,145.24
Humana discounts	- $557.54
Benefit exclusions	- $233.67
Other Insurance	- $0.00
Amount Humana Paid	- $329.03
Your Share	$25.00

Part D prescription drug claims (see page 10)

Total cost this month	$4.55
Other Payments	- $0.00
Amount Humana Paid	- $0.00
Your Share	$4.55



SmartSummary®
Your personal prescription and medical benefits statement
Page 3 of 14
John Doe

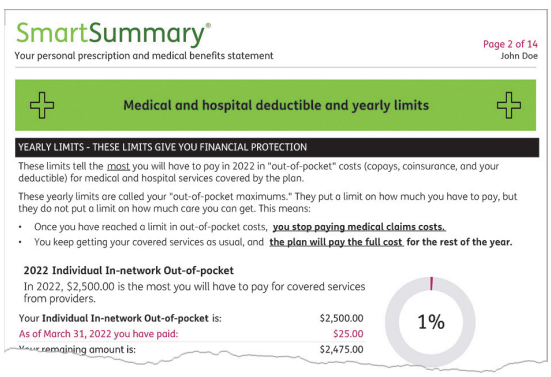
Details for Medical and Hospital Claims processed in March 2022

MEDICAL AND HOSPITAL CLAIMS

Service Date: 02/28/2022 Claim # XXXXXXXXXXXXX
MD SMITH
-New patient office or other outpatient visit, typically 30 minutes
Out-of-network (billing code 99203)[1, 2, 3]

Amount the provider billed the plan	$342.00
Humana Discounts	- $0.00
Benefit Exclusions	- $233.67
Other Insurance	- $0.00
Total Cost (amount the plan approved)	$108.33
Amount Humana Paid	**- $83.33**
Your Share	**$25.00**

1. You pay a $25.00 copayment for New patient office or other outpatient visit, typically 30 minutes from an out-of-network provider.
2. EXPLANATION OF MEMBER RESPONSIBILITY – The estimated member's responsibility amount is based upon information available at the time of claim processing. This amount represents any applicable deductibles, [illegible] ed in your benefit plan document. It includes any [illegible]



SmartSummary®
Your personal prescription and medical benefits statement
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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 2022 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:

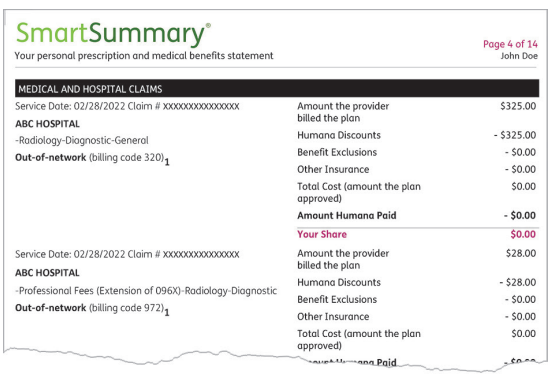
- Once you have reached a limit in out-of-pocket costs, **you stop paying medical claims costs.**
- You keep getting your covered services as usual, and **the plan will pay the full cost for the rest of the year.**

2022 Individual In-network Out-of-pocket

In 2022, $2,500.00 is the most you will have to pay for covered services from providers.

Your **Individual In-network Out-of-pocket** is:	$2,500.00
As of March 31, 2022 you have paid:	$25.00
Your remaining amount is:	$2,475.00

1%



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MEDICAL AND HOSPITAL CLAIMS

Service Date: 02/28/2022 Claim # XXXXXXXXXXXXX
ABC HOSPITAL
-Radiology-Diagnostic-General
Out-of-network (billing code 320)[1]

Amount the provider billed the plan	$325.00
Humana Discounts	- $325.00
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: 02/28/2022 Claim # XXXXXXXXXXXXX
ABC HOSPITAL
-Professional Fees (Extension of 096X)-Radiology-Diagnostic
Out-of-network (billing code 972)[1]

Amount the provider billed the plan	$28.00
Humana Discounts	- $28.00
Benefit Exclusions	- $0.00
Other Insurance	- $0.00
Total Cost (amount the plan approved)	$0.00
Amount Humana Paid	[illegible]

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, getting your Annual Wellness Visit or volunteering. 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.

Activity	Reward*	Activity limit
Annual Wellness Visit	$25	1 per year
Mammogram	$30	1 per year
Colorectal screening Ages 45+		
Colorectal kit	$20	1 per year†
Colonoscopy / Sigmoidoscopy	$50	
Bone density screening	$20	once every 2 years†

*Amounts shown represent the value of the reward, not actual dollars.
†If applicable.

Rewards have no cash value and can only be redeemed in the Go365 Mall. Rewards must be earned and redeemed within the same program year. Rewards not redeemed before Dec. 31 will be forfeited. Some items may be discontinued in the Go365 Mall and new items may be added. For the most updated list, visit **Go365.com** or call **866-677-0999 (TTY: 711)**. Gift cards cannot be used to purchase prescription drugs or medical services that are covered by Medicare, Medicaid or other federal healthcare programs, alcohol, tobacco, e-cigarettes, or firearms. Gift cards must not be converted to cash.

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. Call **800-432-4803 (TTY: 711)** 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

Ready to get started on your path to better health? 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)**, 8 a.m. - 6 p.m., Eastern time.

Humana Neighborhood Center

Humana always has something going on. Humana Neighborhood Centers offer a variety of classes in-person and online, from the comfort of your home.

Watch daily online classes like cooking demos, crafts, and meditation. Check out our calendar to RSVP for upcoming events, browse our video library to see every previous class to date, and create an account to get a personalized experience of each one.

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 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 and definitions

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 and definitions

Catastrophic coverage

What you pay for covered drugs after reaching $7,400
Once your out-of-pocket costs reach the $7,400 maximum, you pay a small coinsurance or a small copayment for covered drug costs until the end of the plan year.

Coinsurance

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

Copayment

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

Deductible

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

Exclusions and limitations

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

Formulary

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

Out-of-pocket

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

Know your numbers

Find important numbers anytime you need them*

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

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

CenterWell Pharmacy™
800-379-0092 (TTY: 711),
Monday – Friday, 8 a.m. - 11 p.m., and Sat., 8 a.m. - 6:30 p.m., Eastern time
CenterWellPharmacy.com

Medicare Health Assessment
888-445-3389 (TTY: 711), 24 hours a day, 7 days a week

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.

Caregivers
866-396-8810 (TTY: 711),
Monday – Friday, 8 a.m. – 9 p.m., Eastern time
Humana.com/caregiver

SilverSneakers®
888-423-4632 (TTY: 711),
Monday – Friday, 8 a.m. – 8 p.m., Eastern time
SilverSneakers.com

Go365 by Humana™
Humana.com/go365

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

State health insurance program offices
800-633-4227 (TTY: 711), 24 hours a day, 7 days a week
www.cms.gov/apps/contacts/#

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

Important

At Humana, it is important you are treated fairly.

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

- The following department has been designated to handle inquiries regarding Humana's non-discrimination policies: Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618, **866-396-8810 (TTY: 711)**.

Auxiliary aids and services, free of charge, are available to you. 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.

