Humana 2023 MAPD

Humana Gold Plus
H0028-025-002
Select Counties in CO
H0028025002MAPDEN23PODBW
ENGLISH

# Giving you more of what matters

## with care that sees and understands you

2023 **MAPD** ENROLLMENT BOOK

Humana

# Care that shows up. And keeps showing up.

Feeling your healthiest is about more than getting treatment when you're sick. It's about having a choice of plans to support your total health, a broad network of doctors and pharmacies you love. At Humana, we'll help you take action that helps lead to more healthy days and overcome challenges that may stand in the way—like having access to healthy food and safe housing. That's the power of human care. We can help connect you with community resources where available, related to:

- **Food programs and nutrition tips**
- **Social connections and loneliness support**
- **Transportation options**
- **Housing assistance and resources**
- **Financial resources**

To find out more about how we're helping members with their personal needs, visit

**PopulationHealth.Humana.com**

for more information.

# What's inside

- How your plan works
- Understanding your Medicare options
- Understanding the coverage gap
- The Humana difference
- Plan-specific information
- Important resources guide
- What's next

## Your agent information

Agent name _____

Agent phone number _____

Agent email _____

### Let's talk

Call your licensed Humana sales agent. They're ready to walk you through your options and help you enroll.

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# How your plan works

HMO

## Health maintenance organization (HMO)

HMO plans have their own network of doctors, hospitals and other healthcare providers. You receive care within the HMO network, which generally means your monthly premium is lower and you may expect to pay less out of pocket.

A Humana HMO plan gives you services you don't get with Original Medicare, which may include:

- Access to virtual and in-home providers in the network*
- Access to mail-order pharmacies, for up to a three-month supply of maintenance and diabetic supplies
- SmartSummary®, a personalized update that shows you how you've used your plan and what you've spent to help you get the most from your plan
- Rx Calculator to help estimate your monthly drug costs
- Preventive dental coverage with two free cleanings a year. Or, get $500 or more a year to cover many dental bills. That includes cleanings, exams, and more.†
- Tier 1 prescriptions with no copays or deductibles. And $0 for eight routine vaccines, plus shingles. At any network pharmacy.

## Using your HMO plan

- You choose an in-network primary care physician (PCP) to coordinate your care.
- To see a specialist, you need a referral from your PCP on most plans.
- Any care you receive outside your HMO network is only covered in true emergencies.

* You may pay a lower cost share by seeing in-network doctors, which may save you money.

† $500 or more dental coverage for in-network services, excluding cosmetic.

# How your plan works

PPO

## Preferred provider organization (PPO)

PPO plans give you the freedom to receive care in or out of network. You can see any doctor or specialist or go to any hospital. PPO plans tend to have higher monthly premiums and offer predictable copayments and coinsurance. If you choose to see a provider in the network, you may save by paying a lower cost share.

A Humana PPO plan gives you services you don't get with Original Medicare, which may include:

- Access to virtual and in-home providers in the network*
- Access to mail-order pharmacies, for up to a three-month supply of maintenance and diabetic supplies
- SmartSummary®, a personalized update that shows you how you've used your plan and what you've spent to help you get the most from your plan
- Rx Calculator to help estimate your monthly drug costs
- Preventive dental coverage with two free cleanings a year. Or, get $500 or more a year to cover many dental bills. That includes cleanings, exams, and more.†
- Tier 1 prescriptions with no copays or deductibles. And $0 for eight routine vaccines, plus shingles. At any network pharmacy.

## Using your PPO plan

- Many of our plans provide emergency care coverage while you are traveling worldwide.
- You can see any doctor or use any hospital that accepts Medicare and the plan terms.
- Generally, you don't need a referral from your primary care physician (PCP) to see a specialist.

* You may pay a lower cost share by seeing in-network doctors, which may save you money.

† $500 or more dental coverage for in-network services, excluding cosmetic.

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# How your plan works

PFFS

## Private fee-for-service (PFFS)

PFFS plans give you the flexibility to see almost any Medicare-approved doctor, as long as the doctor accepts Humana's terms and conditions. PFFS plans determine how much doctors, providers and hospitals will receive and the amount you pay for care.

