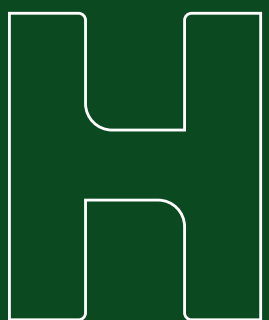
Humana Group Medicare
Humana Inc.
P.O. Box 669
Louisville, KY 40201-0669

2027

Important plan information



Humana®

Your journey to better health, for better retirement

Humana Group Medicare



Humana®

A more human way to healthcare™

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BC27

HUMANA GROUP MEDICARE ADVANTAGE PPO PLAN

&

PRESCRIPTION DRUG PLAN

Humana MA PPO Plan &
Prescription Drug Plan (PDP)
State of Oklahoma Retirees

We're here for you

Humana Group Medicare Customer Care
866-396-8810 (TTY: 711)
Monday – Friday, 7 a.m. – 8 p.m., Central time
your.Humana.com/ok-medicare

Humana is a Medicare Advantage PPO plan and a stand-alone prescription drug 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.

Go365 Rewards have no cash value and must be earned and redeemed within the same plan year. Rewards not redeemed before Dec. 31st will be forfeited.

All product names, logos, brands and trademarks are property of their respective owners, and any use does not imply endorsement.

Humana®

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Humana.

Understanding your benefits and coverage

Inside this packet you'll find:

Your benefits include

Frequently asked questions

What to expect after you enroll

Manage your Humana account online

Find Care tool

Member to Provider—Take this to your Provider

Humana Community Navigator

Know your numbers

Medical Summary of Benefits

Prescription Summary of Benefits

Prescription Drug Guide

SilverSneakers Flyer

Learn more about the benefits, extra programs and services included in your Humana plan

Scan the QR code with your mobile device.

Your benefits



Get the care you deserve

All the benefits of Original Medicare, plus extra benefits

- Your benefit levels are the same for in-network and out-of-network providers, as long as the provider is eligible to participate in Medicare
- A network of providers, specialists and hospitals to choose from
- There are more than 61,000 participating pharmacies in our network
- 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



Coverage that fits the way you live

Maximum out-of-pocket protections

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



Care delivered how and where you need it

Worldwide emergency coverage

Many Humana Medicare Advantage plans offer worldwide emergency coverage for sudden illnesses or injuries while traveling outside the U.S. and its territories. This coverage is intended for true emergencies—situations where there is a risk of serious harm to life, limb, or health if immediate care is not received. Members may need to pay out-of-pocket and submit claims for reimbursement.



Benefits that put you first

Programs to help improve health and well-being

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

Frequently asked questions

To be eligible for the Humana Group Medicare PPO plan, you must have Medicare Part A and be enrolled in Medicare Part B, as this plan is a Group Medicare Advantage plan.

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 and PDP plan enrollment is confirmed.

Is your provider and pharmacy in-network or out-of-network?

You can find a doctor or pharmacy in your network by using Humana's Find Care tool, visit **FindCare.Humana.com.**

What does insurance cover?

- Every health plan is different. Check coverage details before you see a doctor, use services or have procedures.
- Sometimes, your plan may not cover procedures and treatments, or may require prior authorization. Knowing what is and is not covered may save you time and money.
- All the details about your coverage may be found in your Evidence of Coverage (EOC) or by signing in to your MyHumana account at **Humana.com/PlanDocuments**.

What if I have other health insurance coverage?

You can enroll in only one Medicare Advantage plan and one Medicare prescription drug plan at a time. Enrollment in these plans will cancel your enrollment in a different Medicare Advantage plan and Medicare prescription drug plan.

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 plans 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.

Do I need to show my red, white and blue Medicare ID 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 if my provider says they will not accept my plan?

If your provider says they will not accept your PPO plan, you can give your provider the "Member to Provider" information page in this packet. It explains how your PPO plan works. You can also call Humana Customer Care to have a Humana representative contact your provider and explain how your PPO plan works.

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

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

What to expect after you enroll

Enrollment confirmation

You'll receive two confirmation of enrollment letters from Humana—one for medical, one for pharmacy—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. Once you receive your Humana member ID card, you can create a MyHumana profile. Having access to your important health documents online, all in one place, is a great way to stay organized, and you can get to your information at any time. To activate your account, visit **Humana.com/Registration**.

Evidence of Coverage (EOC)

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

Your personalized benefits statement

Humana's SmartSummary® provides a comprehensive overview of your health benefits and healthcare spending. You'll receive these statements 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.

Health and Well-being Assessment (HWA)

This is a yearly detailed health review conducted in the comfort of your home or virtually, 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 HWA vendors 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're here for you

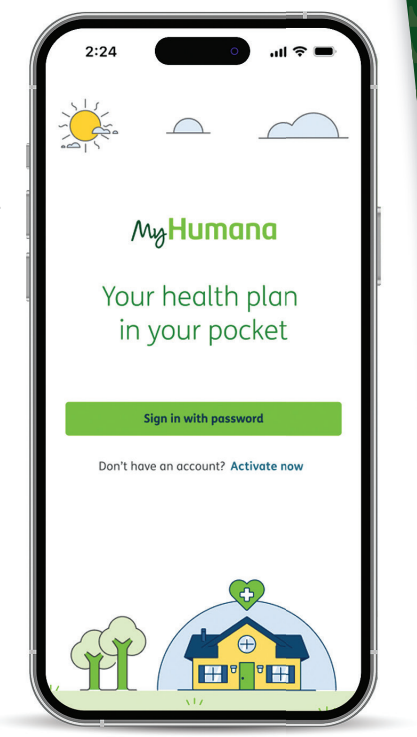
If you have questions or need help, call Humana Group Medicare Customer Care, **866-396-8810 (TTY: 711)**, Monday – Friday, 7 a.m. – 8 p.m., Central time.

Manage your Humana plan online

MyHumana is a secure online portal with tools to manage your plan. Sign in or activate your account to get safe, immediate access to your plan information. Then, take your Humana essentials with you wherever you go with the MyHumana mobile app.*

Depending on your plan, you can use the MyHumana mobile app to:

- **Explore coverage and benefit details** the moment you need them
- **Get your Humana member ID card** and add it to your phone's wallet
- **Find care close to you** and get directions on your phone's map app
- **Review claims status**
- **Access your exclusive member discounts**
- **Choose** your preferences
- **Check your wellness rewards** balance and find more ways to earn



Humana mobile apps—an easier way to manage your benefits

Once your Humana plan coverage begins, go to **MyHumana.com** to activate your account or download the MyHumana mobile app and register. You can find the MyHumana app for iOS and Android in the App Store and Google Play app store.†

go365 by Humana®

Discover Go365 by Humana® in the app

Our wellness and rewards program is personalized to suit your unique needs, with activities and learning opportunities that matter most to you.

Scan this QR Code

Scan this QR code with your mobile device to create your account. Learn more at **Humana.com/member/manage-your-account**.

*Standard data rates may apply.

†App Store and Google Play app store are registered trademarks of Apple Inc. and Google. All rights reserved. Apple and Google are not participants in or sponsors of this promotion.

Find a doctor using Humana's Find Care search tool

Choosing a doctor or healthcare facility is an important decision. You can use Humana's Find Care search tool to find in-network doctors, pharmacies, and more.

Go to

FindCare.Humana.com

Search as a Member or Guest

- Sign in to your secure MyHumana account to conduct a search, or
- Search as a guest by entering your location.

Choose the type of care you are looking for

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

Find medical care

- Choose your medical network, **Group Medicare PPO Plus**, from the drop-down menu.
- Select a tab to search by Provider Name, Facility or Specialty.

Find a pharmacy

- Choose your pharmacy network, **Humana Medicare Employer Plan (Medicare Group) Network**, from the drop-down menu.

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.

Use Humana's Find Care tool on the MyHumana mobile app

Once your plan begins you can use the MyHumana mobile app to find a provider near you, wherever you are. Select "Find Care" at the bottom of the app.

Scan this QR code

Scan this QR code with your mobile device to find care near you.

Member to provider—take this to your provider

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

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

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

A message for your provider

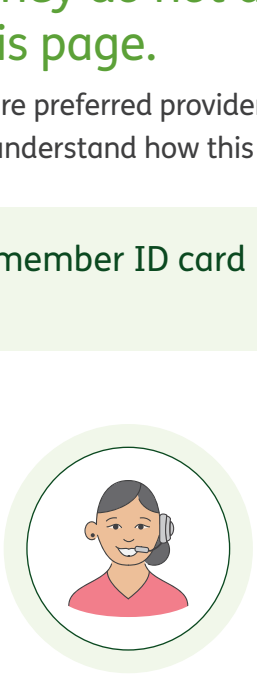
Humana will provide coverage for this member under a Group Medicare PPO plan. The in-network and out-of-network benefits are structured the same for any member of this plan. This means you can provide services to this member or any member of this plan if you are a provider who is eligible to participate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

Contracted healthcare providers

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

Out-of-network healthcare providers

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



Claims process for providers

For additional information regarding Humana's claims procedures or becoming a contracted provider for the Humana Medicare Employer PPO plan, please contact Provider Relations at 800-626-2741, 8 a.m. – 5 p.m., Central time.

This number is not for patient use.

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

Humana Community Navigator®

Humana Community Navigator, powered by findhelp, offers an online directory of community resources providing individuals access to more than 600,000 social service programs across the United States. Find what is available in your area.

Search for and connect to personalized resources

- Access one, easy-to-use directory of community resources at no cost - whether you're a Humana member or not
- Robust directory including food, housing, transportation, education, employment and more
- Review search results in your preferred language
- Save resources that matter most to you by sending them via text, email or print
- All resources are either free, reduced cost or based on a sliding scale

Create and manage your own free account

Access Humana Community Navigator at **Humana.findhelp.com**. Choose 'Sign Up' from the top right corner to create an account; unlocking additional features like the ability to save personalized search results, connect to programs, and write reviews.

Get started

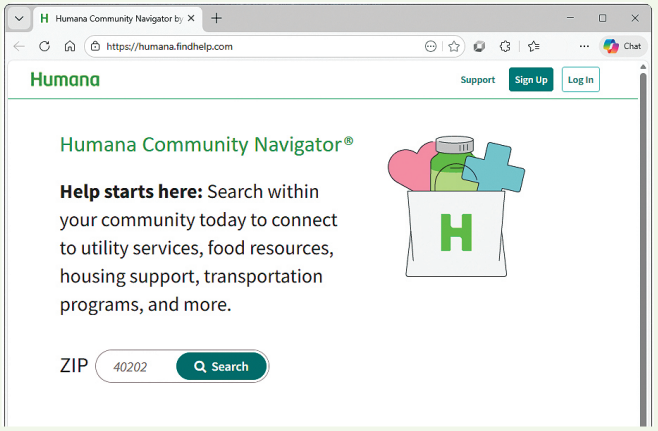
Visit **Humana.findhelp.com**, enter your zip code and click search to access resources.

Review resources

Type in a keyword or select a category to review resources.

Connect now or save for later

Choose the resources that best fit your situation and email, text or print to save.



Scan the QR code on your mobile device

You can also access Humana Community Navigator on your mobile device by scanning the QR code.

Know your numbers

Find important numbers anytime you need them*

Humana Group Medicare Customer Care
866-396-8810 (TTY: 711),
Monday – Friday, 7 a.m. – 8 p.m., Central time

Health and Well-being Assessment
866-396-8810 (TTY: 711),
Monday – Friday, 7 a.m. – 8 p.m., Central time

MyHumana
Sign in to or register for MyHumana to access your personal, secure plan information and check your Go365 wellness rewards balance and find more ways to earn at **MyHumana.com**.

MyHumana mobile app
MyHumana.com/mobile-apps

Doctors in your network
FindCare.Humana.com

Telehealth
Contact your local provider to ask about virtual visit options, or use Humana's "Find Care" tool at **FindCare.Humana.com**. You can also call the number on the back of your member ID to connect with a provider offering telehealth services.

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

Humana Care Management
800-558-0187 (TTY: 711),
Monday – Friday, 7:30 a.m. – 4:30 p.m., Central time

Post-discharge Transportation
866-396-8810 (TTY: 711),
Monday – Friday, 7 a.m. – 8 p.m., Central time

Post-discharge Personal Home Care Services (PHCS)
866-396-8810 (TTY: 711),
Monday – Friday, 7 a.m. – 8 p.m., Central time
https://www.humana.com/home-care/home-health-personal-care

Post-discharge Meal Program
866-396-8810 (TTY: 711),
Monday – Friday, 7 a.m. – 8 p.m., Central time
Humana.com/home-care/well-dine

Wellness Coaching
877-567-6450 (TTY: 711),
Monday – Friday, 7a.m. – 5p.m., Central time

Caregiver Support
Humana.com/caregiver

Medication Therapy Management
833-349-4114 (TTY: 711),
Monday – Friday, 8 a.m. – 4:30 p.m., Central time

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

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

State health insurance program offices
800-633-4227 (TTY: 711), daily
www.cms.gov/apps/contacts/#

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

2027

Summary of Benefits

Humana Group Medicare Advantage PPO Plan
PPO 079/449

State of Oklahoma

Humana®

Our service area includes specific counties within the United States, Puerto Rico and all other major U.S. territories.