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。

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Humana® A more human way to healthcare™

2023 enhanced vaccine and insulin coverage

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

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

$0 vaccines

Member cost share of all Part D vaccines listed on the Advisory Committee on Immunization Practices (ACIP) list[1] will be **$0**.

$35 insulin copay

Member cost share of this plan's covered insulin products covered under Part B[2] and Part D will be **no more than $35** for every one-month (up to a 30-day) supply.

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

→ Please check **Humana.com** frequently for updates on these benefit enhancements.

→ If you have questions about these benefit enhancements or general questions about the plan, contact Humana Group Medicare Customer Care.

Humana®

[1]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.

[2]Part B insulin coverage will be no more than $35 for a one-month (up to a 30-day) supply starting July 1, 2023.

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2023

Summary of Benefits

Humana Group Medicare Advantage PPO Plan
PPO 079/187

Humana®

Our service area includes the following: **Alabama**: Baldwin, Barbour, Chambers, Clarke, Coffee, Covington, Dale, Escambia, Geneva, Henry, Houston, Lee, Mobile, Randolph, Russell; **Arizona**: Cochise, Gila, Graham, Greenlee, Maricopa, Pima, Pinal, Santa Cruz; **Arkansas**: Crittenden; **Colorado**: Adams, Alamosa, Arapahoe, Archuleta, Bent, Boulder, Broomfield, Chaffee, Clear Creek, Conejos, Costilla, Crowley, Custer, Delta, Denver, Dolores, Douglas, El Paso, Elbert, Fremont, Gilpin, Grand, Gunnison, Hinsdale, Huerfano, Jackson, Jefferson, La Plata, Lake, Larimer, Las Animas, Lincoln, Logan, Mesa, Mineral, Montezuma, Montrose, Morgan, Otero, Ouray, Park, Pueblo, Rio Blanco, Rio Grande, Saguache, San Juan, San Miguel, Summit, Teller, Washington, Weld; **Florida**: Alachua, Baker, Bay, Bradford, Broward, Calhoun, Clay, Columbia, Dixie, Duval, Escambia, Flagler, Franklin, Gadsden, Gilchrist, Gulf, Hamilton, Holmes, Jackson, Jefferson, Lafayette, Levy, Liberty, Madison, Miami-Dade, Nassau, Okaloosa, Palm Beach, Putnam, Saint Johns, Santa Rosa, Suwannee, Taylor, Union, Volusia, Wakulla, Walton, Washington; **Illinois**: Bond, Calhoun, Clinton, Cook, Dekalb, DuPage, Jersey, Kane, Kankakee, Kendall, Lake, Macoupin, Madison, McHenry, Monroe, Saint Clair, Will; **Kansas**: Allen, Anderson, Atchison, Bourbon, Brown, Cherokee, Coffey, Crawford, Doniphan, Douglas, Ellsworth, Franklin, Geary, Greenwood, Jackson, Jefferson, Johnson, Labette, Leavenworth, Linn, Lyon, Marshall, Miami, Montgomery, Nemaha, Neosho, Osage, Pawnee, Pottawatomie, Riley, Russell, Shawnee, Wabaunsee, Washington, Wilson, Wyandotte; **Missouri**: Adair, Andrew, Atchison, Audrain, Barry, Barton, Bates, Benton, Bollinger, Boone, Butler, Caldwell, Callaway, Camden, Carroll, Carter, Cass, Cedar, Chariton, Christian, Clark, Clay, Clinton, Cole, Cooper, Crawford, Dade, Dallas, Daviess, Dekalb, Douglas, Dunklin, Franklin, Gasconade, Gentry, Greene, Grundy, Henry, Hickory, Holt, Howard, Howell, Iron, Jackson, Jasper, Jefferson, Johnson, Knox, Laclede, Lafayette, Lawrence, Lewis, Lincoln, Linn, Livingston, Macon, Madison, Maries, Marion, McDonald, Mercer, Miller, Mississippi, Moniteau, Monroe, Montgomery, Morgan, New Madrid, Newton, Oregon, Osage, Ozark, Pemiscot, Perry, Pettis, Phelps, Pike, Platte, Polk, Pulaski, Putnam, Ralls, Randolph, Ray, Reynolds, Ripley, Saint Charles, Saint Clair, Saint Francois, Saint Louis, Saint Louis City, Sainte Genevieve, Saline, Schuyler, Scotland, Shannon, Shelby, Stoddard, Stone, Sullivan, Taney, Texas, Vernon, Warren, Washington, Webster, Worth, Wright; **Nevada**: Clark, Mineral, Nye; **New Mexico**: Dona Ana, Luna, Otero; **Utah**: Beaver, Box Elder, Cache, Davis, Duchesne, Emery, Grand, Iron, Juab, Kane, Millard, Morgan, Rich, Salt Lake, San Juan, Summit, Tooele, Utah, Wasatch, Washington, Weber.

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 **1-866-396-8810** for questions **(TTY/TDD 711)**

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

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

Humana Group Medicare Advantage 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 Humana, your employer/union group, or your employer group benefits plan administrator.	
Medical deductible	This plan does not have a deductible.	
Maximum out-of-pocket responsibility The most you pay for copays, coinsurance and other costs for medical services for the year.	**In-Network Maximum Out-of-Pocket** **$4,000** out-of-pocket limit for Medicare-covered services. The following services do not apply to the maximum out-of-pocket: Part D Pharmacy; Dental Services (Routine); Fitness Program; Health Education Services; Hearing Services (Routine); Meal Benefit; OTC Drugs and Supplies; Post-Discharge Personal Home Care; Post-Discharge Transportation Services; 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** **$6,700** out-of-pocket limit for Medicare-covered services. In-Network Exclusions: Part D Pharmacy; Dental Services (Routine); Fitness Program; Health Education Services; Hearing Services (Routine); Meal Benefit; OTC Drugs and Supplies; Post-Discharge Personal Home Care; Post-Discharge Transportation Services; 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; Dental Services (Routine); Hearing Services (Routine); 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 out-of-pocket costs, we will pay the full cost for the rest of the year on covered hospital and medical services.