A Humana PFFS plan gives you services you don't get with Original Medicare, which may include:

- Full coverage for most annual preventive screenings, prescription drugs, inpatient care and emergency care anywhere in or outside of the U.S.
- Access to virtual and in-home providers in the network*
- Access to mail-order pharmacies, for up to a three-month supply of maintenance and diabetic supplies
- SmartSummary®, a personalized update that shows you how you've used your plan and what you've spent to help you get the most from your plan
- Rx Calculator to help estimate your monthly drug costs
- Preventive dental coverage with two free cleanings a year. Or, get $1,000 or more a year to cover many dental bills. That includes cleanings, exams, and more.†
- Tier 1 prescriptions with no copays or deductibles. And $0 for eight routine vaccines, plus shingles. At any network pharmacy.

## Using your PFFS plan

- This plan may offer more freedom to choose providers.
- You don't need a referral to see a specialist.
- Providers must accept Medicare and bill the plan per its terms and conditions.
- Be sure to always take your member ID card with you and clarify coverage before you receive services.

* You may pay a lower cost share by seeing in-network doctors, which may save you money.

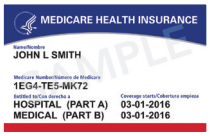
† $1,000 or more dental coverage for in-network services, excluding cosmetic.

# Understanding your Medicare options

To help you decide the best fit for you, here is an overview of the Medicare options and what each one covers. **Follow these 2 steps to get started:**

## Step 1 — Enroll in Original Medicare—offered by the federal government

**Part A** helps pay for hospital stays and inpatient care.




**Part B** helps pay for doctor visits and outpatient care.

## Step 2 — After enrolling in Original Medicare, you can choose from various types of coverage—offered by private companies

**Option 1:** Choose a Medicare Advantage plan

OR

**Option 2:** Add one or both of the following to Original Medicare

**Medicare Part C (Medicare Advantage)** is made up of Part A, Part B and may include Part D (prescription drug benefits) as well as extra benefits like coverage for hearing, dental and vision.

**Medicare Part D** is a stand-alone prescription drug plan.

**Medicare Supplement insurance (Medigap)** plans help pay for some of Original Medicare's out-of-pocket costs.

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# Understanding the coverage gap

Most Medicare prescription drug plans have a coverage gap where you may have to pay a higher percentage of drug costs.

**Stage 1**
Deductible

You pay all costs until the deductible is met.

**Stage 2**
Initial coverage

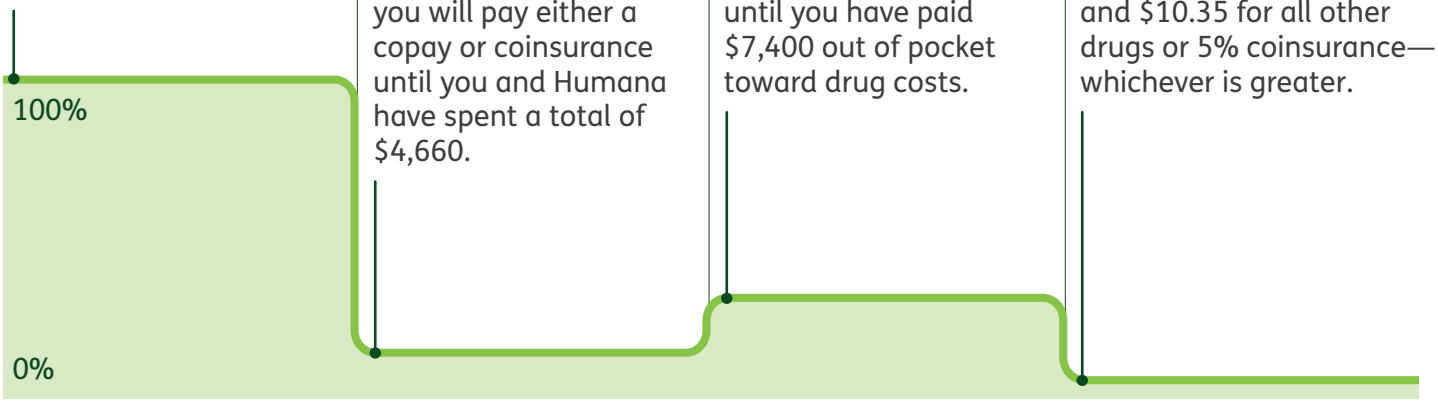
You and Humana split costs. For most plans, you will pay either a copay or coinsurance until you and Humana have spent a total of $4,660.