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

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

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

To be eligible

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

Plan name:

Humana Group Medicare Advantage PPO plan

How to reach us:

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

Call Monday – Friday, 7 a.m. – 8 p.m., Central time.

Or visit our website: **your.Humana.com/OK-medicare**

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

A healthy partnership

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

Monthly Premium, Deductible and Limits

PLAN COSTS	
Monthly premium You must keep paying your Medicare Part B premium.	For information concerning the actual premiums you will pay, please contact your employer/union group.
Medical deductible	**$250** per year for some combined in- and out-of-network services
Medical 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** **$500** out-of-pocket limit for Medicare-covered services. The following services do not apply to the maximum out-of-pocket: Part D Pharmacy; Fitness Program; Health Education Services; Meal Benefit; Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Smoking Cessation (Additional); Uniform Flexibility Non-Emergency Medical Transportation; Uniform Flexibility Virtual Cardiac Recovery Program and the Plan Premium do not apply to the in-network maximum out-of-pocket. 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** **$500** out-of-pocket limit for Medicare-covered services. In-Network Exclusions: Part D Pharmacy; Fitness Program; Health Education Services; Meal Benefit; Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Smoking Cessation (Additional); Uniform Flexibility Non-Emergency Medical Transportation; Uniform Flexibility Virtual Cardiac Recovery Program and the Plan Premium do not apply to the combined maximum out-of-pocket. Out-of-Network Exclusions: Part D Pharmacy, Fitness Program; Meal Benefit; Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Uniform Flexibility Non-Emergency Medical Transportation; Uniform Flexibility Virtual Cardiac Recovery Program; 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: *This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: Humana.com/PAL.*

Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
ACUTE INPATIENT HOSPITAL CARE		
This 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** per admit	**$250** per admit
OUTPATIENT HOSPITAL COVERAGE		
Diagnostic colonoscopy	**$0** copay	**$0** copay
Diagnostic mammography	**$0** copay	**$0** copay
Observation services	**$0** copay	**$0** copay
Surgery services	**$0** copay	**$0** copay
AMBULATORY SURGICAL CENTER		
Diagnostic colonoscopy	**$0** copay	**$0** copay
Surgery services	**$0** copay	**$0** copay
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	**$0** copay	**$0** copay
Specialists	**$0** copay	**$0** copay

Note: *This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: Humana.com/PAL.*

Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
PREVENTIVE CARE		
This plan covers all Medicare preventative services including: • Abdominal aortic aneurysm screening • Alcohol misuse screening & counseling • Annual wellness visit • Bone mass measurement • Breast cancer screening • Cardiovascular disease behavioral therapy • Cardiovascular disease screening • Cervical and vaginal cancer screening • Colorectal cancer screening • Depression screening • Diabetes self-management training • Diabetes screening • Glaucoma screening • Hepatitis C screening • HIV screening • Kidney disease education services • Lung cancer screening • Medical nutrition therapy • Obesity screening and therapy • Physical exams (routine) • Prostate cancer screening exam • Smoking and tobacco use cessation • STI screening and counseling • "Welcome to Medicare" preventative visit	**Covered at no cost**	**Covered at no cost**
• Immunizations • Medicare diabetes prevention program (MDPP) Any additional preventative services approved by Medicare during the contract year will be covered.	**Covered at no cost**	**Covered at no cost**

Note: *This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: Humana.com/PAL.*

Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
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.	**$50** copay for Medicare-covered emergency room visit(s)	**$50** copay for Medicare-covered emergency room visit(s)
Urgently needed services		
• Primary care provider (PCP)	**$0** copay	**$0** copay
• Specialist's office	**$0** copay	**$0** copay
• Urgent care center	**$0** copay	**$0** copay
Urgently needed services are care provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.		
DIAGNOSTIC SERVICES, LABS AND IMAGING		
Advanced imaging services (MRI, MRA, PET and CT Scan)		
• Primary care provider (PCP)	**$0** copay	**$0** copay
• Specialist's office	**$0** copay	**$0** copay
• Freestanding radiological facility	**$0** copay	**$0** copay
• Outpatient Hospital	**$0** copay	**$0** copay
Diagnostic mammography		
• Primary care provider (PCP)	**$0** copay	**$0** copay
• Specialist's office	**$0** copay	**$0** copay
• Freestanding radiological facility	**$0** copay	**$0** copay
• Outpatient Hospital	**$0** copay	**$0** copay
Diagnostic procedures and tests		
• Primary care provider (PCP)	**$0** copay	**$0** copay
• Specialist's office	**$0** copay	**$0** copay
• Urgent care center	**$0** copay	**$0** copay
• Freestanding radiological facility	**$0** copay	**$0** copay
• Outpatient Hospital	**$0** copay	**$0** copay
EKG screening		
• Primary care provider (PCP)	**$0** copay	**$0** copay
• Specialist's office	**$0** copay	**$0** copay

Note: *This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: Humana.com/PAL.*

Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
• Freestanding radiological facility	**$0** copay	**$0** copay
• Outpatient Hospital	**$0** copay	**$0** copay
Lab services		
• Primary care provider (PCP)	**$0** copay	**$0** copay
• Specialist's office	**$0** copay	**$0** copay
• Urgent care center	**$0** copay	**$0** copay
• Freestanding laboratory	**$0** copay	**$0** copay
• Outpatient Hospital	**$0** copay	**$0** copay
Nuclear medicine services		
• Freestanding radiological facility	**$0** copay	**$0** copay
• Outpatient Hospital	**$0** copay	**$0** copay
Outpatient x-rays		
• Primary care provider (PCP)	**$0** copay	**$0** copay
• Specialist's office	**$0** copay	**$0** copay
• Urgent care center	**$0** copay	**$0** copay
• Freestanding radiological facility	**$0** copay	**$0** copay
• Outpatient Hospital	**$0** copay	**$0** copay
Radiation therapy		
• Specialist's office	**$0** copay	**$0** copay
• Freestanding radiological facility	**$0** copay	**$0** copay
• Outpatient Hospital	**$0** copay	**$0** copay
HEARING SERVICES		
Medicare-covered hearing: diagnostic hearing and balance exams	**$0** copay	**$0** copay
DENTAL SERVICES		
Medicare-covered dental	**$0** copay	**$0** copay
VISION SERVICES		
Medicare-covered vision services	**$0** copay	**$0** copay
Medicare-covered diabetic eye exam (1 per year)	**$0** copay	**$0** copay

Note: *This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: Humana.com/PAL.*

Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
Medicare-covered glaucoma screening (1 per year)	**$0** copay	**$0** copay
Medicare-covered eyewear (post-cataract)	**$0** copay	**$0** copay
MENTAL HEALTH SERVICES		
Inpatient The inpatient hospital care limit applies to inpatient mental services provided in a general hospital or a psychiatric facility. 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** per admit	**$250** per admit
Partial Hospitalization	**$0** copay	**$0** copay
Intensive Outpatient Services	**$0** copay	**$0** copay
Outpatient group and individual therapy visits		
• Primary care provider (PCP)	**$0** copay	**$0** copay
• Specialist's office	**$0** copay	**$0** copay
• Urgent care	**$0** copay	**$0** copay
• Outpatient Hospital	**$0** copay	**$0** copay
SKILLED NURSING FACILITY (SNF)		
This plan covers up to 100 days in a SNF. No 3-day hospital stay is required. Plan pays $0 after 100 days.	**$0** copay per day for days 1-100	**$0** copay per day for days 1-100
AMBULANCE		
Per date of service regardless of the number of trips. Limited to Medicare-covered transportation.	**$0** copay	**$0** copay

Note: *This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: Humana.com/PAL.*

Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
TRANSPORTATION		
Uniformity Flexibility Non-Emergency Medical Transportation	**$0** copay for plan approved location up to unlimited one-way trip(s) per year by car, rideshare services, van, wheelchair access vehicle for members with a Chronic Kidney Disease (CKD), End Stage Renal Disease (ESRD), or Cancer Diagnosis. This benefit is not to exceed 50 miles per trip.	**95%** coinsurance for plan approved location by car, rideshare services, van, wheelchair access vehicle for members with a Chronic Kidney Disease (CKD), End Stage Renal Disease (ESRD), or Cancer Diagnosis. This benefit is not to exceed 50 miles per trip. Member is required to pay the full cost at the time of service when utilizing an out-of-network provider. To receive reimbursement from Humana for eligible items/services, the member must submit required documentation. Reimbursement will be limited to up to 5% of the allowed amount on eligible items/services. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
MEDICARE PART B PRESCRIPTION DRUGS		
Chemotherapy drugs		
• Specialist's office	**$0** copay	**$0** copay
• Outpatient Hospital	**$0** copay	**$0** copay
Medicare Part B covered drugs		
• Primary care provider (PCP)	**$0** copay	**$0** copay
• Specialist's office	**$0** copay	**$0** copay
• Outpatient Hospital	**$0** copay	**$0** copay
• Pharmacy	**0%** of the cost	**0%** of the cost
Medicare Part B insulin drugs		
• Primary care provider (PCP)	**$0** copay	**$0** copay
• Specialist's office	**$0** copay	**$0** copay
• Outpatient Hospital	**$0** copay	**$0** copay
• Pharmacy	**0%** of the cost	**0%** of the cost

Note: *This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: Humana.com/PAL.*

Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
ACUPUNCTURE SERVICES		
Medicare-covered acupuncture visit(s) for chronic low back pain	**$0** copay for acupuncture for chronic low back pain visits up to 20 combined in and out of network visit(s) per year.	**$0** copay for acupuncture for chronic low back pain visits up to 20 combined in and out of network visit(s) per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
ALLERGY		
Allergy shots & serum		
• Primary care provider (PCP)	**$0** copay	**$0** copay
• Specialist's office	**$0** copay	**$0** copay
CHIROPRACTIC SERVICES		
Medicare-covered chiropractic visit(s)	**$0** copay	**$0** copay
DIABETES SERVICES AND SUPPLIES		
Continuous glucose monitor (CGM)		
• Durable medical equipment provider	**0%** of the cost	**0%** of the cost
• Pharmacy	**0%** of the cost	**0%** of the cost
• Preferred Pharmacy	**$0** copay	Not Covered
Diabetes management training		
• Primary care provider (PCP)	**$0** copay	**$0** copay
• Specialist's office	**$0** copay	**$0** copay
• Outpatient hospital	**$0** copay	**$0** copay
Diabetes monitoring supplies		
• Durable medical equipment provider	**$0** copay	**$0** copay
• Pharmacy	**$0** copay	**$0** copay
• Preferred diabetic supplier	**$0** copay	Not Covered
Diabetes screening		
• Primary care provider (PCP)	**$0** copay	**$0** copay
• Specialist's office	**$0** copay	**$0** copay
FOOT CARE (PODIATRY)		
Medicare-covered foot care	**$0** copay	**$0** copay
HOME HEALTH CARE		
	$0 copay	**$0** copay

Note: *This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: Humana.com/PAL.*

Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
HOSPICE You must get care from a Medicare-certified hospice. You must consult with this plan before you select hospice.		
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment		
• Durable medical equipment provider	**0%** of the cost	**0%** of the cost
• Pharmacy	**0%** of the cost	**0%** of the cost
Medical supplies (includes but not limited to: catheters, IV set-up and supplies)		
• Medical supply provider	**0%** of the cost	**0%** of the cost
• Pharmacy	**0%** of the cost	**0%** of the cost
Prosthetics (artificial limbs or braces)		
• Prosthetics provider	**0%** of the cost	**0%** of the cost
OUTPATIENT SUBSTANCE ABUSE		
Outpatient group and individual substance abuse treatment visits		
• Primary care provider (PCP)	**$0** copay	**$0** copay
• Specialist's office	**$0** copay	**$0** copay
• Urgent care	**$0** copay	**$0** copay
• Outpatient hospital	**$0** copay	**$0** copay
REHABILITATION SERVICES		
Audiology Therapy		
• Specialist's office	**$0** copay	**$0** copay
• Comprehensive outpatient rehab facility	**$0** copay	**$0** copay
• Outpatient hospital	**$0** copay	**$0** copay
Cardiac rehabilitation		
• Specialist's office	**$0** copay	**$0** copay
• Outpatient hospital	**$0** copay	**$0** copay
Occupational therapy		
• Specialist's office	**$0** copay	**$0** copay
• Comprehensive outpatient rehab facility	**$0** copay	**$0** copay
• Outpatient hospital	**$0** copay	**$0** copay

Note: *This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: Humana.com/PAL.*