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
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.	**$250** copay per day for days 1-5	**$295** copay per day for days 1-5
OUTPATIENT HOSPITAL COVERAGE		
Outpatient hospital visits	**$0** to **$200** copay or **20%** of the cost	**20%** to **50%** of the cost
Ambulatory surgical center	**$150** copay	**50%** of the cost
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	**$0** copay	**$65** copay
Specialists	**$35** copay	**$65** 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**	**$0** copay or **0%** to **50%** of the cost for Medicare-covered preventive services **50%** of the cost for a supplemental annual physical exam
EMERGENCY CARE		
Emergency room If you are admitted to the hospital within 24 hours for the same condition, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.	**$90** copay for Medicare-covered emergency room visit(s)	**$90** 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** to **$35** copay	**$0** to **$65** 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 SERVICES, LABS AND IMAGING		
Diagnostic radiology	**$150** to **$175** copay or **20%** of the cost	**50%** of the cost
Lab services	**$0** copay	**50%** of the cost
Diagnostic tests and procedures	**$0** to **$35** copay or **20%** of the cost	**$0** to **$65** copay or **50%** of the cost
Outpatient X-rays	**$0** to **$35** copay or **20%** of the cost	**$0** to **$65** copay or **50%** of the cost
Radiation therapy	**$35** copay or **20%** of the cost	**$65** copay or **50%** of the cost
HEARING SERVICES		
Medicare-covered hearing	**$35** copay	**$65** copay
Routine hearing	**$0** copay for routine hearing exams up to 1 per year.	**$0** copay for routine hearing exams up to 1 per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
DENTAL SERVICES		
Medicare-covered dental	**$35** 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)	**$65** 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** copay for bitewing x-rays up to 1 set(s) per year. **$0** copay for amalgam filling, oral evaluation, prophylaxis (cleaning) up to 1 per year.	**$0** copay for bitewing x-rays up to 1 set(s) per year. **$0** copay for amalgam filling, oral evaluation, prophylaxis (cleaning) 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
VISION SERVICES		
Medicare-covered vision services	**$35** copay (services include diagnosis and treatment of diseases and injuries of the eye)	**$65** copay (services include diagnosis and treatment of diseases and injuries of the eye)
Medicare-covered diabetic eye exam	**$0** copay	**$65** copay
Medicare-covered glaucoma screening	**$0** copay	**50%** of the cost
Medicare-covered eyewear (post-cataract)	**$35** copay	**$65** copay
Routine vision	**$40** combined maximum benefit coverage amount per year for routine exam (includes refraction) up to 1 per year. **$100** combined maximum benefit coverage amount per year for contact lenses, eyeglasses (lenses and frames), including lens options such as ultraviolet protection and scratch resistant coating, fitting for eyeglasses (lenses and frames).	**$40** combined maximum benefit coverage amount per year for routine exam (includes refraction) up to 1 per year. **$100** combined maximum benefit coverage amount per year for contact lenses, eyeglasses (lenses and frames), including lens options such as ultraviolet protection and scratch resistant coating, fitting for eyeglasses (lenses and frames). 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	**$250** copay per day for days 1-5	**$295** copay per day for days 1-5
Outpatient group and individual therapy visits	**Outpatient therapy visit:** **$0** to **$35** copay or **20%** of the cost **Partial Hospitalization:** **$35** copay	**Outpatient therapy visit:** **$0** to **$65** copay or **50%** of the cost **Partial Hospitalization:** **$65** 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 1-20 **$160** copay per day for days 21-100	**$250** copay per day for days 1-58 **$0** copay per day for days 59-100
PHYSICAL THERAPY		
	$10 copay	**$65** copay or **50%** of the cost
AMBULANCE		
Per date of service regardless of the number of trips. Limited to Medicare-covered transportation.	**$240** copay	**$240** copay
PART B PRESCRIPTION DRUGS		
	0% to **20%** of the cost	**0%** to **20%** 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 **20** combined In & Out-of-Network visit limit per plan year Your plan allows services to be received by a provider licensed to perform acupuncture or by providers meeting the Original Medicare provider requirements.	**$35** copay	**$65** copay
ALLERGY		
Allergy shots & serum	**$0** to **$35** copay	**$65** copay
CHIROPRACTIC SERVICES		
Medicare-covered chiropractic visit(s)	**$20** copay	**$65** copay
COVID-19		
Testing and Treatment	Plan specific cost share is applicable to hospitalization, medical services, and FDA approved Rx with confirmed COVID-19 diagnosis.	
DIABETES MANAGEMENT TRAINING		
	$0 copay	**50%** of the cost
FOOT CARE (PODIATRY)		
Medicare-covered foot care	**$35** copay	**$65** copay
HOME HEALTH CARE		
	$0 copay	**50%** of the cost
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment (like wheelchairs or oxygen)	**17%** to **20%** of the cost	**20%** of the cost
Medical supplies	**20%** of the cost	**20%** to **25%** of the cost
Prosthetics (artificial limbs or braces)	**20%** of the cost	**25%** of the cost
Diabetes monitoring supplies	**10%** to **17%** of the cost	**22%** to **50%** of the cost

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Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
OUTPATIENT SUBSTANCE ABUSE		
Outpatient group and individual substance abuse treatment visits	**$0** to **$35** copay or **20%** of the cost	**$0** to **$65** copay or **50%** of the cost
OVER-THE-COUNTER ITEMS		
	$75 maximum benefit coverage amount per quarter (3 months) for select over-the-counter health and wellness products.	
REHABILITATION SERVICES		
Occupational and speech therapy	**$10** copay	**$65** copay or **50%** of the cost
Cardiac rehabilitation	**$10** copay	**$65** copay or **50%** of the cost
Pulmonary rehabilitation	**$10** copay	**$65** copay or **50%** of the cost
RENAL DIALYSIS		
Renal dialysis	**20%** of the cost	**20%** of the cost
Kidney disease education services	**$0** copay	**50%** of the cost
TELEHEALTH SERVICES (in addition to Original Medicare)		
Primary care provider (PCP)	**$0** copay	Not Covered
Specialist	**$35** copay	Not Covered
Urgent care services	**$0** copay	Not Covered
Substance abuse or behavioral health services	**$0** copay	Not Covered
THERAPEUTIC SHOES AND INSERTS		
	$10 copay	**50%** of the cost

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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.		

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

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

Japanese: 当社の健康健康保険と薬品処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。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。日本語を話す人者が支援いたします。これは無料のサービスです。

Find out **more**

You can see your plan's 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

SB079187EN23

2023

Prescription Drug Summary of Benefits

Humana Group Medicare Advantage Plan
Rx 413

Humana®

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

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

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

Deductible

Pharmacy (Part D) deductible This plan has a **$150** deductible for Tier 2, Tier 3, Tier 4.

Prescription Drug Benefits

Initial coverage (after you pay your deductible, if applicable)
You pay the following until your total yearly drug costs reach **$4,660**. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

Tier	Standard Retail Pharmacy	Standard Mail Order
30-day supply		
1 (Generic or Preferred Generic)	**$2** copay	**$2** copay
2 (Preferred Brand)	**$47** copay	**$47** copay
3 (Non-Preferred Drug)	**$100** copay	**$100** copay
4 (Specialty Tier)	**30%** of the cost	**30%** of the cost
90-day supply		
1 (Generic or Preferred Generic)	**$6** copay	**$0** copay
2 (Preferred Brand)	**$141** copay	**$131** copay
3 (Non-Preferred Drug)	**$300** copay	**$290** copay
4 (Specialty Tier)	N/A	N/A

There may be generic and brand-name drugs, as well as Medicare-covered drugs, in each of the tiers. To identify commonly prescribed drugs in each tier, see the Prescription Drug Guide/Formulary. To view the most complete and current Drug Guide information online, visit **www.humana.com/SearchResources**, locate Prescription Drug section, select **www.humana.com/MedicareDrugList** link; under Printable drug lists, click Printable Drug lists, select future plan year, select Group Medicare under Plan Type and search for GRP**1**.

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

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

ADDITIONAL DRUG COVERAGE

Home Infusion Therapy Drugs	If you take certain types of infusion drugs covered under our Medicare Advantage Prescription Drug plans (MA/PD), you may qualify for this service, which helps you and your doctor manage your care without ongoing hospitalization. In some situations home infusion drugs will be covered based on the tier of the drug at the same cost share amount as listed in the chart above when you have reached a total yearly drug cost of **$4,660**. This service includes coverage for the "Coverage Gap" portion of your plan. Drugs included in this coverage are those that would be used as an alternative to inpatient treatment. Your cost for the medication may be the same as it is before the coverage gap sets in. Your out-of-pocket expenses while using this service apply to your "true out-of-pocket" maximum, which is **$7,400** for 2023.