**Stage 3**
Coverage gap

You are paying no more than 25% of total costs until you have paid $7,400 out of pocket toward drug costs.

**Stage 4**
Catastrophic coverage

You pay $4.15 for generic/preferred drugs and $10.35 for all other drugs or 5% coinsurance—whichever is greater.




Your share of drug costs

**Stage 1: Deductible—you pay 100%**

- A deductible is the amount you pay of your medication costs before your plan pays its share.
- Some plans do not have a deductible for Tier 1 and Tier 2.

**Stage 2: Initial coverage—shared cost with insurance company**

- For most plans, both you and your insurance plan pay medication costs until the shared total drug costs equal $4,660.
- You're generally responsible for copays and coinsurance during this stage.

**Stage 3: Coverage gap**

- The coverage gap begins after you and your plan have spent $4,660 for covered drugs, and ends when your out-of-pocket cost reaches $7,400 for them.
- In this stage, you pay no more than 25% of the cost of brand-name and generic drugs.
- Any medication-related deductible, discounts you receive on covered brand-name drugs, coinsurance, copayments and the amounts you pay in the coverage gap count toward the $7,400 limit.

**Stage 4: Catastrophic coverage stage—follows the coverage gap**

- This stage begins when you reach the $7,400 coverage gap limit.
- In this stage, you pay $4.15 for generic/preferred drugs and $10.35 for all other drugs, or 5% of your medication costs—whichever is greater.

# The Humana difference

Humana Medicare Advantage plans are designed to fit your needs. We start with Medicare-required coverage and add benefits and services created with you in mind, often included in the plan at no extra cost to you. (Benefits and services may not be available on all plans or in all areas.)

## Humana Neighborhood Center®

Visitors can participate in a variety of free activities such as healthy cooking demos, nutrition education classes, trivia and other fun social events. Plus they can meet one-on-one to get their questions answered with a health educator or Customer Care specialist, and even take classes on how to manage chronic conditions. Services are offered in locations throughout the U.S. and Puerto Rico, and virtually via both live Zoom sessions and on-demand videos.

→ Visit **HumanaNeighborhoodCenter.com** to learn more.

## SilverSneakers® fitness program

Get moving, have fun and work toward being healthier when you attend classes at a local fitness club, gym, rec center or online. Want to start working out at home or can't get to a fitness location? Enjoy SilverSneakers LIVE virtual classes, over 200+ video workouts or download the SilverSneakers GO™ app. You can also request an in-home kit. Kits are available to members who can't get to a fitness center or prefer to exercise at home.

→ Call **888-423-4632 (TTY: 711)**, Monday – Friday, 8 a.m. – 8 p.m., Eastern time. Most Humana Medicare Advantage plans include this benefit. Ask your licensed Humana sales agent if it is included in your plan.

→ Visit www.SilverSneakers.com/StartHere to check your eligibility.

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# The Humana difference

## Go365 by Humana™

Get rewarded for completing eligible activities that help you make healthy choices with most Humana Medicare Advantage plans—at no extra charge. Getting started is easy. Just sign in to **MyHumana.com** or visit **Go365.com**. If you prefer to participate by paper, simply call the number on the back of your Humana member ID card.

**Earn rewards you can redeem for gift cards when you:**

- Schedule and attend your Annual Wellness Visit and more. (See full list at **Go365.com/Medicare**).
- Complete eligible healthy activities such as preventive screenings, exercise, social and health education classes.

You can earn more than $200 each plan year in rewards.‡

→ Sign in to **MyHumana.com** or visit **Go365.com** for more information.

## Pharmacy

Humana Medicare members can use their prescription drug benefits through participating retail and mail-delivery pharmacies, including CenterWell Pharmacy™, the preferred cost-sharing mail-order pharmacy on most Humana plans.

→ If you have questions, just call CenterWell Pharmacy at **855-310-5799 (TTY: 711)**, Monday – Friday, 8 a.m. – 11 p.m., and Saturday, 8 a.m. – 6:30 p.m., Eastern time. Learn more at **CenterWellPharmacy.com**. Other pharmacies are available in our network.

Go365 is not included on some contracts in Georgia.