Covered Medical Benefits

	IN-NETWORK	OUT-OF-NETWORK
Physical therapy		
• Specialist's office	**$0** copay	**$0** copay
• Comprehensive outpatient rehab facility	**$0** copay	**$0** copay
• Outpatient hospital	**$0** copay	**$0** copay
Pulmonary rehabilitation		
• Specialist's office	**$0** copay	**$0** copay
• Comprehensive outpatient rehab facility	**$0** copay	**$0** copay
• Outpatient hospital	**$0** copay	**$0** copay
Speech therapy		
• Specialist's office	**$0** copay	**$0** copay
• Comprehensive outpatient rehab facility	**$0** copay	**$0** copay
• Outpatient hospital	**$0** copay	**$0** copay
RENAL DIALYSIS		
Renal dialysis services		
• Dialysis center	**$0** copay	**$0** copay
• Outpatient hospital	**$0** copay	**$0** copay
Kidney disease education services		
• Primary care provider (PCP)	**$0** copay	**$0** copay
• Specialist's office	**$0** copay	**$0** copay
• Outpatient hospital	**$0** copay	**$0** copay
HUMANA IN-NETWORK TELEHEALTH VENDORS, i.e. MDLive (in addition to Original Medicare)		
Primary care provider (PCP)	**$0** copay	Not Covered
Specialist	**$0** copay	Not Covered
Urgent care services	**$0** copay	Not Covered
Substance abuse or behavioral health services	**$0** copay	Not Covered

Note: *This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: Humana.com/PAL.*

Additional Benefits

	IN-NETWORK	OUT-OF-NETWORK
FITNESS AND WELLNESS		
Live a healthier, more active life through fitness and social connection at participating SilverSneakers® locations and online.	**$0** copay	**95%** coinsurance for out-of-network fitness centers. Member is required to pay the full cost at the time of service when utilizing an out-of-network provider. To receive reimbursement from Humana for eligible items/services, the member must submit required documentation. Reimbursement will be limited to up to 5% of the allowed amount on eligible items/services. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
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.	**$0** copay	Not Applicable

Note: *This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: Humana.com/PAL.*

Additional Benefits

	IN-NETWORK	OUT-OF-NETWORK
POST-DISCHARGE SERVICES		
• Assistance from a qualified aid to help perform activities of daily living within the home. Minimum of 4 hours per day, up to a maximum of 8 hours. Types of assistance include bathing, dressing, toileting, walking, eating and preparing meals. • 2 meals per day for 14 days, up to 28 meals delivered to your door. • Transportation up to 12 one-way trips to plan approved locations by rideshare services, car, van or wheelchair accessible vehicle. • In-network services must be scheduled by approved vendors, scheduled within 30 days of discharge event and utilized within 60 days of discharge.	**$0** copay per discharge event following each inpatient or skilled nursing facility stay.	**95%** coinsurance for out-of-network post-discharge services. Member is required to pay the full cost at the time of service when utilizing an out-of-network provider. To receive reimbursement from Humana for eligible items/services, the member must submit required documentation. Reimbursement will be limited to up to 5% of the allowed amount on eligible items/services. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
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.	**$0** copay	Not Applicable

Note: *This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: Humana.com/PAL.*

Additional Benefits

	IN-NETWORK	OUT-OF-NETWORK
UNIFORMITY FLEXIBILITY VIRTUAL CARDIAC RECOVERY		
Delivered via telehealth, virtual cardiac recovery program provides up to 36 covered sessions to support recovery and reduce the risk of hospital readmission.	**$0** copay	**95%** coinsurance for cardiac recovery services provided via telehealth under virtual supervision by a physician or qualified practitioner. Member is required to pay the full cost at the time of service when utilizing an out-of-network provider. To receive reimbursement from Humana for eligible items/services, the member must submit required documentation. Reimbursement will be limited to up to 5% of the allowed amount on eligible items/services. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.

Note: *This plan requires prior authorization for certain items and services. The following link will take you to a list of items and services that may be subject to prior authorization: Humana.com/PAL.*

Notes

Notice of Availability - Auxiliary Aids and Services Notice

English: Free language, auxiliary aid, and alternate format services are available. Call **877-320-1235 (TTY: 711)**.

አማርኛ [Amharic]፦ነፃ ቋንቋ፣ አጋዥ ማዳመጫ፣ እና አማራጭ ቅርፀት ያላቸው አገልግሎቶችም ይገኛሉ። በ **877-320-1235 (TTY: 711)** ላይ ይደውሉ።

العربية [Arabic]: تتوفر خدمات اللغة والمساعدة الإضافية والتنسّيق البديل مجاناً. اتصل على الرقم **877-320-1235 (الهاتف النصي: 711)**.

Հայերեն [Armenian]: Հասանելի են անվճար լեզվական, աջակցման և այլընտրանքային ձևաչափի ծառայություններ: Զանգահարե՛ք **877-320-1235 (TTY՝ 711)** հեռախոսահամարով:

Bǎsóò [Bassa]: Wudu-xwíníín-mú-zà-zà kǔà, hwòdǒ-fónɔ́-nyɔ̀,, kè nyɔ-bɔ̌-po-kà ɓě ɓé wa nyuɛsé wídí péè-péèdò kɔ̀. Ɓá **877-320-1235 (TTY: 711)**.

বাংলা [Bengali]: বিনামূল্যে ভাষা, আনুষঙ্গিক সহায়তা, এবং বিকল্প বিন্যাসে পরিষেবা উপলব্ধ। ফোন করুন **877-320-1235 (TTY: 711)** নম্বরে।

简体中文 [Simplified Chinese]：我们可提供免费的语言、辅助设备以及其他格式版本服务。请致电 **877-320-1235**（听障专线：**711**）。

繁體中文 [Traditional Chinese]：我們可提供免費的語言、輔助設備以及其他格式版本服務。請致電 **877-320-1235**（聽障專線：**711**）。

Kreyòl Ayisyen [Haitian Creole]: Gen sèvis lengwistik gratis, èd oksilyè, ak lòt fòma sèvis ki disponib. Rele **877-320-1235 (TTY: 711).**

Hrvatski [Croatian]: Dostupne su besplatne jezične usluge, usluge dodatne pomoći i alternativnog formata. Nazovite **877-320-1235 (TTY: 711)**.

فارسی [Farsi] : خدمات زبان رایگان، کمک های اضافی و فرمت های جایگزین در دسترس است. با **877-320-1235 (TTY: 711)** تماس بگیرید.

Français [French]: Des services gratuits d’assistance linguistique, d’aide auxiliaire et de format alternatif sont disponibles. Appelez le **877-320-1235 (ATS : 711)**.

Deutsch [German]: Es stehen kostenlose unterstützende Hilfs- und Sprachdienste sowie alternative Dokumentformate zur Verfügung. Telefon: **877-320-1235 (TTY: 711)**.

Ελληνικά [Greek]: Διατίθενται δωρεάν γλωσσικές υπηρεσίες, βοηθήματα και υπηρεσίες σε εναλλακτικές προσβάσιμες μορφές. Καλέστε στο **877-320-1235 (TTY: 711)**.

ગુજરાતી [Gujarati] : મફત ભાષા, સહાયક સહાય અને વૈકલ્પિક ફોર્મેટ સેવાઓ ઉપલબ્ધ છે. **877-320-1235 (TTY: 711)** પર કૉલ કરો.

עברית [Hebrew]: שירותים אלה זמינים בחינם: שירותי תרגום, אביזרי עזר וטקסטים בפורמטים חלופיים. נא התקשר למספר **877-320-1235 (TTY: 711)**

हिंदी [Hindi]: निःशुल्क भाषा, सहायक मदद और वैकल्पिक प्रारूप सेवाएं उपलब्ध हैं। **877-320-1235 (TTY:711)** पर कॉल करें।

Hmoob [Hmong]: Muaj kev pab txhais lus, pab kom hnov suab, thiab lwm tus qauv pab cuam. Hu **877-320-1235 (TTY: 711)**.

Bekee [Igbo]: Asụsụ n’efu, enyemaka nkwarụ, na ọrụ usoro ndị ọzọ dị. Kpọọ **877-320-1235 (TTY: 711)**.

GHHNOA2026HUM_0526

Italiano [Italian]: Sono disponibili servizi gratuiti di supporto linguistico, assistenza ausiliaria e formati alternativi. Chiamare il numero **877-320-1235 (TTY: 711)**.

日本語 [Japanese]:言語支援サービス、補助支援サービス、代替形式サービスを無料でご利用いただけます。**877-320-1235 (TTY: 711)** までお電話ください。

ភាសាខ្មែរ [Khmer]៖ សេវាកម្មផ្នែកភាសា ជំនួយ និង សេវាកម្មជាទម្រង់ផ្សេងជំនួសអាចរកបាន។ ទូរសព្ទទៅលេខ **877-320-1235 (TTY: 711)** ។

한국어 [Korean]: 무료 언어, 보조 지원 및 대체 형식 서비스를 이용하실 수 있습니다. **877-320-1235 (TTY: 711)** 번으로 문의하십시오.

ພາສາລາວ [Lao]: ມີບໍລິການພາສາ, ອຸປະກອນຊ່ວຍເຫຼືອ ແລະ ຮູບແບບທາງເລືອກອື່ນບໍ່ເສຍຄ່າໃຫ້. ໂທ **877-320-1235 (TTY: 711)**.

Diné [Navajo]: Saad bee áná'álwo', bee haz'áanii, dóó naaltsoos t'áá ajiłii'ígíí bee ak'e'elyaaígíí t'áá jiik'eh hóló. **877-320-1235 (TTY: 711)** bich'į' hodíílnih.

नेपाली [Nepali]: नि:शुल्क भाषा सेवा, सहायक सामग्री र वैकल्पिक ढाँचाका सेवाहरू उपलब्ध छन् । **877-320-1235 (TTY: 711)** मा कल गर्नुहोस् ।

Polski [Polish]: Dostępne są bezpłatne usługi językowe, pomocnicze i alternatywne formaty. Zadzwoń pod numer **877-320-1235 (TTY: 711)**.

Português [Brazilian Portuguese]: Estão disponíveis serviços gratuitos de ajuda linguística auxiliar e outros formatos alternativos. Ligue **877-320-1235 (TTY: 711)**.

ਪੰਜਾਬੀ [Punjabi]: ਮੁਫ਼ਤ ਭਾਸ਼ਾ, ਸਹਾਇਕ ਸਹਾਇਤਾ, ਅਤੇ ਵਿਕਲਪਿਕ ਫਾਰਮੈਟ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। **877-320-1235 (TTY: 711)** 'ਤੇ ਕਾਲ ਕਰੋ।

Русский [Russian]: Предоставляются бесплатные услуги языковой поддержки, вспомогательные средства и материалы в альтернативных форматах. Звоните по номеру **877-320-1235 (TTY: 711)**.

Español [Spanish]: Los servicios gratuitos de asistencia lingüística, ayuda auxiliar y servicios en otro formato están disponibles. Llame al **877-320-1235 (TTY: 711)**.

Tagalog [Tagalog]: Magagamit ang mga libreng serbisyong pangwika, serbisyo o device na pantulong, at kapalit na format. Tumawag sa **877-320-1235 (TTY: 711)**.

தமிழ் [Tamil]: மொழி,, உதவிப் பொருட்கள் மற்றும் மாற்று வடிவமைப்புச் சேவைகள் இலவசமாகக் கிடைக்கின்றன. **877-320-1235 (TTY: 711)** எண்ணை அழைக்கவும்.

తెలుగు [Telugu]: ఉచిత భాష, సహాయక మద్దతు, మరియు ప్రత్యామ్నాయ ఫార్మాట్ సేవలు అందుబాటులో గలవు. **877-320-1235 (TTY: 711)** కి కాల్ చేయండి.

اردو [Urdu]: مفت زبان، معاون امداد، اور متبادل فارمیٹ کی خدمات دستیاب ہیں۔ کال **877-320-1235 (TTY: 711)**۔

Tiếng Việt [Vietnamese]: Có sẵn miễn phí các dịch vụ ngôn ngữ, hỗ trợ phụ trợ và định dạng thay thế. Hãy gọi **877-320-1235 (TTY: 711)**.

Òyìnbó [Yoruba]: Àwọn iṣẹ́ àtìlẹ́hìn ìrànlọ́wọ́ èdè, àti ọ̀nà kíkà míràn wà lárọwọ́tó lọ́fẹ̀ẹ́. Pe **877-320-1235 (TTY: 711)**.

This notice is available at **https://www.humana.com/legal/multi-language-support**.

Find out **more**

You can see this plan's provider directory at **your.Humana.com/OK-medicare** 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 this 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.

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Humana®

your.Humana.com/OK-medicare

SB079449EN27

2027

Summary of Benefits

Humana Group Medicare PDP
PDP 037/472

State of Oklahoma

Humana®

Our service area includes specific counties within the United States, Puerto Rico and all other major U.S. territories.



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

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

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

To be eligible

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

Plan name:

Humana Group Medicare PDP

How to reach us:

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

Call Monday – Friday, 7 a.m. – 8 p.m., Central time.

Or visit our website: **your.Humana.com/OK-medicare**

Deductible

Pharmacy (Part D) deductible This plan has a **$250** deductible.

Prescription Drug Benefits

Initial coverage (after you pay your deductible, if applicable)
You pay the following until your total out-of-pocket drug costs reach **$2,400**. Once you reach this amount, you will enter the Catastrophic Stage.