Coverage Gap

Most Medicare drug plans have a coverage gap (also called the "donut hole"). The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches **$4,660**. After you enter the coverage gap, you pay a portion of the plan's cost for covered brand name drugs and covered generic drugs until your costs total **$7,400**, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$7,400**, you pay the greater of either:

- **$4.15** for generic (including brand drugs treated as generic) and a **$10.35** copay for all other drugs, OR
- **5%** coinsurance

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

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

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

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

Japanese: 当社の健康健康保険と薬品処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。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。日本語を話す人者が支援いたします。これは無料のサービスです。

Find out **more**

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

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

Humana is a Medicare Advantage HMO, PPO organization and a stand-alone prescription drug plan with a Medicare contract. Enrollment in any Humana plan depends on contract renewal.

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RX413EN23

2023

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.

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This abridged formulary was updated on 10/12/2022 and is not a complete list of drugs covered by our plan. For a complete listing, or other questions, please contact Humana Medicare Employer Plan with any questions at the number on the back of your membership card or for TTY users, 711, Monday through Friday, from 8 a.m. - 9 p.m. Eastern time. Our automated phone system is available after hours, weekends, and holidays. Our website is also available 24 hours a day 7 days a week by visiting **Humana.com.**

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

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

Instructions for getting information about all covered drugs are inside.

Humana®

Welcome to The Humana Medicare Employer Plan!

Note to existing members: This formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take. When this drug list (formulary) refers to "we," "us", or "our," it means Humana. When it refers to "plan" or "our plan," it means the Humana Medicare Employer Plan. This document includes a partial list of the drugs (formulary) for our plan which is current as of January 1, 2023. For a complete, updated formulary, please contact us on our website at **Humana.com/PlanDocuments** 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**. The Drug List Search tool lets you search for your drug by name or drug type.

If you are thinking about enrolling in a Humana Medicare Employer Plan and need help or a complete list of covered drugs, please contact Group Medicare Customer Care number listed in your enrollment materials. If you are a current member, call the number or visit the website listed in your Annual Notice of Change (ANOC) or Evidence of Coverage (EOC), or call the number on the back of your Humana member identification card. Our live representatives are available from 8 a.m. to 9 p.m. (EST), Monday through Friday. Our automated phone system is available after hours, weekends, and holidays.

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

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

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

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

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

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

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2023 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2023 coverage year except as described above. This means these drugs will remain available at the same cost sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs.

What if you are affected by a Drug List change?
We will notify you by mail at least 30 days before one of these changes happens or we will provide a 30-day refill of the affected medicine with notice of the change.

The enclosed formulary is current as of January 1, 2023. We will update the printed formularies each month and they will be available on **Humana.com/medicaredruglist**.

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

How do I use the formulary?
There are two ways to find your drug in the formulary:

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

Alphabetical listing
If you are not sure about your drug's group, you should look for your drug in the Index that begins on page 26. The Index is an alphabetical list of all of the drugs included in this document. Both brand-name drugs and generic drugs are listed. Look in the Index to search for your drug. Next to each drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of the drug in the first column of the list.

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

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

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

The amount of money you pay depends on:

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

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

Are there any restrictions on my coverage?
Some covered drugs may have additional requirements or limits on coverage. These are called Utilization Management Requirements. These requirements and limits may include:

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

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

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

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

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

What if my drug is not on the formulary?
If your drug is not included in this list of covered drugs, visit **Humana.com/medicaredruglist** to see if your plan covers your drug. You can also call Group Medicare Customer Care and ask if your drug is covered.

If the Humana Medicare Employer Plan does not cover your drug, you have two options:
- You can ask Group Medicare Customer Care for a list of similar drugs that the Humana Medicare Employer Plan covers. Show the list to your doctor and ask him or her to prescribe a similar drug that is covered by the Humana Medicare Employer Plan.
- You can ask the Humana Medicare Employer Plan to make an exception and cover your drug. See below for information about how to request an exception.

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

How do I request an exception to the Humana formulary?
You can ask the Humana Medicare Employer Plan to make an exception to the coverage rules. There are several types of exceptions that you can ask to be made.
- **Formulary exception:** You can request that your drug be covered if it is not on the formulary. If approved, this drug will be covered at a pre-determined cost sharing level, and you would not be able to ask us to provide the drug at a lower cost sharing level.
- **Utilization restriction exception:** You can request coverage restrictions or limits not be applied to your drug. For example, if your drug has a quantity limit, you can ask for the limit not to be applied and to cover more doses of the drug.
- **Tier exception:** You can request a higher level of coverage for your drug. For example, if your drug is usually considered a non-preferred drug, you can request it to be covered as a preferred drug instead. This would lower how much money you must pay for your drug. Please remember a higher level of coverage cannot be requested for the drug if approval was granted to cover a drug that was not on the formulary. *You can ask us to cover a formulary drug at a lower cost-sharing level, unless the drug is on the specialty tier.*

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

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

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

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

Will my plan cover my drugs if they are not on the formulary?
You may take drugs that your plan does not cover. Or you may talk to your provider about taking a different drug that your plan covers, but that drug might have a Utilization Management Requirement, such as a Prior

Authorization or Step Therapy, that keeps you from getting the drug right away. In certain cases, we may cover as much as a 30-day supply of your drug during the first 90 days you are a member of the plan.

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

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

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

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

Throughout the plan year, your treatment setting (the place where you receive and take your medicine) may change. These changes include:

- Members who are discharged from a hospital or skilled-nursing facility to a home setting
- Members who are admitted to a hospital or skilled-nursing facility from a home setting
- Members who transfer from one skilled-nursing facility to another and use a different pharmacy
- Members who end their skilled-nursing facility Medicare Part A stay (where payments include all pharmacy charges) and who now need to use their Part D plan benefit
- Members who give up Hospice Status and go back to standard Medicare Part A and B coverage
- Members discharged from chronic psychiatric hospitals with highly individualized drug regimens

For these changes in treatment settings, the Humana Medicare Employer Plan will cover as much as a 31-day temporary supply of a Part D-covered drug when you fill your prescription at a pharmacy. If you change treatment settings multiple times within the same month, you may have to request an exception or prior authorization and receive approval for continued coverage of your drug. The Humana Medicare Employer Plan will review requests for continuation of therapy on a case-by-case basis understanding when you are on a stabilized drug regimen that, if changed, is known to have risks.

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

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

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

Other pharmacies are available in our network.

For More Information

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

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

Humana Medicare Employer Plan Formulary

The formulary that begins on the next page provides coverage information about the drugs covered by the Humana Medicare Employer Plan. If you have trouble finding your drug in the list, turn to the Index that begins on page 26.

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**.

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:
HI - Home Infusion drugs that are covered in the gap
DL - Dispensing Limit; Drugs that may be limited to a 30 day supply, regardless of tier placement.
MO - Drugs that are typically available through mail-order. Please contact your mail-order pharmacy to make sure your drug is available.
LA - Limited Access; The health plan has authorized certain pharmacies to dispense this medicine, as it requires extra handling, doctor coordination or patient education. Please call the number on the back of your ID card for additional information.