‡ Rewards have no cash value and must be earned and redeemed within the same program year. Any rewards not redeemed by Dec. 31 will expire.

# The Humana difference

## Find a Doctor with Care Highlight

Need help finding a doctor? Our Find a Doctor page at **Humana.com/FindADoctor** can help. Plus, we can help you make sure it's the right doctor for you, with a physician rating system that has earned National Committee for Quality Assurance (NCQA) accreditation.

To help you make more informed choices about your healthcare, Care Highlight® recognizes doctor practices that meet quality and cost-efficiency guidelines. You can find a doctor's ratings** on the Humana Find a Doctor tool when we have enough information to measure a doctor's quality and cost-efficiency.

**This system is built on two graphic icons: a heart and a badge**

Highest rating

Lowest rating

Highest rating

Lowest rating

**Clinical quality** is based on quality of care, or the effectiveness of treatment that members received.

**Cost-efficiency** is based on the cost of treatment that members received compared to the cost of treatment by similar physicians.

Care Highlight is intended for informational purposes only. Quality of care and cost-efficiency ratings are available in most (but not all) states and are not available for all specialists. Members have access to all physicians in the Humana network whether or not the physician has received a Care Highlight rating. Ratings should not be the sole basis for selecting a doctor. Humana does not give performance-based payments to doctors based on these ratings. Ratings do not guarantee the quality or outcome of healthcare services.

→ Learn more at **Humana.com/CareHighlight**.

** Ratings are not available in Alaska.

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# The Humana difference

We help make it easier to get checkups, sick visits and wellness checks virtually or telephonically, when it's most comfortable and convenient for you. There are providers available in the network that provide home healthcare or virtual visits. Check the Find a Doctor tool to see if there are doctors in your area that offer home healthcare or virtual visits. Not all doctors offer home healthcare or virtual visits.

Eligible members may receive individualized care at home for primary, urgent and more serious conditions, which may be included in your Medicare Advantage plan.

## Home healthcare offers:

**Comfort**: Have peace of mind being at home, where you are most at ease.

**Convenience**: No more stress of traveling to the doctor, sitting in waiting rooms or being transported to another facility. Care for yourself at home and receive help if you need it.

**Individualized care**: Get personalized one-on-one time with providers who address your needs and prescribe the right medication.

**Continuity of care**: Help minimize the risk of falling after surgery or being exposed to other illnesses.

**Cost**: Get the most from your plan with affordable at-home care rather than extending your hospital stay. Most services have the same copays you'd have at facilities. Call the number on the back of your Humana medical ID card to see if they are available near you.

→ For more information on home healthcare services that may be available to you, visit **Humana.com/Home-Care**

## Virtual visits

Connect with a doctor without leaving home†† over your computer, tablet or phone. You may be able to receive care from your own doctor—just ask.

Medical virtual visits, also known as telehealth or telemedicine, are a convenient way to get treatment for many nonemergency injuries or illnesses, order lab tests, get medication refills and even help you and your PCP manage certain chronic conditions. You can make an appointment or receive care on demand, and your information may be shared with your PCP. You can also schedule virtual emotional health visits to talk to a doctor about a variety of nonemergency mental and emotional health issues.

Not all providers offer telehealth services.

→ Visit **Humana.com/VirtualVisits** to learn more.

†† Internet access required.

# Have the flexibility to do more for your health with the new Humana Flex allowance

## Get $250 or more a year to use toward your plan's covered dental, vision or hearing services

Having extra money set aside for healthcare expenses just got a lot easier. Now you can boost your dental, vision and hearing benefits and pay for services under your plan. Spend your allowance on one type of service or all three—it's up to you.

### How to use your allowance

Your Flex allowance is automatically loaded to your Humana Spending Account Card. You can use your allowance toward out-of-pocket costs for your plan's covered preventive and comprehensive dental, vision or hearing services, including copays. You can use your Flex allowance at participating providers where the primary business is dental care, vision services, or hearing services and where Visa® is accepted. Your allowance will be available on the day your coverage begins.

**New for 2023**

**One card for all your plan allowances**

Your Flex allowance will automatically be loaded to your new Humana Spending Account Card, so you only have one card to keep track of for allowances included in your plan.


Allowance amounts cannot be combined with other benefit allowances. Limitations and restrictions may apply.