Tier	Standard Retail Pharmacy	Standard Mail Order
30-day supply		
1 (Generic or Preferred Generic)	**$5** copay	**$5** copay
2 (Preferred Brand)	**$45** copay	**$45** copay
3 (Non-Preferred Drug)	**$75** copay	**$75** copay
4 (Specialty Tier)	**$100** copay	**$100** copay
100-day supply		
1 (Generic or Preferred Generic)	**$10** copay	**$10** copay
2 (Preferred Brand)	**$90** copay	**$90** copay
3 (Non-Preferred Drug)	**$150** copay	**$150** copay
4 (Specialty Tier)	N/A	N/A

Excluded drug coverage: Additional drugs, vaccines and/or supplies covered on your plan

- Buproban
- Chantix
- Nicotrol
- Generic Statins

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**2**.

Important Message About What You Pay for Vaccines – This plan covers most Part D vaccines at no cost to you (even if you haven't paid your deductible, if applicable). Call Humana Group Medicare 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 this plan, no matter what cost-sharing tier it's on (even if you haven't paid your deductible, if applicable). Note: Not all tiers may include insulin. Please refer to your Prescription Drug Guide to confirm insulin coverage.

Catastrophic Coverage

After your total out-of-pocket costs reach **$2,400**, you pay **$0** for plan-covered Part D and plan-covered excluded drugs.

Notice of Availability - Auxiliary Aids and Services Notice

English: Free language, auxiliary aid, and alternate format services are available. Call **877-320-1235 (TTY: 711)**.

አማርኛ [Amharic]፦ነፃ ቋንቋ፣ አጋዥ ማዳመጫ፣ እና አማራጭ ቅርፀት ያላቸው አገልግሎቶችም ይገኛሉ። በ **877-320-1235 (TTY: 711)** ላይ ይደውሉ።

العربية [Arabic]: تتوفر خدمات اللغة والمساعدة الإضافية والتنسّيق البديل مجاناً. اتصل على الرقم **877-320-1235 (الهاتف النصي: 711)**.

Հայերեն [Armenian]: Հասանելի են անվճար լեզվական, աջակցման և այլընտրանքային ձևաչափի ծառայություններ: Զանգահարե՛ք **877-320-1235 (TTY՝ 711)** հեռախոսահամարով:

Bǎsóò [Bassa]: Wudu-xwíníín-mú-zà-zà kǔà, hwòdǒ-fónɔ́-nyɔ̀,, kè nyɔ-bɔ̌-po-kà ɓě ɓé wa nyuɛsé wídí péè-péèdò kɔ̀. Ɓá **877-320-1235 (TTY: 711)**.

বাংলা [Bengali]: বিনামূল্যে ভাষা, আনুষঙ্গিক সহায়তা, এবং বিকল্প বিন্যাসে পরিষেবা উপলব্ধ। ফোন করুন **877-320-1235 (TTY: 711)** নম্বরে।

简体中文 [Simplified Chinese]：我们可提供免费的语言、辅助设备以及其他格式版本服务。请致电 **877-320-1235**（听障专线：**711**）。

繁體中文 [Traditional Chinese]：我們可提供免費的語言、輔助設備以及其他格式版本服務。請致電 **877-320-1235**（聽障專線：**711**）。

Kreyòl Ayisyen [Haitian Creole]: Gen sèvis lengwistik gratis, èd oksilyè, ak lòt fòma sèvis ki disponib. Rele **877-320-1235 (TTY: 711).**

Hrvatski [Croatian]: Dostupne su besplatne jezične usluge, usluge dodatne pomoći i alternativnog formata. Nazovite **877-320-1235 (TTY: 711)**.

فارسی [Farsi] : خدمات زبان رایگان، کمک های اضافی و فرمت های جایگزین در دسترس است. با **877-320-1235 (TTY: 711)** تماس بگیرید.

Français [French]: Des services gratuits d’assistance linguistique, d’aide auxiliaire et de format alternatif sont disponibles. Appelez le **877-320-1235 (ATS : 711)**.

Deutsch [German]: Es stehen kostenlose unterstützende Hilfs- und Sprachdienste sowie alternative Dokumentformate zur Verfügung. Telefon: **877-320-1235 (TTY: 711)**.

Ελληνικά [Greek]: Διατίθενται δωρεάν γλωσσικές υπηρεσίες, βοηθήματα και υπηρεσίες σε εναλλακτικές προσβάσιμες μορφές. Καλέστε στο **877-320-1235 (TTY: 711)**.

ગુજરાતી [Gujarati] : મફત ભાષા, સહાયક સહાય અને વૈકલ્પિક ફોર્મેટ સેવાઓ ઉપલબ્ધ છે. **877-320-1235 (TTY: 711)** પર કૉલ કરો.

עברית [Hebrew]: שירותים אלה זמינים בחינם: שירותי תרגום, אביזרי עזר וטקסטים בפורמטים חלופיים. נא התקשר למספר **877-320-1235 (TTY: 711)**

हिंदी [Hindi]: निःशुल्क भाषा, सहायक मदद और वैकल्पिक प्रारूप सेवाएं उपलब्ध हैं। **877-320-1235 (TTY:711)** पर कॉल करें।

Hmoob [Hmong]: Muaj kev pab txhais lus, pab kom hnov suab, thiab lwm tus qauv pab cuam. Hu **877-320-1235 (TTY: 711)**.

Bekee [Igbo]: Asụsụ n’efu, enyemaka nkwarụ, na ọrụ usoro ndị ọzọ dị. Kpọọ **877-320-1235 (TTY: 711)**.

GHHNOA2026HUM_0526

Italiano [Italian]: Sono disponibili servizi gratuiti di supporto linguistico, assistenza ausiliaria e formati alternativi. Chiamare il numero **877-320-1235 (TTY: 711)**.

日本語 [Japanese]:言語支援サービス、補助支援サービス、代替形式サービスを無料でご利用いただけます。**877-320-1235 (TTY: 711)** までお電話ください。

ភាសាខ្មែរ [Khmer]៖ សេវាកម្មផ្នែកភាសា ជំនួយ និង សេវាកម្មជាទម្រង់ផ្សេងជំនួសអាចរកបាន។ ទូរសព្ទទៅលេខ **877-320-1235 (TTY: 711)** ។

한국어 [Korean]: 무료 언어, 보조 지원 및 대체 형식 서비스를 이용하실 수 있습니다. **877-320-1235 (TTY: 711)** 번으로 문의하십시오.

ພາສາລາວ [Lao]: ມີບໍລິການພາສາ, ອຸປະກອນຊ່ວຍເຫຼືອ ແລະ ຮູບແບບທາງເລືອກອື່ນບໍ່ເສຍຄ່າໃຫ້. ໂທ **877-320-1235 (TTY: 711)**.

Diné [Navajo]: Saad bee áná'álwo', bee haz'áanii, dóó naaltsoos t'áá ajiłii'ígíí bee ak'e'elyaaígíí t'áá jiik'eh hóló. **877-320-1235 (TTY: 711)** bich'į' hodíílnih.

नेपाली [Nepali]: नि:शुल्क भाषा सेवा, सहायक सामग्री र वैकल्पिक ढाँचाका सेवाहरू उपलब्ध छन् । **877-320-1235 (TTY: 711)** मा कल गर्नुहोस् ।

Polski [Polish]: Dostępne są bezpłatne usługi językowe, pomocnicze i alternatywne formaty. Zadzwoń pod numer **877-320-1235 (TTY: 711)**.

Português [Brazilian Portuguese]: Estão disponíveis serviços gratuitos de ajuda linguística auxiliar e outros formatos alternativos. Ligue **877-320-1235 (TTY: 711)**.

ਪੰਜਾਬੀ [Punjabi]: ਮੁਫ਼ਤ ਭਾਸ਼ਾ, ਸਹਾਇਕ ਸਹਾਇਤਾ, ਅਤੇ ਵਿਕਲਪਿਕ ਫਾਰਮੈਟ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। **877-320-1235 (TTY: 711)** 'ਤੇ ਕਾਲ ਕਰੋ।

Русский [Russian]: Предоставляются бесплатные услуги языковой поддержки, вспомогательные средства и материалы в альтернативных форматах. Звоните по номеру **877-320-1235 (TTY: 711)**.

Español [Spanish]: Los servicios gratuitos de asistencia lingüística, ayuda auxiliar y servicios en otro formato están disponibles. Llame al **877-320-1235 (TTY: 711)**.

Tagalog [Tagalog]: Magagamit ang mga libreng serbisyong pangwika, serbisyo o device na pantulong, at kapalit na format. Tumawag sa **877-320-1235 (TTY: 711)**.

தமிழ் [Tamil]: மொழி,, உதவிப் பொருட்கள் மற்றும் மாற்று வடிவமைப்புச் சேவைகள் இலவசமாகக் கிடைக்கின்றன. **877-320-1235 (TTY: 711)** எண்ணை அழைக்கவும்.

తెలుగు [Telugu]: ఉచిత భాష, సహాయక మద్దతు, మరియు ప్రత్యామ్నాయ ఫార్మాట్ సేవలు అందుబాటులో గలవు. **877-320-1235 (TTY: 711)** కి కాల్ చేయండి.

اردو [Urdu]: مفت زبان، معاون امداد، اور متبادل فارمیٹ کی خدمات دستیاب ہیں۔ کال **877-320-1235 (TTY: 711)**۔

Tiếng Việt [Vietnamese]: Có sẵn miễn phí các dịch vụ ngôn ngữ, hỗ trợ phụ trợ và định dạng thay thế. Hãy gọi **877-320-1235 (TTY: 711)**.

Òyìnbó [Yoruba]: Àwọn iṣẹ́ àtìlẹ́hìn ìrànlọ́wọ́ èdè, àti ọ̀nà kíkà míràn wà lárọwọ́tó lọ́fẹ̀ẹ́. Pe **877-320-1235 (TTY: 711)**.

This notice is available at **https://www.humana.com/legal/multi-language-support**.

Find out **more**

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

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

Humana is a stand-alone prescription drug plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

If you want to compare this 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.

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SB037472EN27

2027

Prescription Drug Guide

Humana Medicare Employer Plan Abbreviated Formulary

Partial List of covered drugs or "Drug List"

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

2

Formulary 27800

This abridged formulary was updated on 10/13/2026 and is not a complete list of drugs covered by our plan. For a complete listing, or other questions, please contact the Humana Medicare Employer Plan Customer Care Team with any questions at the number on the back of your membership card, or for TTY users, 711, Monday through Friday, from 8 a.m. - 9 p.m., Eastern time. Our automated phone system is available after hours, weekends, and holidays. Our website is also available 24 hours a day, 7 days a week, by visiting **Humana.com**.

Instructions for getting information about all covered drugs are inside.

Humana®

Welcome to The Humana Medicare Employer Plan!

Note to existing members: This Formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take. When this Drug List (Formulary) refers to "we," "us", or "our," it means Humana. When it refers to "plan" or "our plan", it means the Humana Medicare Employer Plan. This document includes a partial Drug List (formulary) for our plan which is current as of January 1, 2027. For a complete, updated Drug List (formulary), please contact us. Our contact information, along with the date we last updated the Drug List (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 Humana Medicare Employer abridged formulary?
In this document, we use the terms Drug List and formulary to mean the same thing. 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 and includes only some of the drugs covered by Humana Medicare Employer Plan. For a complete listing of all prescription drugs covered by Humana Medicare Employer Plan, please visit our website or call us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

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

Can the formulary change?
Most changes in drug coverage happen on January 1, but we may add or remove drugs on the formulary during the year, move them to different cost sharing tiers, or add new restrictions. We must follow Medicare rules in making these changes. Updates to the formulary are posted monthly to our website here: **Humana.com/medicaredruglist**.

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

- **Immediate substitutions of certain new versions of brand name drugs and original biological products**. We may immediately remove a drug on our formulary if we are replacing it with a certain new version of that drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. When we add a new version of a drug to our formulary, we may decide to keep the brand name drug or biological product on our formulary, but immediately move it to a different cost-sharing tier or add new restrictions.

  We can make these immediate changes only if we are adding a new generic version of a brand name drug, or adding certain new biosimilar versions of an original biological product, that was already on the formulary (for example, adding an interchangeable biosimilar that can be substituted for an original biological product by a pharmacy without a new prescription).

If you are currently taking the brand name drug or biological product, we may not tell you in advance before we make an immediate 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 for you the drug that is being changed. For more information, see the section below titled "How do I request an exception to the Humana Formulary?"

Some of these drug types may be new to you. For more information, see the section below titled "What are original biological products and how are they related to biosimilars?"

- **Drugs removed from the market**. If a drug is withdrawn from sale by the manufacturer or the Food and Drug Administration (FDA) determines to be withdrawn for safety or effectiveness reasons, we may immediately remove the drug from our formulary and later 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 remove a brand name drug from the formulary when adding a generic equivalent or remove an original biological product when adding a biosimilar. We may also apply new restrictions to the brand name drug or original biological product, or move it to a different cost-sharing tier, or both. 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. Alternatively, when a member requests a refill of the drug, they may receive a 30-day supply of the drug and a notice of the change.

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 drug you have been taking. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below titled "How do I request an exception to the Humana Formulary?"

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 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 formulary 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 happen 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, 2027. To get updated information about the drugs covered by Humana please contact us. Our contact information appears on the front and back cover pages.