The second column lists the tier of the drug. See page 5 for more details on the drug tiers in your plan.

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

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

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

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

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

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

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

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

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
Antineoplastics		
ALECENSA 150 MG CAPSULE DL	4	PA,QL(240 per 30 days)
ALUNBRIG 180 MG, 90 MG TABLET DL	4	PA,QL(30 per 30 days)
ALUNBRIG 30 MG TABLET DL	4	PA,QL(180 per 30 days)
ALUNBRIG 90 MG (7)- 180 MG (23) TABLET, DOSE PACK DL	4	PA,QL(30 per 30 days)
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(90 per 30 days)
IMBRUVICA 420 MG, 560 MG TABLET DL	4	PA,QL(28 per 28 days)
IMBRUVICA 70 MG CAPSULE DL	4	PA,QL(28 per 28 days)
NUBEQA 300 MG TABLET DL	4	PA,QL(120 per 30 days)
VERZENIO 100 MG, 150 MG, 200 MG, 50 MG TABLET DL	4	PA,QL(60 per 30 days)
XTANDI 40 MG CAPSULE DL	4	PA,QL(120 per 30 days)
XTANDI 40 MG TABLET DL	4	PA,QL(120 per 30 days)
XTANDI 80 MG TABLET DL	4	PA,QL(60 per 30 days)
Antiparasitics		
hydroxychloroquine 200 mg TABLET MO	1	
nitazoxanide 500 mg TABLET DL	4	QL(40 per 30 days)
Antiparkinson Agents		
carbidopa-levodopa 25-100 mg TABLET MO	1	
KYNMOBI 10 MG, 15 MG, 20 MG, 25 MG, 30 MG FILM DL	4	PA,QL(150 per 30 days)
RYTARY 23.75-95 MG CAPSULE, ER MO	3	ST,QL(360 per 30 days)
Antipsychotics		
ABILIFY 10 MG, 15 MG, 2 MG, 20 MG, 30 MG, 5 MG TABLET DL	4	PA
ABILIFY MAINTENA 300 MG, 400 MG SUSPENSION, ER, RECON DL	4	QL(1 per 28 days)
ABILIFY MAINTENA 300 MG, 400 MG SUSPENSION, ER, SYRINGE DL	4	QL(1 per 28 days)
ABILIFY MYCITE 30 MG TABLET WITH SENSOR AND PATCH DL	4	PA,QL(30 per 30 days)
ABILIFY MYCITE MAINTENANCE KIT 15 MG, 2 MG, 20 MG, 5 MG TABLET WITH SENSOR AND STRIP DL	4	PA,QL(30 per 30 days)
ABILIFY MYCITE STARTER KIT 10 MG TABLET W/SENSOR AND STRIP, POD DL	4	PA,QL(30 per 30 days)
ARISTADA 1,064 MG/3.9 ML SUSPENSION, ER, SYRINGE	4	QL(3.9 per 56 days)

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

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

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
INVOKAMET 150-1,000 MG, 150-500 MG, 50-1,000 MG, 50-500 MG TABLET MO	2	QL(60 per 30 days)
INVOKAMET XR 150-1,000 MG, 150-500 MG, 50-1,000 MG, 50-500 MG TABLET, IR/ER 24 HR., BIPHASIC MO	2	QL(60 per 30 days)
INVOKANA 100 MG, 300 MG TABLET MO	2	QL(30 per 30 days)
JANUMET 50-1,000 MG TABLET MO	2	QL(60 per 30 days)
JANUMET XR 100-1,000 MG TABLET, ER 24 HR., MULTIPHASE MO	2	QL(30 per 30 days)
JANUMET XR 50-1,000 MG TABLET, ER 24 HR., MULTIPHASE MO	2	QL(60 per 30 days)
JANUVIA 100 MG, 25 MG, 50 MG TABLET MO	2	QL(30 per 30 days)
JARDIANCE 10 MG, 25 MG TABLET MO	2	QL(30 per 30 days)
JENTADUETO 2.5-1,000 MG, 2.5-500 MG, 2.5-850 MG TABLET MO	2	QL(60 per 30 days)
JENTADUETO XR 2.5-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC MO	2	QL(60 per 30 days)
JENTADUETO XR 5-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC MO	2	QL(30 per 30 days)
KOMBIGLYZE XR 2.5-1,000 MG TABLET, ER 24 HR., MULTIPHASE MO	3	QL(60 per 30 days)
KOMBIGLYZE XR 5-1,000 MG TABLET, ER 24 HR., MULTIPHASE MO	3	QL(30 per 30 days)
LANTUS SOLOSTAR U-100 INSULIN 100 UNIT/ML (3 ML) INSULIN PEN MO	2	
LANTUS U-100 INSULIN 100 UNIT/ML SOLUTION MO	2	
LEVEMIR FLEXTOUCH U-100 INSULN 100 UNIT/ML (3 ML) INSULIN PEN MO	2	
LEVEMIR U-100 INSULIN 100 UNIT/ML SOLUTION MO	2	
metformin 1,000 mg, 500 mg TABLET MO	1	
metformin 500 mg TABLET, ER 24 HR. MO	1	QL(120 per 30 days)
NOVOLIN 70-30 FLEXPEN U-100 100 UNIT/ML (70-30) INSULIN PEN MO	2	
NOVOLIN 70/30 U-100 INSULIN 100 UNIT/ML (70-30) SUSPENSION MO	2	
NOVOLIN N FLEXPEN 100 UNIT/ML (3 ML) INSULIN PEN MO	2	
NOVOLIN N NPH U-100 INSULIN 100 UNIT/ML SUSPENSION MO	2	
NOVOLOG FLEXPEN U-100 INSULIN 100 UNIT/ML (3 ML) INSULIN PEN MO	2	
NOVOLOG MIX 70-30 U-100 INSULN 100 UNIT/ML (70-30) SOLUTION MO	2	
NOVOLOG MIX 70-30FLEXPEN U-100 100 UNIT/ML (70-30) INSULIN PEN MO	2	
NOVOLOG PENFILL U-100 INSULIN 100 UNIT/ML CARTRIDGE MO	2	
NOVOLOG U-100 INSULIN ASPART 100 UNIT/ML SOLUTION MO	2	
ONGLYZA 2.5 MG, 5 MG TABLET MO	3	QL(30 per 30 days)
OZEMPIC 0.25 MG OR 0.5 MG(2 MG/1.5 ML) PEN INJECTOR MO	2	QL(1.5 per 28 days)
OZEMPIC 1 MG/DOSE (4 MG/3 ML), 2 MG/DOSE (8 MG/3 ML) PEN INJECTOR MO	2	QL(3 per 28 days)
pioglitazone 15 mg, 30 mg TABLET MO	1	QL(30 per 30 days)
RYBELSUS 14 MG, 3 MG, 7 MG TABLET MO	2	QL(30 per 30 days)
SOLIQUA 100/33 100 UNIT-33 MCG/ML INSULIN PEN MO	2	QL(15 per 24 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
SYNJARDY 12.5-1,000 MG, 12.5-500 MG, 5-1,000 MG, 5-500 MG TABLET MO	2	QL(60 per 30 days)
SYNJARDY XR 10-1,000 MG, 25-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC MO	2	QL(30 per 30 days)
SYNJARDY XR 12.5-1,000 MG, 5-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC MO	2	QL(60 per 30 days)
TOUJEO MAX U-300 SOLOSTAR 300 UNIT/ML (3 ML) INSULIN PEN MO	2	
TOUJEO SOLOSTAR U-300 INSULIN 300 UNIT/ML (1.5 ML) INSULIN PEN MO	2	
TRADJENTA 5 MG TABLET MO	2	QL(30 per 30 days)
TRESIBA FLEXTOUCH U-100 100 UNIT/ML (3 ML) INSULIN PEN MO	2	
TRESIBA U-100 INSULIN 100 UNIT/ML SOLUTION MO	2	
TRIJARDY XR 10-5-1,000 MG, 25-5-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC MO	2	QL(30 per 30 days)
TRIJARDY XR 12.5-2.5-1,000 MG, 5-2.5-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC MO	2	QL(60 per 30 days)
TRULICITY 0.75 MG/0.5 ML, 1.5 MG/0.5 ML, 3 MG/0.5 ML, 4.5 MG/0.5 ML PEN INJECTOR MO	2	QL(2 per 28 days)
VICTOZA 3-PAK 0.6 MG/0.1 ML (18 MG/3 ML) PEN INJECTOR MO	2	QL(9 per 30 days)
XIGDUO XR 10-1,000 MG, 10-500 MG TABLET, IR/ER 24 HR., BIPHASIC MO	3	QL(30 per 30 days)
XULTOPHY 100/3.6 100 UNIT-3.6 MG /ML (3 ML) INSULIN PEN MO	2	QL(15 per 30 days)
ZEGALOGUE AUTOINJECTOR 0.6 MG/0.6 ML AUTO-INJECTOR MO	2	
ZEGALOGUE SYRINGE 0.6 MG/0.6 ML SYRINGE MO	2	
Blood Products And Modifiers		
BRILINTA 60 MG, 90 MG TABLET MO	2	QL(60 per 30 days)
clopidogrel 75 mg TABLET MO	1	QL(30 per 30 days)
ELIQUIS 2.5 MG TABLET MO	2	QL(60 per 30 days)
ELIQUIS 5 MG TABLET MO	2	QL(74 per 30 days)
ELIQUIS DVT-PE TREAT 30D START 5 MG (74 TABS) TABLET, DOSE PACK MO	2	QL(74 per 30 days)
NIVESTYM 300 MCG/0.5 ML SYRINGE DL	4	PA,QL(7 per 30 days)
NIVESTYM 300 MCG/ML SOLUTION DL	4	PA,QL(14 per 30 days)
NIVESTYM 480 MCG/0.8 ML SYRINGE DL	4	PA,QL(11.2 per 30 days)
NIVESTYM 480 MCG/1.6 ML SOLUTION DL	4	PA,QL(22.4 per 30 days)
PROCRIT 10,000 UNIT/ML SOLUTION MO	3	PA,QL(14 per 30 days)
RETACRIT 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML, 40,000 UNIT/ML SOLUTION MO	3	PA,QL(14 per 30 days)
UDENYCA 6 MG/0.6 ML SYRINGE DL	4	PA,QL(1.2 per 28 days)
warfarin 5 mg TABLET MO	1	
XARELTO 1 MG/ML SUSPENSION FOR RECONSTITUTION MO	2	ST,QL(600 per 30 days)
XARELTO 10 MG, 20 MG TABLET MO	2	QL(30 per 30 days)