Humana is a Medicare Advantage HMO, HMO SNP, PPO, PPO SNP and PFFS organization with a Medicare contract. Humana is also a Coordinated Care plan with a Medicare contract and a contract with the state Medicaid program. Enrollment in any Humana plan depends on contract renewal.

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# Important

## At Humana, it is important you are treated fairly.

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

- The following department has been designated to handle inquiries regarding Humana's non-discrimination policies: Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618, **877-320-1235 (TTY: 711)**.

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

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

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

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

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

# 2023 **Health Plan Benefits** at a Glance

Humana Gold Plus H0028-025 (HMO) Colorado

| Plan Costs | With Medicare Only | With Medicare & State Cost-Share Protection |
|---|---|---|
| Monthly plan premium | $0 | $0 |
| Annual out-of-pocket maximum | $4,900 in-network | $0 |
| | **With Medicare only In-Network** | **With Medicare & State Cost-Share Protection** |
| **Doctor Office Visits** | | |
| Primary care provider (PCP) | $0 copay | $0 copay |
| Specialist | $35 copay | $0 copay |
| **Preventive Care** | | |
| Including: Medicare covered screenings | Covered at no cost when you see an in-network provider | $0 copay |
| **Telehealth Services (in addition to Original Medicare)** | | |
| Primary care provider (PCP) | $0 copay | $0 copay |
| Specialist | $35 copay | $0 copay |
| Urgent care services | $0 copay | $0 copay |
| Substance abuse or behavioral health services | $0 copay | $0 copay |
| **Inpatient Care** | | |
| Acute inpatient hospital care | $225 copay per day for days 1-6<br>$0 copay per day for days 7-90 | $0 copay |
| **Lab Services** | | |
| Lab tests from lab facility | $0 copay | $0 copay |
| Lab tests from outpatient hospital facility | $0 copay | $0 copay |
| **Outpatient Care** | | |
| Outpatient surgery at ambulatory surgical center | $175 copay | $0 copay |
| Physical therapy at therapy facility | $30 copay | $0 copay |
| X-rays at outpatient hospital facility | $30 copay | $0 copay |

Continued:

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| Outpatient Care (continued) | | |
|---|---|---|
| Diagnostic testing at outpatient hospital facility | $100 copay | $0 copay |
| **Mental Health Services** | | |
| Inpatient psychiatric hospital<br><br>Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. | $225 copay per day for days 1-6<br>$0 copay per day for days 7-90 | $0 copay |
| Specialist's office | $20 copay | $0 copay |
| Outpatient hospital | $20 copay | $0 copay |
| Partial hospitalization | $20 copay | $0 copay |
| **Emergency Services** | | |
| Urgently needed services at an urgent care center | $40 copay | $0 copay |
| Ambulance services | $290 copay per date of service | $0 copay |
| Emergency room | $90 copay | $0 copay |
| **Additional Benefits & Programs** | | |
| Humana Flex Allowance | **$250** Annual allowance on a prepaid card to use at participating providers to pay out of pocket costs towards the plan's Preventive and Comprehensive Dental, Vision and Hearing services. Unused amount expires at the end of the plan year.<br>Allowance is available on the Humana Spending Account Card. | |
| HMO travel benefit | Included | |
| Routine dental services DEN086 | Included - cost share may apply. Please refer to the Summary of Benefits for additional details. | |
| Routine vision services VIS733 | Included - cost share may apply. Please refer to the Summary of Benefits for additional details. | |
| Routine hearing services HER939 | Included - cost share may apply. Please refer to the Summary of Benefits for additional details. | |
| Over-the-Counter (OTC) Allowance | **$75** maximum benefit coverage amount per quarter (3 months) for over-the-counter (OTC) prepaid card to purchase eligible OTC health and wellness products at participating retailers. Unused amount expires at the end of the quarter.<br>Allowance is available on the Humana Spending Account Card. | |
| Personal Home Care | Included | |

| Additional Benefits & Programs (continued) | |
|---|---|
| Transportation services | **$0** copay for plan approved location up to 24 one-way trip(s) per year. This benefit is not to exceed 125 miles per trip. |
| SilverSneakers® fitness program | Included |
| Humana Well Dine® Meal Program | Included |

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# 2023 **Prescription Drug Benefits** at a Glance

Humana Gold Plus H0028-025 (HMO) Colorado

**Important Message About What You Pay for Vaccines**
Our plan covers most Part D vaccines at no cost to you, no matter what cost-sharing tier it's on.