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

Medical condition
The formulary starts on page 11. We have put the drugs into groups depending on the type of medical conditions that they are used to treat. For example, drugs that treat a heart condition are listed under the category "Cardiovascular Agents." If you know what medical condition your drug is used for, look for the category name in the list that begins on page 11. Then look under the category name for your drug. The formulary also lists the Tier and Utilization Management Requirements for each drug (see page 6 for more information on Utilization Management Requirements).

Alphabetical listing
If you are not sure what category to look under, you should look for your drug in the Index that begins on page 29. The Index provides an alphabetical list of all of the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find 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.

What are generic drugs?
Humana 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 work just as well as and usually cost less than brand name drugs. There are generic drug substitutes available for many brand name drugs. Generic drugs usually can be substituted for the brand name drug at the pharmacy without needing a new prescription, depending on state laws.

What are original biological products and how are they related to biosimilars?
On the formulary, when we refer to drugs, this could mean a drug or a biological product. Biological products are drugs that are more complex than typical drugs. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, biosimilars work just as well as the original biological product and may cost less. There are biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state laws, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

- For discussion of drug types, please see the Evidence of Coverage, Chapter 5, Section 3.1, “The ‘Drug List’ tells which Part D drugs are covered” if you have a Medicare Advantage plan. If you have a Prescription Drug Plan (PDP), please see the Evidence of Coverage, Chapter 3, Section 3.1, "The 'Drug List' tells which Part D drugs are covered". The type of plan can be found at the top of your Evidence of Coverage.

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 requirements and limits may include:

- **Prior Authorization (PA):** The Humana Medicare Employer Plan requires you to get prior authorization for certain drugs. This means that you will need to get approval from the Humana Medicare Employer Plan based on specific criteria 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 certain 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 we will cover 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 (BvsD):** Some drugs may be covered under Medicare Part B or Part D, depending upon the circumstances. Information may need to be submitted to the Humana Medicare Employer Plan that describes the use and the place where you receive and take the drug so a determination can be made.

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

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 11.

You can also get more information about the restrictions applied to specific covered drugs by visiting **Humana.com/medicaredruglist**. We have posted online documents that explain our prior authorization and step therapy restrictions. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask the Humana Medicare Employer Plan to make an exception to these restrictions, limits or for a list of other, similar drugs that may treat your health condition. See the section "**How do I request an exception to the Humana Formulary?**" on page 7 for information about how to request an exception.

What if my drug is not on the Formulary?
If your drug is not included in this formulary (list of covered drugs), you should first contact Humana Medicare Employer Plan Customer Care and ask if your drug is covered. This document includes only a partial list of covered drugs, so Humana Group Medicare Plan may cover your drug. For more information, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

If you learn that 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 are covered by Humana Medicare Employer Plan. When you receive the list, show it to your doctor and ask them to prescribe a similar drug that is covered by the Humana Medicare Employer Plan.
- You can ask the Humana Medicare Employer Plan to make an exception and cover your drug. See below for information about how to request an exception.

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 us to make.

- **Formulary exception:** You can ask us to cover a drug even if it is not on our 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 ask us to waive a coverage restriction including prior authorization, step therapy, or a quantity limit on your drug. For example, for certain drugs, Humana Group Medicare Plan limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

- **Tier exception:** You can ask us to cover a formulary drug at lower cost-sharing level unless the drug is on the specialty tier. If approved, this would lower the amount you must pay for your drug.

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 applying the restriction would not be as effective for you and/or would cause you to have adverse effects.

You or your prescriber should contact us to ask for a tiering or formulary exception, including an exception to a coverage restriction. **When you request an exception, your prescriber will need to explain the medical reasons why you need the exception**. Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can ask for an expedited (fast) decision if you believe, and we agree, that your health could be seriously harmed by waiting up to 72 hours for a decision. If we agree, or if your prescriber asks for a fast decision, we must give you a decision no later than 24 hours after we get your prescriber's supporting statement.

What can I do if my drug is not on the formulary or has a restriction?
As a new or continuing member in our plan you may be taking drugs that are not on our formulary. Or, you may be taking a drug that is on our formulary but has a coverage restriction, such as prior authorization. You should talk to your prescriber about requesting a coverage decision to show that you meet the criteria for approval, switching to an alternative drug that we cover, or requesting a formulary exception so that we will cover the drug you take. While you and your doctor determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs that is not on our formulary or has a coverage restriction, we will cover a temporary 30-day supply. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum 30 day supply of medication. If coverage is not approved, after your first 30-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility and you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that 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 31 days of a drug) while you pursue a formulary exception.

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 review your Evidence of Coverage and other plan materials.

If you have questions about Humana Group Medicare Plan, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

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 abridged formulary that begins on the next page provides coverage information about some of 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 29.

Remember: This is only a partial list of drugs covered by Humana. If your prescription drug is not listed in this partial formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

How to read your formulary
The first column of the chart lists categories of medical conditions in alphabetical order. The drug names are then listed in alphabetical order within each category. Brand-name drugs are CAPITALIZED and generic drugs are listed in lower-case italics. Next to the drug name or Utilization Management column, you may see an indicator to tell you about additional coverage information for that drug. You might see the following indicators:

DL - Dispensing Limit; Drugs that may be limited to a 30 day supply, regardless of tier placement.
MO - Drugs that are typically available through mail-order. Please contact your mail-order pharmacy to make sure your drug is available.
LA - Limited Access; The health plan has authorized certain pharmacies to dispense this medicine, as it requires extra handling, doctor coordination or patient education. Please call the number on the back of your ID card for additional information.
CI – Covered insulin products; Part D insulin products covered by your plan. For more information on cost sharing for your covered insulin products, please refer to your Evidence of Coverage.
AV – Advisory Committee on Immunization Practices (ACIP) Covered Part D vaccines; Part D vaccines recommended by ACIP for adults that may be available at no cost to you; additional restrictions may apply. For more information, please refer to your Evidence of Coverage.
PDS – Preferred Diabetic Supplies; BD/Embecta and HTL-Droplet products are the preferred diabetic syringe and pen needle brands for the plan.

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

The third column shows the Utilization Management Requirements for the drug. The Humana Medicare Employer Plan may have special requirements for covering that drug. If the column is blank, then there are no utilization requirements for that drug. The supply for each drug is based on benefits and whether your health care provider prescribes a supply for 30, 60, 90, or 100 days. The amount of any quantity limits will also be in this column (Example: "QL - 30 for 30 days" means you can only get 30 doses every 30 days). See page 6 for more information about these requirements.

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
ANALGESICS		
celecoxib 100 mg, 200 mg CAPSULE **MO**	1	
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	
meloxicam 15 mg TABLET **MO**	1	QL(30 per 30 days)
meloxicam 7.5 mg TABLET **MO**	1	QL(60 per 30 days)
naproxen 500 mg TABLET **MO**	1	
oxycodone 10 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)
ANESTHETICS		
lidocaine 5 % ADHESIVE PATCH, MEDICATED **MO**	1	QL(90 per 30 days)
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS		
KLOXXADO 8 MG/ACTUATION SPRAY, NON-AEROSOL **MO**	3	
OPVEE 2.7 MG/ACTUATION SPRAY, NON-AEROSOL **MO**	3	
ZUBSOLV 0.7-0.18 MG, 1.4-0.36 MG, 11.4-2.9 MG, 2.9-0.71 MG, 5.7-1.4 MG, 8.6-2.1 MG SUBLINGUAL TABLET **MO**	1	
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	
DIFICID 200 MG TABLET **DL**	4	
DIFICID 40 MG/ML SUSPENSION FOR RECONSTITUTION **DL**	4	
doxycycline hyclate 100 mg CAPSULE **MO**	1	
doxycycline hyclate 100 mg TABLET **MO**	1	
levofloxacin 500 mg TABLET **MO**	1	
nitrofurantoin monohyd/m-cryst 100 mg CAPSULE **MO**	1	
sulfamethoxazole-trimethoprim 800-160 mg TABLET **MO**	1	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
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)
levetiracetam 500 mg TABLET **MO**	1	
NAYZILAM 5 MG/SPRAY (0.1 ML) SPRAY, NON-AEROSOL **DL**	3	QL(10 per 30 days)
ANTIDEMENTIA AGENTS		
donepezil 10 mg, 5 mg TABLET **MO**	1	
memantine 10 mg, 5 mg TABLET **MO**	1	PA
NAMZARIC 14-10 MG, 21-10 MG, 28-10 MG, 7-10 MG CAPSULE ER SPRINKLE 24 HR. **MO**	3	PA,QL(30 per 30 days)
ANTIDEPRESSANTS		
amitriptyline 25 mg TABLET **MO**	1	
AUVELITY 45-105 MG TABLET, IR/ER, BIPHASIC **MO**	3	ST,QL(60 per 30 days)
bupropion hcl 150 mg TABLET, ER 24 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, 20 mg, 40 mg TABLET **MO**	1	
escitalopram oxalate 10 mg, 20 mg, 5 mg TABLET **MO**	1	
fluoxetine 20 mg CAPSULE **MO**	1	QL(120 per 30 days)
fluoxetine 40 mg CAPSULE **MO**	1	QL(90 per 30 days)
mirtazapine 15 mg, 30 mg, 7.5 mg TABLET **MO**	1	
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, 8 mg TABLET, DISINTEGRATING **MO**	1	BvsD
ondansetron hcl 4 mg TABLET **MO**	1	BvsD
ANTIFUNGALS		
clotrimazole-betamethasone 1-0.05 % CREAM **MO**	1	QL(180 per 30 days)
fluconazole 150 mg TABLET **MO**	1	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
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	
colchicine 0.6 mg TABLET **MO**	1	QL(120 per 30 days)
ANTIMIGRAINE AGENTS		
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)
QULIPTA 10 MG, 30 MG, 60 MG TABLET **MO**	3	PA,QL(30 per 30 days)
UBRELVY 100 MG, 50 MG TABLET **MO**	2	PA,QL(16 per 30 days)
ANTIMYASTHENIC AGENTS		
VYVGART 20 MG/ML SOLUTION **DL**	4	PA
VYVGART HYTRULO 1,000 MG-10,000 UNIT/5 ML SYRINGE **DL**	4	PA,QL(20 per 28 days)
VYVGART HYTRULO 1,008 MG-11,200 UNIT/5.6 ML SOLUTION **DL**	4	PA,QL(22.4 per 28 days)
ANTINEOPLASTICS		
ALECENSA 150 MG CAPSULE **DL**	4	PA,QL(240 per 30 days)
ALUNBRIG 180 MG, 90 MG TABLET **DL**	4	PA,QL(30 per 30 days)
ALUNBRIG 30 MG TABLET **DL**	4	PA,QL(180 per 30 days)
ALUNBRIG 90 MG (7)- 180 MG (23) TABLET, DOSE PACK **DL**	4	PA,QL(30 per 30 days)
anastrozole 1 mg TABLET **MO**	1	QL(30 per 30 days)
BRUKINSA 80 MG CAPSULE **DL**	4	PA,QL(120 per 30 days)
CABOMETYX 20 MG, 40 MG, 60 MG TABLET **DL**	4	PA,QL(30 per 30 days)
CALQUENCE (ACALABRUTINIB MAL) 100 MG TABLET **DL**	4	PA,QL(60 per 30 days)
ERIVEDGE 150 MG CAPSULE **DL**	4	PA,QL(28 per 28 days)
ERLEADA 240 MG TABLET **DL**	4	PA,QL(30 per 30 days)
ERLEADA 60 MG TABLET **DL**	4	PA,QL(120 per 30 days)
IBRANCE 100 MG, 125 MG, 75 MG CAPSULE **DL**	4	PA,QL(21 per 28 days)
IBRANCE 100 MG, 125 MG, 75 MG TABLET **DL**	4	PA,QL(21 per 28 days)
IMBRUVICA 140 MG CAPSULE **DL**	4	PA,QL(120 per 30 days)
IMBRUVICA 140 MG, 280 MG TABLET **DL**	4	PA
IMBRUVICA 420 MG TABLET **DL**	4	PA,QL(28 per 28 days)
IMBRUVICA 70 MG CAPSULE **DL**	4	PA,QL(28 per 28 days)
IMBRUVICA 70 MG/ML SUSPENSION **DL**	4	PA
KISQALI 200 MG/DAY (200 MG X 1) TABLET **DL**	4	PA,QL(21 per 28 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
KISQALI 400 MG/DAY (200 MG X 2) TABLET DL	4	PA,QL(42 per 28 days)
KISQALI 600 MG/DAY (200 MG X 3) TABLET DL	4	PA,QL(63 per 28 days)
LORBRENA 25 MG TABLET DL	4	PA,QL(90 per 30 days)
LUMAKRAS 120 MG TABLET DL	4	PA,QL(240 per 30 days)
LUMAKRAS 240 MG TABLET DL	4	PA,QL(120 per 30 days)
LUMAKRAS 320 MG TABLET DL	4	PA,QL(90 per 30 days)
LYNPARZA 100 MG, 150 MG TABLET DL	4	PA,QL(120 per 30 days)
NUBEQA 300 MG TABLET DL	4	PA,QL(120 per 30 days)
ORGOVYX 120 MG TABLET DL	4	PA,QL(32 per 30 days)
RUXIENCE 10 MG/ML SOLUTION DL	4	PA
TRAZIMERA 150 MG, 420 MG RECON SOLUTION DL	4	PA
VERZENIO 100 MG, 150 MG, 200 MG, 50 MG TABLET DL	4	PA,QL(60 per 30 days)
XTANDI 40 MG CAPSULE DL	4	PA,QL(120 per 30 days)
XTANDI 40 MG TABLET DL	4	PA,QL(120 per 30 days)
XTANDI 80 MG TABLET DL	4	PA,QL(60 per 30 days)
ZEJULA 100 MG, 200 MG, 300 MG TABLET DL	4	PA,QL(30 per 30 days)
ZIRABEV 25 MG/ML SOLUTION DL	4	PA
ANTIPARASITICS		
hydroxychloroquine 200 mg TABLET MO	1	
ANTIPARKINSON AGENTS		
carbidopa-levodopa 25-100 mg TABLET MO	1	
CREXONT 35-140 MG, 52.5-210 MG, 70-280 MG, 87.5-350 MG CAPSULE, IR/ER, BIPHASIC MO	3	ST,QL(180 per 30 days)
RYTARY 23.75-95 MG, 48.75-195 MG CAPSULE, ER MO	3	ST,QL(360 per 30 days)
RYTARY 36.25-145 MG CAPSULE, ER MO	3	ST,QL(270 per 30 days)
RYTARY 61.25-245 MG CAPSULE, ER MO	3	ST,QL(300 per 30 days)
ANTIPSYCHOTICS		
ABILIFY 10 MG, 15 MG, 2 MG, 20 MG, 30 MG, 5 MG TABLET MO	3	
ABILIFY ASIMTUFII 720 MG/2.4 ML SUSPENSION, ER, SYRINGE	4	QL(2.4 per 56 days)
ABILIFY ASIMTUFII 960 MG/3.2 ML SUSPENSION, ER, SYRINGE	4	QL(3.2 per 56 days)
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)
ARISTADA 1,064 MG/3.9 ML SUSPENSION, ER, SYRINGE	4	QL(3.9 per 56 days)
ARISTADA 441 MG/1.6 ML SUSPENSION, ER, SYRINGE DL	4	QL(1.6 per 28 days)
ARISTADA 662 MG/2.4 ML SUSPENSION, ER, SYRINGE DL	4	QL(2.4 per 28 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
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 3 MG, 9 MG TABLET, ER 24 HR. **MO**	3	QL(30 per 30 days)
INVEGA 6 MG TABLET, ER 24 HR. **MO**	3	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)
LYBALVI 10-10 MG, 15-10 MG, 20-10 MG, 5-10 MG TABLET **MO**	3	PA,QL(30 per 30 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)
REXULTI 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG TABLET **MO**	3	PA,QL(30 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 **MO**	3	QL(60 per 30 days)
RISPERDAL 1 MG/ML SOLUTION **MO**	3	
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	
tizanidine 4 mg TABLET **MO**	1	
ANTIVIRALS		
BIKTARVY 30-120-15 MG, 50-200-25 MG TABLET **DL**	4	QL(30 per 30 days)
DESCOVY 120-15 MG, 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)
ODEFSEY 200-25-25 MG TABLET **DL**	4	QL(30 per 30 days)
oseltamivir 75 mg CAPSULE **MO**	1	QL(112 per 365 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
PAXLOVID 150 MG (10)- 100 MG (10) TABLET, DOSE PACK **MO**	1	QL(40 per 10 days)
PAXLOVID 150 MG (6)- 100 MG (5) TABLET, DOSE PACK **MO**	1	QL(22 per 10 days)
PAXLOVID 300 MG (150 MG X 2)-100 MG TABLET, DOSE PACK **MO**	1	QL(60 per 10 days)
sofosbuvir-velpatasvir 400-100 mg TABLET **DL**	4	PA,QL(28 per 28 days)
valacyclovir 1 gram, 500 mg TABLET **MO**	1	
VEMLIDY 25 MG TABLET **DL**	4	QL(30 per 30 days)
VOSEVI 400-100-100 MG TABLET **DL**	4	PA,QL(28 per 28 days)
ANXIOLYTICS		
alprazolam 0.25 mg, 0.5 mg, 1 mg TABLET **DL**	1	QL(120 per 30 days)
buspirone 10 mg, 5 mg TABLET **MO**	1	
clonazepam 0.5 mg, 1 mg TABLET **DL**	1	
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	
FARXIGA 10 MG, 5 MG TABLET **MO**	2	PA,QL(30 per 30 days)
FIASP FLEXTOUCH U-100 INSULIN 100 UNIT/ML (3 ML) INSULIN PEN **CI,MO**	2	
FIASP PENFILL U-100 INSULIN 100 UNIT/ML (3 ML) CARTRIDGE **CI,MO**	2	
FIASP U-100 INSULIN 100 UNIT/ML SOLUTION **CI,MO**	2	
glimepiride 2 mg, 4 mg TABLET **MO**	1	
glipizide 10 mg, 5 mg TABLET **MO**	1	
GLYXAMBI 10-5 MG, 25-5 MG TABLET **MO**	3	PA,QL(30 per 30 days)
GVOKE PFS 1-PACK SYRINGE 1 MG/0.2 ML SYRINGE **MO**	2	
HUMALOG JUNIOR KWIKPEN U-100 100 UNIT/ML INSULIN PEN, HALF-UNIT **CI,MO**	3	ST
HUMALOG KWIKPEN INSULIN 100 UNIT/ML, 200 UNIT/ML (3 ML) INSULIN PEN **CI,MO**	3	ST
HUMALOG MIX 50-50 KWIKPEN 100 UNIT/ML (50-50) INSULIN PEN **CI,MO**	3	ST
HUMALOG MIX 75-25 KWIKPEN 100 UNIT/ML (75-25) INSULIN PEN **CI,MO**	3	ST
HUMALOG MIX 75-25(U-100)INSULN 100 UNIT/ML (75-25) SUSPENSION **CI,MO**	3	ST
HUMALOG TEMPO PEN(U-100)INSULN 100 UNIT/ML INSULIN PEN, SENSOR **CI,MO**	3	ST
HUMALOG U-100 INSULIN 100 UNIT/ML CARTRIDGE **CI,MO**	3	ST