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

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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	
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)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
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)
REGRANEX 0.01 % GEL DL	4	PA
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	
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)
PYLERA 140-125-125 MG CAPSULE MO	3	QL(120 per 30 days)
sucralfate 1 gram TABLET MO	1	
XIFAXAN 200 MG TABLET DL	4	PA,QL(9 per 30 days)
XIFAXAN 550 MG TABLET DL	4	PA,QL(84 per 28 days)
Genetic/enzyme/protein Disorder: Replacement, Modifiers, Treatment		
CERDELGA 84 MG CAPSULE DL	4	PA
CREON 24,000-76,000 -120,000 UNIT CAPSULE, DR/EC MO	2	
PROLASTIN-C 1,000 MG RECON SOLUTION DL	4	PA
ZENPEP 25,000-79,000- 105,000 UNIT CAPSULE, DR/EC MO	3	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
Genitourinary Agents		
finasteride 5 mg TABLET **MO**	1	QL(30 per 30 days)
GEMTESA 75 MG TABLET **MO**	3	QL(30 per 30 days)
MYRBETRIQ 25 MG, 50 MG TABLET, ER 24 HR. **MO**	2	QL(30 per 30 days)
MYRBETRIQ 8 MG/ML SUSPENSION, ER, RECON **MO**	2	QL(300 per 30 days)
oxybutynin chloride 10 mg, 5 mg TABLET, ER 24 HR. **MO**	1	QL(60 per 30 days)
oxybutynin chloride 5 mg TABLET **MO**	1	
tamsulosin 0.4 mg CAPSULE **MO**	1	
Hormonal Agents, Stimulant/replacement/modifying (adrenal)		
ACTHAR 80 UNIT/ML GEL **DL**	4	PA,QL(30 per 30 days)
methylprednisolone 4 mg TABLET, DOSE PACK **MO**	1	
prednisone 10 mg, 20 mg, 5 mg TABLET **MO**	1	BvsD
triamcinolone acetonide 0.1 % CREAM **MO**	1	
Hormonal Agents, Stimulant/replacement/modifying (pituitary)		
OMNITROPE 10 MG/1.5 ML (6.7 MG/ML), 5 MG/1.5 ML (3.3 MG/ML) CARTRIDGE **DL**	4	PA
OMNITROPE 5.8 MG RECON SOLUTION **DL**	4	PA
Hormonal Agents, Stimulant/replacement/modifying (sex Hormones/modifiers)		
DUAVEE 0.45-20 MG TABLET **MO**	3	PA,QL(30 per 30 days)
OSPHENA 60 MG TABLET **MO**	2	PA
PREMARIN 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG TABLET **MO**	3	
PREMARIN 0.625 MG/GRAM CREAM **MO**	2	
Hormonal Agents, Stimulant/replacement/modifying (thyroid)		
levothyroxine 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 25 mcg, 50 mcg, 75 mcg, 88 mcg TABLET **MO**	1	
liothyronine 25 mcg, 5 mcg, 50 mcg TABLET **MO**	1	
Hormonal Agents, Suppressant (pituitary)		
LUPRON DEPOT-PED 11.25 MG KIT **DL**	4	PA,QL(1 per 28 days)
ORGOVYX 120 MG TABLET **DL**	4	PA,QL(32 per 30 days)
Immunological Agents		
COSENTYX 75 MG/0.5 ML SYRINGE **DL**	4	PA,QL(2 per 28 days)
COSENTYX (2 SYRINGES) 150 MG/ML SYRINGE **DL**	4	PA,QL(8 per 28 days)
COSENTYX PEN (2 PENS) 150 MG/ML PEN INJECTOR **DL**	4	PA,QL(8 per 28 days)
DUPIXENT PEN 200 MG/1.14 ML PEN INJECTOR **DL**	4	PA,QL(3.42 per 28 days)
DUPIXENT PEN 300 MG/2 ML PEN INJECTOR **DL**	4	PA,QL(8 per 28 days)
DUPIXENT SYRINGE 100 MG/0.67 ML SYRINGE **DL**	4	PA,QL(1.34 per 28 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
DUPIXENT SYRINGE 200 MG/1.14 ML SYRINGE DL	4	PA,QL(3.42 per 28 days)
DUPIXENT SYRINGE 300 MG/2 ML SYRINGE DL	4	PA,QL(8 per 28 days)
ENBREL 25 MG (1 ML) RECON SOLUTION DL	4	PA,QL(8 per 28 days)
ENBREL 25 MG/0.5 ML (0.5), 50 MG/ML (1 ML) SYRINGE DL	4	PA,QL(8 per 28 days)
ENBREL 25 MG/0.5 ML SOLUTION DL	4	PA,QL(8 per 28 days)
ENBREL MINI 50 MG/ML (1 ML) CARTRIDGE DL	4	PA,QL(8 per 28 days)
ENBREL SURECLICK 50 MG/ML (1 ML) PEN INJECTOR DL	4	PA,QL(8 per 28 days)
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(56 per 365 days)
SHINGRIX (PF) 50 MCG/0.5 ML SUSPENSION FOR RECONSTITUTION DL	1	
SKYRIZI 150 MG/ML PEN INJECTOR	4	PA,QL(6 per 365 days)
SKYRIZI 150 MG/ML SYRINGE	4	PA,QL(6 per 365 days)
SKYRIZI 150MG/1.66ML(75 MG/0.83 ML X2) SYRINGE KIT	4	PA,QL(6 per 365 days)
STELARA 45 MG/0.5 ML SOLUTION DL	4	PA,QL(1.5 per 84 days)
STELARA 45 MG/0.5 ML SYRINGE DL	4	PA,QL(1.5 per 84 days)
STELARA 90 MG/ML SYRINGE DL	4	PA,QL(3 per 84 days)
TDVAX 2-2 LF UNIT/0.5 ML SUSPENSION DL	1	