**Important Message About What You Pay for Insulin**
You won't pay more than $35 for a one-month (up to 30-day) supply of each Part D insulin product covered by our plan, no matter what cost-sharing tier it's on. This applies to all Part D covered insulins, including the Select Insulins covered under the Insulin Savings Program as described below. If you receive "Extra Help", you will still pay no more than $35 for a one-month supply for each Part D covered insulin. Please see your Prescription Drug Guide to find all Part D insulins covered by your plan.

**If you don't receive "Extra Help" for your drugs, you'll pay the following:**

**Deductible** This plan does not have a deductible.

**Initial Coverage** You pay the following until your total yearly drug costs reach **$4,660**. Total yearly drug costs are the total drug costs paid by both you and our plan. Once you reach this amount, you will enter the Coverage Gap.

## Mail Order Cost-Sharing

| **Pharmacy options**<br><br>**Get more value with cost-share options in bold** | **Standard**<br><br>Walmart Mail, PillPack<br>Other pharmacies are available in our network. To find the pharmacy mail order options, go to **Humana.com/pharmacyfinder** | | **Preferred**<br>CenterWell Pharmacy™ | |
|---|---|---|---|---|
| | **30-day supply** | **90-day supply*** | **30-day supply** | **90-day supply*** |
| **Tier 1:** Preferred Generic | $10 | $30 | $0 | **$0** |
| **Tier 2:** Generic | $20 | $60 | $5 | **$0** |
| **Tier 3:** Preferred Brand | $47 | $141 | $45 | **$90** |
| **Tier 4:** Non-Preferred Drug | $100 | $300 | $95 | **$190** |
| **Tier 5:** Specialty Tier | 33% | N/A | 33% | N/A |

## Retail Cost-Sharing

| **Pharmacy options** | **Retail** All network retail pharmacies. To find the retail pharmacies near you, go to **Humana.com/pharmacyfinder** | |
|---|---|---|
| | **30-day supply** | **90-day supply*** |
| **Tier 1:** Preferred Generic | $0 | $0 |
| **Tier 2:** Generic | $5 | $15 |

Continued:

| | | |
|---|---|---|
| **Tier 3:** Preferred Brand | $45 | $135 |
| **Tier 4:** Non-Preferred Drug | $95 | $285 |
| **Tier 5:** Specialty Tier | 33% | N/A |

Once your total yearly drug costs—what is paid both by you and our plan—reach **$4,660** the costs of your drugs may go up. Please refer to the Summary of Benefits for more information.

You can get more out of your plan by doing the following:

- **Stay in–network.** You'll pay less for your drugs at in-network pharmacies.
- **Use your preferred mail order cost–sharing pharmacies.** They offer a lower cost-share than standard mail order cost-sharing pharmacies for most drugs (your cost-share for specialty drugs is the same at any in-network pharmacy).
- **Get a 90-day supply of many of the drugs you take all of the time.** You'll get more and may pay less, especially when you fill at a preferred cost-sharing mail-order pharmacy.

**Insulin Savings Program**
Your plan participates in the Insulin Savings Program. You will pay no more than $35 for a one-month (up to a 30-day) supply for Select Insulins, no matter what cost-sharing tier it's on. To identify which Select Insulins are included within the Insulin Savings Program, look for the ***ISP*** indicator in your Prescription Drug Guide. Please refer to the Summary of Benefits for additional details.

Your plan also provides enhanced insulin coverage which means you will pay no more than $35 for a one-month (up to 30-day) supply for all Part D insulins covered by our plan, including Select Insulins, no matter what cost-sharing tier it's on. The enhanced insulin coverage is available, even if you receive "Extra Help".

### If you receive "Extra Help" for your drugs, you'll pay the following:

**Deductible** This plan does not have a deductible.

| **Pharmacy cost-sharing** | | |
|---|---|---|
| **For generic drugs** (including brand drugs treated as generic), either: | **30-day supply** | **90-day supply*** |
| | $0 copay; or<br>$1.45 copay; or<br>$4.15 copay; or<br>15% of the cost | $0 copay; or<br>$1.45 copay; or<br>$4.15 copay; or<br>15% of the cost |
| **For all other drugs**, either: | $0 copay; or<br>$4.30 copay; or<br>$10.35 copay; or<br>15% of the cost | $0 copay; or<br>$4.30 copay; or<br>$10.35 copay; or<br>15% of the cost |

Other pharmacies are available in our network.