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
HUMALOG U-100 INSULIN 100 UNIT/ML SOLUTION **CI,MO**	3	ST
HUMULIN 70/30 U-100 INSULIN 100 UNIT/ML (70-30) SUSPENSION **CI,MO**	3	ST
HUMULIN 70/30 U-100 KWIKPEN 100 UNIT/ML (70-30) INSULIN PEN **CI,MO**	3	ST
HUMULIN N NPH INSULIN KWIKPEN 100 UNIT/ML (3 ML) INSULIN PEN **CI,MO**	3	ST
HUMULIN N NPH U-100 INSULIN 100 UNIT/ML SUSPENSION **CI,MO**	3	ST
HUMULIN R REGULAR U-100 INSULN 100 UNIT/ML SOLUTION **CI,MO**	3	ST
HUMULIN R U-500 (CONC) KWIKPEN 500 UNIT/ML (3 ML) INSULIN PEN **CI,DL**	4	
INVOKAMET 150-1,000 MG, 150-500 MG, 50-1,000 MG, 50-500 MG TABLET **MO**	3	PA,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**	3	PA,QL(60 per 30 days)
INVOKANA 100 MG TABLET **MO**	3	PA,QL(60 per 30 days)
INVOKANA 300 MG TABLET **MO**	3	PA,QL(30 per 30 days)
JANUMET 50-1,000 MG, 50-500 MG TABLET **MO**	2	PA,QL(60 per 30 days)
JANUMET XR 100-1,000 MG TABLET, ER 24 HR., MULTIPHASE **MO**	2	PA,QL(30 per 30 days)
JANUMET XR 50-1,000 MG, 50-500 MG TABLET, ER 24 HR., MULTIPHASE **MO**	2	PA,QL(60 per 30 days)
JANUVIA 100 MG, 25 MG, 50 MG TABLET **MO**	2	PA,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 TABLET **MO**	3	PA,QL(60 per 30 days)
JENTADUETO XR 2.5-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC **MO**	3	PA,QL(60 per 30 days)
JENTADUETO XR 5-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC **MO**	3	PA,QL(30 per 30 days)
LANTUS SOLOSTAR U-100 INSULIN 100 UNIT/ML (3 ML) INSULIN PEN **CI,MO**	2	
LANTUS U-100 INSULIN 100 UNIT/ML SOLUTION **CI,MO**	2	
LYUMJEV KWIKPEN U-100 INSULIN 100 UNIT/ML INSULIN PEN **CI,MO**	3	ST
LYUMJEV KWIKPEN U-200 INSULIN 200 UNIT/ML (3 ML) INSULIN PEN **CI,MO**	3	ST
LYUMJEV TEMPO PEN(U-100)INSULN 100 UNIT/ML INSULIN PEN, SENSOR **CI,MO**	3	ST
LYUMJEV U-100 INSULIN 100 UNIT/ML SOLUTION **CI,MO**	3	ST
metformin 1,000 mg, 500 mg TABLET **MO**	1	
metformin 500 mg TABLET, ER 24 HR. **MO**	1	QL(120 per 30 days)
MOUNJARO 10 MG/0.5 ML, 12.5 MG/0.5 ML, 15 MG/0.5 ML, 2.5 MG/0.5 ML, 5 MG/0.5 ML, 7.5 MG/0.5 ML PEN INJECTOR **MO**	2	PA,QL(2 per 28 days)
NOVOLIN 70-30 FLEXPEN U-100 100 UNIT/ML (70-30) INSULIN PEN **CI,MO**	2	
NOVOLIN 70/30 U-100 INSULIN 100 UNIT/ML (70-30) SUSPENSION **CI,MO**	2	
NOVOLIN N FLEXPEN 100 UNIT/ML (3 ML) INSULIN PEN **CI,MO**	2	
NOVOLIN N NPH U-100 INSULIN 100 UNIT/ML SUSPENSION **CI,MO**	2	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
NOVOLIN R FLEXPEN 100 UNIT/ML (3 ML) INSULIN PEN **CI,MO**	2	
NOVOLIN R REGULAR U100 INSULIN 100 UNIT/ML SOLUTION **CI,MO**	2	
NOVOLOG FLEXPEN U-100 INSULIN 100 UNIT/ML (3 ML) INSULIN PEN **CI,MO**	2	
NOVOLOG MIX 70-30 U-100 INSULN 100 UNIT/ML (70-30) SOLUTION **CI,MO**	2	
NOVOLOG MIX 70-30FLEXPEN U-100 100 UNIT/ML (70-30) INSULIN PEN **CI,MO**	2	
NOVOLOG PENFILL U-100 INSULIN 100 UNIT/ML CARTRIDGE **CI,MO**	2	
NOVOLOG U-100 INSULIN ASPART 100 UNIT/ML SOLUTION **CI,MO**	2	
OZEMPIC 0.25 MG OR 0.5 MG (2 MG/3 ML), 1 MG/DOSE (4 MG/3 ML), 2 MG/DOSE (8 MG/3 ML) PEN INJECTOR **MO**	2	PA,QL(3 per 28 days)
pioglitazone 30 mg TABLET **MO**	1	QL(30 per 30 days)
RYBELSUS 14 MG, 3 MG, 7 MG TABLET **MO**	2	PA,QL(30 per 30 days)
SOLIQUA 100/33 100 UNIT-33 MCG/ML INSULIN PEN **CI,MO**	2	QL(15 per 24 days)
SYNJARDY 12.5-1,000 MG, 12.5-500 MG, 5-1,000 MG, 5-500 MG TABLET **MO**	3	PA,QL(60 per 30 days)
SYNJARDY XR 10-1,000 MG, 25-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC **MO**	3	PA,QL(30 per 30 days)
SYNJARDY XR 12.5-1,000 MG, 5-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC **MO**	3	PA,QL(60 per 30 days)
TOUJEO MAX U-300 SOLOSTAR 300 UNIT/ML (3 ML) INSULIN PEN **CI,MO**	2	
TOUJEO SOLOSTAR U-300 INSULIN 300 UNIT/ML (1.5 ML) INSULIN PEN **CI,MO**	2	
TRADJENTA 5 MG TABLET **MO**	2	QL(30 per 30 days)
TRESIBA FLEXTOUCH U-100 100 UNIT/ML (3 ML) INSULIN PEN **CI,MO**	2	
TRESIBA FLEXTOUCH U-200 200 UNIT/ML (3 ML) INSULIN PEN **CI,MO**	2	
TRESIBA U-100 INSULIN 100 UNIT/ML SOLUTION **CI,MO**	2	
TRIJARDY XR 10-5-1,000 MG, 25-5-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC **MO**	3	PA,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**	3	PA,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	PA,QL(2 per 28 days)
XIGDUO XR 10-1,000 MG, 10-500 MG, 5-500 MG TABLET, IR/ER 24 HR., BIPHASIC **MO**	3	PA,QL(30 per 30 days)
XIGDUO XR 2.5-1,000 MG, 5-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC **MO**	3	PA,QL(60 per 30 days)
ZEGALOGUE AUTOINJECTOR 0.6 MG/0.6 ML AUTO-INJECTOR **MO**	3	ST
ZEGALOGUE SYRINGE 0.6 MG/0.6 ML SYRINGE **MO**	3	ST
BLOOD PRODUCTS AND MODIFIERS		
clopidogrel 75 mg TABLET **MO**	1	QL(30 per 30 days)
ELIQUIS 2.5 MG TABLET **MO**	2	QL(60 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
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, 480 MCG/0.8 ML SYRINGE **DL**	4	PA
NIVESTYM 300 MCG/ML, 480 MCG/1.6 ML SOLUTION **DL**	4	PA
PROMACTA 12.5 MG POWDER IN PACKET **DL**	4	PA,QL(360 per 30 days)
PROMACTA 12.5 MG, 25 MG TABLET **DL**	4	PA,QL(30 per 30 days)
PROMACTA 25 MG POWDER IN PACKET **DL**	4	PA,QL(180 per 30 days)
PROMACTA 50 MG TABLET **DL**	4	PA,QL(90 per 30 days)
PROMACTA 75 MG TABLET **DL**	4	PA,QL(60 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 SOLUTION **MO**	3	PA,QL(14 per 30 days)
RETACRIT 40,000 UNIT/ML SOLUTION **DL**	4	PA,QL(14 per 30 days)
UDENYCA 6 MG/0.6 ML SYRINGE **DL**	4	PA,QL(1.2 per 28 days)
UDENYCA AUTOINJECTOR 6 MG/0.6 ML AUTO-INJECTOR **DL**	4	PA,QL(1.2 per 28 days)
warfarin 5 mg TABLET **MO**	1	
XARELTO 1 MG/ML SUSPENSION FOR RECONSTITUTION **MO**	3	QL(600 per 30 days)
XARELTO 10 MG, 20 MG TABLET **MO**	3	QL(30 per 30 days)
XARELTO 15 MG, 2.5 MG TABLET **MO**	3	QL(60 per 30 days)
XARELTO DVT-PE TREAT 30D START 15 MG (42)- 20 MG (9) TABLET, DOSE PACK **MO**	3	QL(51 per 30 days)
ZARXIO 300 MCG/0.5 ML, 480 MCG/0.8 ML SYRINGE **DL**	4	PA
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	
diltiazem hcl 120 mg CAPSULE, ER 24 HR. **MO**	1	
ENTRESTO 24-26 MG TABLET **MO**	3	PA,QL(180 per 30 days)
ENTRESTO 49-51 MG, 97-103 MG TABLET **MO**	3	PA,QL(60 per 30 days)
ENTRESTO SPRINKLE 15-16 MG, 6-6 MG PELLET **MO**	3	QL(240 per 30 days)
ezetimibe 10 mg TABLET **MO**	1	QL(30 per 30 days)