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

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
Respiratory Tract/pulmonary Agents		
ADEMPAS 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG TABLET **DL,LA**	4	PA,QL(90 per 30 days)
ADVAIR DISKUS 100-50 MCG/DOSE, 250-50 MCG/DOSE, 500-50 MCG/DOSE BLISTER WITH DEVICE **MO**	2	QL(60 per 30 days)
ADVAIR HFA 115-21 MCG/ACTUATION, 230-21 MCG/ACTUATION, 45-21 MCG/ACTUATION HFA AEROSOL INHALER **MO**	2	QL(12 per 30 days)
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)
FLOVENT DISKUS 250 MCG/ACTUATION, 50 MCG/ACTUATION BLISTER WITH DEVICE **MO**	2	QL(60 per 30 days)
FLOVENT HFA 220 MCG/ACTUATION HFA AEROSOL INHALER **MO**	2	QL(24 per 30 days)
FLOVENT HFA 44 MCG/ACTUATION HFA AEROSOL INHALER **MO**	2	QL(10.6 per 30 days)
fluticasone propion-salmeterol 250-50 mcg/dose BLISTER WITH DEVICE **MO**	2	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)
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)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
SYMBICORT 160-4.5 MCG/ACTUATION, 80-4.5 MCG/ACTUATION HFA AEROSOL INHALER **MO**	2	QL(10.2 per 30 days)
TRELEGY ELLIPTA 100-62.5-25 MCG, 200-62.5-25 MCG BLISTER WITH DEVICE **MO**	2	QL(60 per 30 days)
VENTOLIN HFA 90 MCG/ACTUATION HFA AEROSOL INHALER **MO**	2	QL(36 per 30 days)
zafirlukast 20 mg TABLET **MO**	1	QL(60 per 30 days)
Skeletal Muscle Relaxants		
cyclobenzaprine 10 mg, 5 mg TABLET **MO**	1	
methocarbamol 500 mg, 750 mg TABLET **MO**	1	
Sleep Disorder Agents		
BELSOMRA 10 MG TABLET **MO**	2	QL(60 per 30 days)
BELSOMRA 15 MG, 20 MG TABLET **MO**	2	QL(30 per 30 days)
BELSOMRA 5 MG TABLET **MO**	2	QL(120 per 30 days)
temazepam 15 mg, 30 mg CAPSULE **DL**	1	QL(30 per 30 days)
zolpidem 10 mg, 5 mg TABLET **MO**	1	QL(30 per 30 days)

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  call **711**.
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Multi-Language Insert

Multi-language Interpreter Services

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

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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.

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Notes

This abridged formulary was updated on 10/12/2022 and is not a complete list of drugs covered by our plan. For a complete listing, or other questions, please contact Humana Medicare Employer Plan with any questions at the number on the back of your membership card or, for TTY users, 711, Monday through Friday, from 8 a.m. - 9 p.m. Eastern time. Our automated phone system is available after hours, weekends, and holidays. Our website is also available 24 hours a day 7 days a week by visiting **Humana.com**.

Important Information – Please Read

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

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

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

Be sure to include the following on your application:

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

Humana®

2023
Enrollment Form

Humana Group Medicare

PPO (Preferred Provider Organization)
A Medicare Advantage plan

Follow these easy steps to become a Humana Medicare member

Have your Medicare card ready

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

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

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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 بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-877-320-1235 (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

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Stamp Date

Asterisks (*) indicate required fields

Humana Group Medicare PPO Enrollment Form

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

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

MEDICARE HEALTH INSURANCE

LAST NAME*

FIRST NAME* MI

MEDICARE NUMBER*

N A E N – A E N – A A N N

IS ENTITLED TO	EFFECTIVE DATE
HOSPITAL (PART A)	M M – 0 1 – Y Y Y Y
MEDICAL (PART B)	M M – 0 1 – Y Y Y Y

PROPOSED EFFECTIVE DATE*

M M – 0 1 – 2 0 Y Y

PLAN OPTION*

079 /

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

CATEGORY OF ENROLLEE*

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

DATE OF BIRTH* M M – D D – Y Y Y Y

SEX* M F

RESIDENTIAL ADDRESS* P.O. Box not allowed.

Experiencing homelessness

APT or STE

CITY* ST* ZIP*

COUNTY*

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

APT or STE

CITY ST ZIP

Asterisks (*) indicate required fields

APPLICANT MEDICARE NUMBER*

N A E N – A E N – A A N N

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

TELEPHONE

( ) –

TELEPHONE TYPE

Cellphone Home (landline)

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

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

Asterisks (*) indicate required fields

APPLICANT MEDICARE NUMBER*
N A E N – A E N – A A N N

1. **If you will have other prescription drug coverage (like VA, TRICARE) in addition to this plan for which you are applying, please fill this oval.*** ◯ I will have other prescription drug coverage

Please provide your other prescription drug coverage details here, if applicable.