*Some drugs are limited to a 30-day supply.

If you have questions and are a Humana member, please contact Customer Care at 1-800-457-4708 (TTY: 711). If you are not currently a Humana member, please contact a licensed Humana sales agent at 1-844-775-9622 (TTY: 711), 8 a.m. - 8 p.m. seven days a week from Oct. 1, 2022 - Mar. 31, 2023 and Monday through Friday the rest of the year.

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

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

Allowance amounts cannot be combined with other benefit allowances. Limitations and restrictions may apply.

Get all your health plan details at
**Humana.com/Benefits**

# Important

## At Humana, it is important you are treated fairly.

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

- The following department has been designated to handle inquiries regarding Humana's non-discrimination policies: Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618, **877-320-1235** (**TTY: 711)**.

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

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

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

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

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

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2023

# Summary of Benefits

## Humana Gold Plus H0028-025 (HMO)

Colorado
North and South Colorado Area

Our service area includes the following county/counties in Colorado: Boulder, Clear Creek, El Paso, Elbert, Fremont, Larimer, Pueblo, Teller, Weld.

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## Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1-800-833-2364 (TTY: 711)**.

### Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs and benefits before you enroll. Visit **Humana.com/medicare** or call **1-800-833-2364 (TTY: 711)** to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

### Understanding Important Rules

- ☐ You must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2024.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

2023

# Summary of Benefits

## Humana Gold Plus H0028-025 (HMO)

Colorado
North and South Colorado Area

Our service area includes the following county/counties in Colorado: Boulder, Clear Creek, El Paso, Elbert, Fremont, Larimer, Pueblo, Teller, Weld.

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# Let's talk about Humana Gold Plus H0028-025 (HMO)

Find out more about the Humana Gold Plus H0028-025 (HMO) plan - including the health and drug services it covers - in this easy-to-use guide.

Humana Gold Plus H0028-025 (HMO) is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

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, ask us for the "Evidence of Coverage".

## To be eligible

To join Humana Gold Plus H0028-025 (HMO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area.

## Plan name:

Humana Gold Plus H0028-025 (HMO)

## How to reach us:

If you're a member of this plan, call toll-free: **1-800-457-4708 (TTY: 711)**.

If you're **not** a member of this plan, call toll free: **1-800-833-2364 (TTY: 711)**.

**October 1 - March 31:**
Call 7 days a week from 8 a.m. - 8 p.m.

**April 1 - September 30:**
Call Monday - Friday, 8 a.m. - 8 p.m.

Or visit our website:

**Humana.com/medicare**

## More about Humana Gold Plus H0028-025 (HMO)

Do you have Medicare and Medicaid? If you are a dual-eligible beneficiary enrolled in both Medicare and the state's program, you may not have to pay the medical costs displayed in this booklet and your prescription drug costs will be lower, too.

If you have Medicaid, be sure to show your Medicaid ID card in addition to your Humana membership card to make your provider aware that you may have additional coverage. Your services are paid first by Humana and then by Medicaid.

As a member you must select an in-network doctor to act as your Primary Care Provider (PCP). Humana Gold Plus H0028-025 (HMO) has a network of doctors, hospitals, pharmacies and other providers. If you use providers who aren't in our network, the plan may not pay for these services.

## A healthy partnership

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

## Monthly Premium, Deductible and Limits

| | |
|---|---|
| **Monthly Plan Premium** | **$0**<br>You must keep paying your Medicare Part B premium. |
| **Medical deductible** | This plan does not have a deductible. |
| **Pharmacy (Part D) deductible** | This plan does not have a deductible. |
| **Maximum out-of-pocket responsibility** | **$4,900** in-network<br>The most you pay for copays, coinsurance and other costs for covered medical services for the year. |