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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	
hydralazine 25 mg, 50 mg TABLET **MO**	1	
hydrochlorothiazide 12.5 mg CAPSULE **MO**	1	
hydrochlorothiazide 12.5 mg, 25 mg TABLET **MO**	1	
isosorbide mononitrate 30 mg, 60 mg TABLET, ER 24 HR. **MO**	1	
KERENDIA 10 MG, 20 MG TABLET **MO**	2	PA,QL(30 per 30 days)
lisinopril 10 mg, 2.5 mg, 20 mg, 40 mg, 5 mg TABLET **MO**	1	
lisinopril-hydrochlorothiazide 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)
metoprolol succinate 100 mg, 25 mg, 50 mg TABLET, ER 24 HR. **MO**	1	
metoprolol tartrate 100 mg, 25 mg, 50 mg TABLET **MO**	1	
MULTAQ 400 MG TABLET **MO**	2	QL(60 per 30 days)
NEXLETOL 180 MG TABLET **MO**	2	PA,QL(30 per 30 days)
NEXLIZET 180-10 MG TABLET **MO**	2	PA,QL(30 per 30 days)
nitroglycerin 0.4 mg SUBLINGUAL TABLET **MO**	1	
olmesartan 20 mg, 40 mg TABLET **MO**	1	QL(30 per 30 days)
pravastatin 20 mg, 40 mg TABLET **MO**	1	
REDEMPLO 25 MG/0.5 ML SYRINGE **DL**	4	PA
REPATHA PUSHTRONEX 420 MG/3.5 ML WEARABLE INJECTOR **MO**	2	PA,QL(7 per 28 days)
REPATHA SURECLICK 140 MG/ML PEN INJECTOR **MO**	2	PA,QL(6 per 28 days)
REPATHA SYRINGE 140 MG/ML SYRINGE **MO**	2	PA,QL(6 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	
TRYNGOLZA 80 MG/0.8 ML AUTO-INJECTOR **DL**	4	PA,QL(0.8 per 28 days)
valsartan 160 mg, 320 mg TABLET **MO**	1	QL(60 per 30 days)
VASCEPA 0.5 GRAM CAPSULE **MO**	3	PA,QL(240 per 30 days)
VASCEPA 1 GRAM CAPSULE **MO**	3	PA,QL(120 per 30 days)
VERQUVO 10 MG, 2.5 MG, 5 MG TABLET **MO**	2	PA,QL(30 per 30 days)
ZYPITAMAG 2 MG, 4 MG TABLET **MO**	3	ST,QL(30 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
CENTRAL NERVOUS SYSTEM AGENTS		
AUSTEDO 12 MG, 9 MG TABLET **DL**	4	PA,QL(120 per 30 days)
AUSTEDO 6 MG TABLET **DL**	4	PA,QL(60 per 30 days)
AUSTEDO XR 12 MG, 6 MG TABLET, ER 24 HR. **DL**	4	PA,QL(90 per 30 days)
AUSTEDO XR 18 MG, 30 MG, 36 MG, 42 MG, 48 MG TABLET, ER 24 HR. **DL**	4	PA,QL(30 per 30 days)
AUSTEDO XR 24 MG TABLET, ER 24 HR. **DL**	4	PA,QL(60 per 30 days)
AUSTEDO XR TITRATION KT(WK1-4) 12-18-24-30 MG TABLET, ER 24 HR., DOSE PACK **DL**	4	PA,QL(28 per 28 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)
COPAXONE 40 MG/ML SYRINGE **DL**	4	PA,QL(12 per 28 days)
duloxetine 20 mg CAPSULE, DR/EC **MO**	1	QL(120 per 30 days)
duloxetine 30 mg CAPSULE, DR/EC **MO**	1	QL(90 per 30 days)
duloxetine 60 mg CAPSULE, DR/EC **MO**	1	QL(60 per 30 days)
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)
RADICAVA ORS STARTER KIT SUSP 105 MG/5 ML SUSPENSION **DL**	4	PA,QL(70 per 28 days)
VEOZAH 45 MG TABLET **MO**	3	PA,QL(30 per 30 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	
DERMATOLOGICAL AGENTS		
mupirocin 2 % OINTMENT **MO**	1	
ELECTROLYTES/MINERALS/METALS/VITAMINS		
CARBAGLU 200 MG TABLET, DISPERSIBLE **DL**	4	PA
LOKELMA 10 GRAM, 5 GRAM POWDER IN PACKET **MO**	2	QL(30 per 30 days)
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	
GASTROINTESTINAL AGENTS		
dicyclomine 10 mg CAPSULE **MO**	1	
esomeprazole magnesium 40 mg CAPSULE, DR/EC **MO**	1	QL(60 per 30 days)
famotidine 20 mg, 40 mg TABLET **MO**	1	
LINZESS 145 MCG, 290 MCG, 72 MCG CAPSULE **MO**	2	QL(30 per 30 days)
MOVANTIK 12.5 MG, 25 MG TABLET **MO**	2	QL(30 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
omeprazole 20 mg, 40 mg CAPSULE, DR/EC **MO**	1	
pantoprazole 20 mg, 40 mg TABLET, DR/EC **MO**	1	QL(60 per 30 days)
sucralfate 1 gram TABLET **MO**	1	
SUFLAVE 178.7-7.3-0.5 GRAM RECON SOLUTION **MO**	3	
SUTAB 1.479-0.188- 0.225 GRAM TABLET **MO**	2	
TALICIA 10-250-12.5 MG CAPSULE, IR/DR, BIPHASIC **MO**	3	
VOWST 1 X 10EXP6 TO 3 X 10EXP7 CELL CAPSULE **DL**	4	PA
XIFAXAN 200 MG TABLET **MO**	2	PA,QL(9 per 30 days)
XIFAXAN 550 MG TABLET **DL**	2	PA,QL(84 per 28 days)
GENETIC/ENZYME/PROTEIN DISORDER: REPLACEMENT, MODIFIERS, TREATMENT		
AMVUTTRA 25 MG/0.5 ML SYRINGE **DL**	4	PA,QL(0.5 per 90 days)
ATTRUBY 356 MG TABLET **DL**	4	PA,QL(120 per 30 days)
CREON 12,000-38,000 -60,000 UNIT, 24,000-76,000 -120,000 UNIT, 3,000-9,500- 15,000 UNIT, 36,000-114,000- 180,000 UNIT, 6,000-19,000 -30,000 UNIT CAPSULE, DR/EC **MO**	2	
ELELYSO 200 UNIT RECON SOLUTION **DL**	4	PA
ONPATTRO 2 MG/ML SOLUTION **DL**	4	PA
STRENSIQ 18 MG/0.45 ML, 28 MG/0.7 ML, 40 MG/ML, 80 MG/0.8 ML SOLUTION **DL**	4	PA
VYNDAMAX 61 MG CAPSULE **DL**	4	PA,QL(30 per 30 days)
WAINUA 45 MG/0.8 ML AUTO-INJECTOR **DL**	4	PA,QL(0.8 per 28 days)
ZEMAIRA 1,000 MG RECON SOLUTION **DL**	4	PA
ZENPEP 10,000-32,000 -42,000 UNIT, 15,000-47,000 -63,000 UNIT, 20,000-63,000- 84,000 UNIT, 25,000-79,000- 105,000 UNIT, 3,000-10,000 -14,000-UNIT, 40,000-126,000- 168,000 UNIT, 5,000-17,000- 24,000 UNIT, 60,000-189,600- 252,600 UNIT CAPSULE, DR/EC **MO**	3	
GENITOURINARY AGENTS		
finasteride 5 mg TABLET **MO**	1	QL(30 per 30 days)
GEMTESA 75 MG TABLET **MO**	3	QL(30 per 30 days)
MYRBETRIQ 25 MG, 50 MG TABLET, ER 24 HR. **MO**	2	QL(30 per 30 days)
MYRBETRIQ 8 MG/ML SUSPENSION, ER, RECON **MO**	2	QL(300 per 30 days)
oxybutynin chloride 10 mg 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)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
ACTHAR SELFJECT 40 UNIT/0.5 ML, 80 UNIT/ML PEN INJECTOR **DL**	4	PA,QL(45 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)		
estradiol 0.01 % (0.1 mg/gram) CREAM **MO**	1	
OSPHENA 60 MG TABLET **MO**	2	PA
PREMARIN 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG TABLET **MO**	3	PA
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	
TIROSINT 100 MCG, 112 MCG, 125 MCG, 13 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 37.5 MCG, 44 MCG, 50 MCG, 62.5 MCG, 75 MCG, 88 MCG CAPSULE **MO**	3	
TIROSINT-SOL 100 MCG/ML, 112 MCG/ML, 125 MCG/ML, 13 MCG/ML, 137 MCG/ML, 150 MCG/ML, 175 MCG/ML, 200 MCG/ML, 25 MCG/ML, 37.5 MCG/ML, 44 MCG/ML, 50 MCG/ML, 62.5 MCG/ML, 75 MCG/ML, 88 MCG/ML SOLUTION **MO**	3	PA
HORMONAL AGENTS, SUPPRESSANT (ADRENAL OR PITUITARY)		
SOMATULINE DEPOT 90 MG/0.3 ML SYRINGE **DL**	4	PA,QL(0.3 per 28 days)
IMMUNOLOGICAL AGENTS		
ACTHIB (PF) 10 MCG/0.5 ML RECON SOLUTION **DL**	1	
ADALIMUMAB-ADAZ 10 MG/0.1 ML SYRINGE **DL**	4	PA,QL(0.2 per 28 days)
ADALIMUMAB-ADAZ 20 MG/0.2 ML SYRINGE **DL**	4	PA,QL(1.2 per 28 days)
ADALIMUMAB-ADAZ 40 MG/0.4 ML PEN INJECTOR **DL**	4	PA,QL(2.4 per 28 days)
ADALIMUMAB-ADAZ 40 MG/0.4 ML SYRINGE **DL**	4	PA,QL(2.4 per 28 days)
ADALIMUMAB-ADAZ 80 MG/0.8 ML PEN INJECTOR **DL**	4	PA,QL(4.8 per 28 days)
ADALIMUMAB-ADBM 10 MG/0.2 ML, 20 MG/0.4 ML SYRINGE KIT **DL**	4	PA,QL(2 per 28 days)
ADALIMUMAB-ADBM 40 MG/0.4 ML, 40 MG/0.8 ML PEN INJECTOR KIT **DL**	4	PA,QL(6 per 28 days)
ADALIMUMAB-ADBM 40 MG/0.4 ML, 40 MG/0.8 ML SYRINGE KIT **DL**	4	PA,QL(6 per 28 days)