NAME OF OTHER COVERAGE

ID NUMBER FOR THIS COVERAGE

GROUP NUMBER FOR THIS COVERAGE

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

Preferred Written Language (when available)

◯ English ◯ Spanish ◯ Chinese ◯ Korean ◯ Other _____

Preferred Verbal Language

◯ English ◯ Spanish ◯ Mandarin ◯ Cantonese
◯ Korean ◯ Other _____

If an accessible format is needed, please select one option

◯ Audio ◯ Large print ◯ Accessible screen reader PDF
◯ Oral over the phone ◯ Braille

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

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

◯ No, not of Hispanic, Latino/a, or Spanish origin
◯ Yes, Mexican, Mexican American, Chicano/a
◯ Yes, Puerto Rican
◯ Yes, Cuban
◯ Yes, another Hispanic, Latino/a, or Spanish origin
◯ I choose not to answer

What's your race? Select all that apply.

◯ American Indian or Alaska Native
◯ Asian Indian
◯ Black or African American
◯ Chinese
◯ Filipino
◯ Guamanian or Chamorro
◯ Japanese
◯ Korean
◯ Native Hawaiian
◯ Other Asian
◯ Other Pacific Islander
◯ Samoan
◯ Vietnamese
◯ White
◯ I choose not to answer

PLEASE READ THIS IMPORTANT INFORMATION

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

I understand that when my Humana coverage begins, I must get all of my medical, and prescription drug benefits when applicable, from Humana. Benefits and services provided by Humana and contained in my "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Humana will pay for benefits or services that are not covered. I will abide by the rules of my Evidence of Coverage. Once I am a member of Humana, I have the right to appeal plan decisions about payment or services if I disagree.

This Humana plan serves a specific service area. If I move out of the area that this Humana plan serves, I need to notify Humana as I may have to disenroll and find a new plan in my new area. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.

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

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

Release of Information:
By joining this Medicare plan, I acknowledge that Humana will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by federal law that authorize the collection of this information (see Privacy Act Statement below).

Privacy Act Statement:
The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. **Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.**

Individuals experiencing homelessness:
If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security benefit checks) may be considered your permanent residence address.

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

Asterisks (*) indicate required fields

APPLICANT MEDICARE NUMBER*
N A E N – A E N – A A N N

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

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

SIGNATURE DATE*
M M – D D – 2 0 Y Y

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

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

LAST NAME FIRST NAME MI

STREET ADDRESS

CITY ST ZIP

TELEPHONE
( ) –

RELATIONSHIP TO APPLICANT

INTERNAL MARKETPOINT AGENTS ONLY

WRITING AGENT NAME*

AGENT NUMBER (SAN)*

DATE*
M M – D D – 2 0 Y Y

REFERRING AGENT NAME

REFERRING AGENT NUMBER (SAN)

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Humana.com

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GN85037EN_2023

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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 بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-877-320-1235 (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

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

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

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

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

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

Japanese: 当社の健康健康保険と薬品処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。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。日本語を話す人者が支援いたします。これは無料のサービスです。

Stamp Date

Asterisks (*) indicate required fields

Humana Group Medicare PPO Enrollment Form

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

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

MEDICARE HEALTH INSURANCE

LAST NAME*

FIRST NAME* MI

MEDICARE NUMBER*

N A E N – A E N – A A N N

IS ENTITLED TO	EFFECTIVE DATE
HOSPITAL (PART A)	M M – 0 1 – Y Y Y Y
MEDICAL (PART B)	M M – 0 1 – Y Y Y Y

PROPOSED EFFECTIVE DATE*

M M – 0 1 – 2 0 Y Y

PLAN OPTION*

079 /

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

CATEGORY OF ENROLLEE*

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

DATE OF BIRTH* M M – D D – Y Y Y Y

SEX* M F

RESIDENTIAL ADDRESS* P.O. Box not allowed.

Experiencing homelessness

APT or STE

CITY* ST* ZIP*

COUNTY*

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

APT or STE

CITY ST ZIP

Asterisks (*) indicate required fields

APPLICANT MEDICARE NUMBER*

N A E N – A E N – A A N N

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

TELEPHONE

( ) –

TELEPHONE TYPE

Cellphone Home (landline)

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

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

Asterisks (*) indicate required fields

APPLICANT MEDICARE NUMBER*
N A E N – A E N – A A N N

1. **If you will have other prescription drug coverage (like VA, TRICARE) in addition to this plan for which you are applying, please fill this oval.*** ◯ I will have other prescription drug coverage

Please provide your other prescription drug coverage details here, if applicable.

NAME OF OTHER COVERAGE

ID NUMBER FOR THIS COVERAGE

GROUP NUMBER FOR THIS COVERAGE

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

Preferred Written Language (when available)

◯ English ◯ Spanish ◯ Chinese ◯ Korean ◯ Other _____

Preferred Verbal Language

◯ English ◯ Spanish ◯ Mandarin ◯ Cantonese
◯ Korean ◯ Other _____

If an accessible format is needed, please select one option

◯ Audio ◯ Large print ◯ Accessible screen reader PDF
◯ Oral over the phone ◯ Braille

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

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

◯ No, not of Hispanic, Latino/a, or Spanish origin
◯ Yes, Mexican, Mexican American, Chicano/a
◯ Yes, Puerto Rican
◯ Yes, Cuban
◯ Yes, another Hispanic, Latino/a, or Spanish origin
◯ I choose not to answer

What's your race? Select all that apply.

◯ American Indian or Alaska Native
◯ Asian Indian
◯ Black or African American
◯ Chinese
◯ Filipino
◯ Guamanian or Chamorro
◯ Japanese
◯ Korean
◯ Native Hawaiian
◯ Other Asian
◯ Other Pacific Islander
◯ Samoan
◯ Vietnamese
◯ White
◯ I choose not to answer

PLEASE READ THIS IMPORTANT INFORMATION

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

I understand that when my Humana coverage begins, I must get all of my medical, and prescription drug benefits when applicable, from Humana. Benefits and services provided by Humana and contained in my "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor Humana will pay for benefits or services that are not covered. I will abide by the rules of my Evidence of Coverage. Once I am a member of Humana, I have the right to appeal plan decisions about payment or services if I disagree.

This Humana plan serves a specific service area. If I move out of the area that this Humana plan serves, I need to notify Humana as I may have to disenroll and find a new plan in my new area. I understand that Medicare beneficiaries are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.

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

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

Release of Information:
By joining this Medicare plan, I acknowledge that Humana will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by federal law that authorize the collection of this information (see Privacy Act Statement below).

Privacy Act Statement:
The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. **Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.**

Individuals experiencing homelessness:
If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security benefit checks) may be considered your permanent residence address.

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

Asterisks (*) indicate required fields

APPLICANT MEDICARE NUMBER*
N A E N – A E N – A A N N

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

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

SIGNATURE DATE*
M M – D D – 2 0 Y Y

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

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

LAST NAME FIRST NAME MI

STREET ADDRESS

CITY ST ZIP

TELEPHONE
( ) –

RELATIONSHIP TO APPLICANT

INTERNAL MARKETPOINT AGENTS ONLY

WRITING AGENT NAME*

AGENT NUMBER (SAN)*

DATE*
M M – D D – 2 0 Y Y

REFERRING AGENT NAME

REFERRING AGENT NUMBER (SAN)

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Humana.com

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