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ADALIMUMAB-ADBM(CF) PEN CROHNS 40 MG/0.4 ML, 40 MG/0.8 ML PEN INJECTOR KIT **DL**	4	PA,QL(6 per 28 days)
ADALIMUMAB-ADBM(CF) PEN PS-UV 40 MG/0.4 ML, 40 MG/0.8 ML PEN INJECTOR KIT **DL**	4	PA,QL(6 per 28 days)
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 150 MG/ML PEN INJECTOR **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)
COSENTYX UNOREADY PEN 300 MG/2 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 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)
ENTYVIO PEN 108 MG/0.68 ML PEN INJECTOR **DL**	4	PA,QL(1.36 per 28 days)
ENVARSUS XR 0.75 MG, 1 MG, 4 MG TABLET, ER 24 HR. **MO**	3	PA
GAMUNEX-C 1 GRAM/10 ML (10 %) SOLUTION **DL**	4	PA
HAEGARDA 2,000 UNIT, 3,000 UNIT RECON SOLUTION **DL**	4	PA,QL(24 per 28 days)
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(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) 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 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)
methotrexate sodium 2.5 mg TABLET **MO**	1	BvsD
OTULFI 45 MG/0.5 ML SYRINGE **MO**	2	PA,QL(1.5 per 84 days)
OTULFI 90 MG/ML SYRINGE **DL**	4	PA,QL(3 per 84 days)
RINVOQ 15 MG, 30 MG TABLET, ER 24 HR. **DL**	4	PA,QL(30 per 30 days)
RINVOQ 45 MG TABLET, ER 24 HR. **DL**	4	PA,QL(168 per 365 days)
RINVOQ LQ 1 MG/ML SOLUTION **DL**	4	PA,QL(360 per 30 days)
SHINGRIX (PF) 50 MCG/0.5 ML SUSPENSION FOR RECONSTITUTION **AV,DL**	1	
SKYRIZI 150 MG/ML PEN INJECTOR	4	PA,QL(2 per 84 days)
SKYRIZI 150 MG/ML SYRINGE	4	PA,QL(2 per 84 days)
SKYRIZI 180 MG/1.2 ML (150 MG/ML) WEARABLE INJECTOR **DL**	4	PA,QL(8.4 per 365 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
SKYRIZI 360 MG/2.4 ML (150 MG/ML) WEARABLE INJECTOR DL	4	PA,QL(16.8 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)
TREMFYA 100 MG/ML SYRINGE	4	PA,QL(3 per 84 days)
TREMFYA 200 MG/2 ML SYRINGE DL	4	PA,QL(4 per 28 days)
TREMFYA PEN 200 MG/2 ML PEN INJECTOR DL	4	PA,QL(4 per 28 days)
YESINTEK 45 MG/0.5 ML SOLUTION MO	2	PA,QL(1.5 per 84 days)
YESINTEK 45 MG/0.5 ML SYRINGE MO	2	PA,QL(1.5 per 84 days)
YESINTEK 90 MG/ML SYRINGE DL	4	PA,QL(3 per 84 days)
INFLAMMATORY BOWEL DISEASE AGENTS		
TARPEYO 4 MG CAPSULE, DR/EC DL	4	PA,QL(120 per 30 days)
METABOLIC BONE DISEASE AGENTS		
alendronate 70 mg TABLET MO	1	QL(4 per 28 days)
BOMYNTRA 120 MG/1.7 ML (70 MG/ML) SYRINGE DL	4	PA,QL(1.7 per 28 days)
FORTEO 20 MCG/DOSE (560MCG/2.24ML) PEN INJECTOR DL	4	PA,QL(2.24 per 28 days)
PROLIA 60 MG/ML SYRINGE MO	3	QL(1 per 180 days)
TYMLOS 80 MCG (3,120 MCG/1.56 ML) PEN INJECTOR DL	4	PA,QL(1.56 per 30 days)
MISCELLANEOUS THERAPEUTIC AGENTS		
AUTOSHIELD DUO PEN NEEDLE 30 GAUGE X 3/16" NEEDLE PDS,MO	1	
BD ALCOHOL SWABS PADS, MEDICATED MO	1	
BD AUTOSHIELD DUO PEN NEEDLE 30 GAUGE X 3/16" NEEDLE PDS,MO	1	
BD INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 5/16" SYRINGE PDS,MO	1	
BD INSULIN SYRINGE U-500 1/2 ML 31 GAUGE X 15/64" SYRINGE PDS,MO	1	
BD INSULIN SYRINGE ULTRA-FINE 0.3 ML 30 GAUGE X 1/2", 0.3 ML 31 GAUGE X 5/16", 0.5 ML 30 GAUGE X 1/2", 0.5 ML 31 GAUGE X 5/16", 1 ML 30 GAUGE X 1/2", 1 ML 31 GAUGE X 5/16 SYRINGE PDS,MO	1	
BD NANO 2ND GEN PEN NEEDLE 32 GAUGE X 5/32" NEEDLE PDS,MO	1	
BD ULTRA-FINE MICRO PEN NEEDLE 32 GAUGE X 1/4" NEEDLE PDS,MO	1	
BD ULTRA-FINE MINI PEN NEEDLE 31 GAUGE X 3/16" NEEDLE PDS,MO	1	
BD ULTRA-FINE NANO PEN NEEDLE 32 GAUGE X 5/32" NEEDLE PDS,MO	1	
BD ULTRA-FINE ORIG PEN NEEDLE 29 GAUGE X 1/2" NEEDLE PDS,MO	1	
BD ULTRA-FINE SHORT PEN NEEDLE 31 GAUGE X 5/16" NEEDLE PDS,MO	1	
BD VEO INSULIN SYR (HALF UNIT) 0.3 ML 31 GAUGE X 15/64" SYRINGE PDS,MO	1	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
BD VEO INSULIN SYRINGE UF 0.3 ML 31 GAUGE X 15/64", 1 ML 31 GAUGE X 15/64", 1/2 ML 31 GAUGE X 15/64" SYRINGE **PDS,MO**	1	
CEQUR SIMPLICITY INSERTER MISCELLANEOUS **MO**	2	
DROPLET INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 1/2", 0.3 ML 30 GAUGE X 15/64", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 15/64", 0.3 ML 31 GAUGE X 5/16", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 15/64", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 15/64", 1 ML 31 GAUGE X 5/16 SYRINGE **PDS,MO**	1	
DROPLET MICRON PEN NEEDLE 34 GAUGE X 9/64" NEEDLE **PDS,MO**	1	
DROPLET PEN NEEDLE 29 GAUGE X 1/2", 29 GAUGE X 3/8", 30 GAUGE X 5/16", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 3/16", 32 GAUGE X 5/16", 32 GAUGE X 5/32" NEEDLE **PDS,MO**	1	
DROPSAFE ALCOHOL PREP PADS PADS, MEDICATED **MO**	1	
GIVLAARI 189 MG/ML SOLUTION **DL**	4	PA
INSULIN SYRINGE-NEEDLE U-100 1 ML 28 GAUGE X 1/2" SYRINGE **PDS,MO**	1	
NANO PEN NEEDLE 32 GAUGE X 5/32" NEEDLE **PDS,MO**	1	
OMNIPOD DASH PODS (GEN 4) CARTRIDGE **MO**	2	
OXLUMO 94.5 MG/0.5 ML SOLUTION	4	PA
ULTRA-FINE INS SYR (HALF UNIT) 0.3 ML 31 GAUGE X 15/64" SYRINGE **PDS,MO**	1	
ULTRA-FINE INSULIN SYRINGE 1/2 ML 31 GAUGE X 15/64" SYRINGE **PDS,MO**	1	
ULTRA-FINE PEN NEEDLE 29 GAUGE X 1/2" NEEDLE **PDS,MO**	1	
XDEMVY 0.25 % DROPS **MO**	3	PA,QL(10 per 42 days)
OPHTHALMIC AGENTS		
brimonidine 0.2 % DROPS **MO**	1	
CEQUA 0.09 % DROPPERETTE **MO**	3	PA,QL(60 per 30 days)
COMBIGAN 0.2-0.5 % DROPS **MO**	3	PA
dorzolamide-timolol 22.3-6.8 mg/ml DROPS **MO**	1	
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)
latanoprost 0.005 % DROPS **MO**	1	QL(5 per 25 days)
LOTEMAX 0.5 % DROPS, GEL **MO**	3	ST
LOTEMAX 0.5 % DROPS, SUSPENSION **MO**	3	ST
LOTEMAX 0.5 % OINTMENT **MO**	3	ST
LOTEMAX SM 0.38 % DROPS, GEL **MO**	3	
LUMIGAN 0.01 % DROPS **MO**	3	PA,QL(2.5 per 25 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
MIEBO (PF) 100 % DROPS **MO**	3	QL(3 per 30 days)
prednisolone acetate 1 % DROPS, SUSPENSION **MO**	1	
RHOPRESSA 0.02 % DROPS **MO**	2	ST,QL(2.5 per 25 days)
ROCKLATAN 0.02-0.005 % DROPS **MO**	2	ST
SIMBRINZA 1-0.2 % DROPS, SUSPENSION **MO**	3	
timolol maleate 0.5 % DROPS **MO**	1	
TRYPTYR 0.003 % DROPPERETTE **MO**	3	QL(60 per 30 days)
VYZULTA 0.024 % DROPS **MO**	3	QL(2.5 per 25 days)
ZERVIATE 0.24 % DROPPERETTE **MO**	3	QL(60 per 30 days)
RESPIRATORY TRACT/PULMONARY AGENTS		
ADEMPAS 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG TABLET **DL**	4	PA,QL(90 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)
AIRSUPRA 90-80 MCG/ACTUATION HFA AEROSOL INHALER **MO**	2	QL(32.1 per 30 days)
albuterol sulfate 2.5 mg /3 ml (0.083 %) SOLUTION FOR NEBULIZATION **MO**	1	BvsD
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)
AUVI-Q 0.1 MG/0.1 ML, 0.15 MG/0.15 ML, 0.3 MG/0.3 ML AUTO-INJECTOR **MO**	2	QL(4 per 30 days)
azelastine 137 mcg (0.1 %) SPRAY, NON-AEROSOL **MO**	1	QL(30 per 25 days)
BREO ELLIPTA 100-25 MCG/DOSE, 200-25 MCG/DOSE, 50-25 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 10 MG/0.5 ML SYRINGE **DL**	4	PA,QL(0.5 per 28 days)
FASENRA 30 MG/ML SYRINGE **DL**	4	PA,QL(1 per 28 days)
FASENRA PEN 30 MG/ML AUTO-INJECTOR **DL**	4	PA,QL(1 per 28 days)
fluticasone propionate 50 mcg/actuation SPRAY, SUSPENSION **MO**	1	QL(16 per 30 days)
ipratropium bromide 42 mcg (0.06 %) SPRAY, NON-AEROSOL **MO**	1	QL(45 per 30 days)
ipratropium-albuterol 0.5 mg-3 mg(2.5 mg base)/3 ml SOLUTION FOR NEBULIZATION **MO**	1	BvsD
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)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
NUCALA 100 MG/ML SYRINGE **DL**	4	PA,QL(3 per 28 days)
NUCALA 40 MG/0.4 ML SYRINGE **DL**	4	PA,QL(0.4 per 28 days)
OFEV 100 MG, 150 MG CAPSULE **DL**	4	PA,QL(60 per 30 days)
OPSUMIT 10 MG TABLET **DL**	4	PA,QL(30 per 30 days)
OPSYNVI 10-20 MG, 10-40 MG TABLET **DL**	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)
SYMBICORT 160-4.5 MCG/ACTUATION, 80-4.5 MCG/ACTUATION HFA AEROSOL INHALER **MO**	2	QL(30.6 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)
TYVASO DPI 16 MCG, 32 MCG, 48 MCG, 64 MCG CARTRIDGE WITH INHALER **DL**	4	PA,QL(112 per 28 days)
TYVASO DPI 16(112)-32(112) -48(28) MCG CARTRIDGE WITH INHALER **DL**	4	PA,QL(252 per 28 days)
UPTRAVI 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG TABLET **DL**	4	PA,QL(60 per 30 days)
UPTRAVI 200 MCG (140)- 800 MCG (60) TABLET, DOSE PACK **DL**	4	PA,QL(200 per 30 days)
VENTOLIN HFA 90 MCG/ACTUATION HFA AEROSOL INHALER **MO**	2	QL(36 per 30 days)
YUTREPIA 26.5 MCG CAPSULE, W/INHALATION DEVICE **DL**	4	PA
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)
sodium oxybate 500 mg/ml SOLUTION **DL**	4	PA,QL(540 per 30 days)
temazepam 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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Notice of Availability - Auxiliary Aids and Services Notice

English: Free language, auxiliary aid, and alternate format services are available. Call **877-320-1235 (TTY: 711)**.

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GHHNOA2026HUM_0526

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This notice is available at **https://www.humana.com/legal/multi-language-support**.

This abridged formulary was updated on 10/13/2026 and is not a complete list of drugs covered by our plan. For a complete listing, or other questions, please contact the Humana Medicare Employer Plan Customer Care Team 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**.

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