## Covered Medical and Hospital Benefits

| | |
|---|---|
| **Acute inpatient hospital care** | **$225** copay per day for days 1-6<br>**$0** copay per day for days 7-90<br>Your plan covers an unlimited number of days for an inpatient stay. |
| **Outpatient hospital coverage** | • Outpatient surgery at Outpatient Hospital: **$225** copay<br>• Outpatient surgery at Ambulatory Surgical Center: **$175** copay |
| **Doctor visits** | • Primary care provider: **$0** copay<br>• Specialist: **$35** copay |

*You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.*

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## Covered Medical and Hospital Benefits (cont.)

| | |
|---|---|
| **Preventive care** | **Our plan covers many preventive services at no cost when you see an in-network provider including:**<br>• Abdominal aortic aneurysm screening<br>• Alcohol misuse counseling<br>• Bone mass measurement<br>• Breast cancer screening (mammogram)<br>• Cardiovascular disease (behavioral therapy)<br>• Cardiovascular screenings<br>• Cervical and vaginal cancer screening<br>• Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)<br>• Depression screening<br>• Diabetes screenings<br>• HIV screening<br>• Medical nutrition therapy services<br>• Obesity screening and counseling<br>• Prostate cancer screenings (PSA)<br>• Sexually transmitted infections screening and counseling<br>• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)<br>• Vaccines, including flu shots, hepatitis B shots, pneumococcal shots<br>• "Welcome to Medicare" preventive visit (one-time)<br>• Annual Wellness Visit<br>• Lung cancer screening<br>• Routine physical exam<br>• Medicare diabetes prevention program<br>Any additional preventive services approved by Medicare during the contract year will be covered. |
| **EMERGENCY CARE** | |
| **Emergency room** | **$90** copay<br>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for the emergency care. |
| **Urgently needed services** | **$40** copay at an urgent care center<br>Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention. |

*You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.*

## Covered Medical and Hospital Benefits (cont.)

**OUTPATIENT CARE AND SERVICES**

| | |
|---|---|
| **Diagnostic services, labs and imaging**<br>Cost share may vary depending on the service and where service is provided | • Diagnostic mammography: **$0** copay<br>• Diagnostic colonoscopy **$0** copay<br>• Diagnostic radiology: **$175** copay<br>• Lab services: **$0** copay<br>• Diagnostic tests and procedures: **$0** to **$100** copay<br>• Outpatient X-rays: **$0** to **$30** copay<br>• Radiation therapy: **$35** copay or **20%** of the cost |
| **Hearing** | Medicare-covered hearing exam: **$35** copay<br><br>**Routine hearing:**<br>In-Network:<br>**HER939**<br>• **$0** copay for routine hearing exams up to 1 per year.<br>• **$499** copay for each Advanced level hearing aid up to 1 per ear per year.<br>• **$799** copay for each Premium level hearing aid up to 1 per ear per year.<br>Hearing aid purchase includes:<br>• Unlimited follow-up provider visits during first year following TruHearing hearing aid purchase<br>• 60-day trial period<br>• 3-year extended warranty<br>• 80 batteries per aid for non-rechargeable models<br>**You must see a TruHearing provider to use this benefit. Call 1-844-255-7144 to schedule an appointment (for TTY, dial 711).** |
| **Dental** | Medicare-covered dental services: **$35** copay<br><br>**Routine dental:**<br>In-Network:<br>**DEN086**<br>• Plan covers up to **$2,000** allowance every year for non-Medicare covered preventive and comprehensive dental services.<br>• You are responsible for any amount above the dental coverage limit.<br>• Any amount unused at the end of the year will expire.<br>• Your benefit can be used for most dental treatments such as:<br>• Preventive dental services, such as exams, routine cleanings, etc.<br>• Basic dental services, such as fillings, extractions, etc.<br>• Major dental services, such as periodontal scaling, crowns, dentures, root canals, bridges, etc.<br>• Note: The allowance cannot be used on cosmetic services and implants. |

*You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.*

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## Covered Medical and Hospital Benefits (cont.)

| | |
|---|---|
| | Dental services are subject to our standard claims review procedures which could include dental history to approve coverage. Dental benefits under this plan may not cover all American Dental Association procedure codes. Information regarding each plan is available at **Humana.com/sb**.<br><br>Network dentists have agreed to provide services at contracted fees (the in-network fee schedules, of INFS). If a member visits a participating network dentist, the member will not receive a bill for changes more than the negotiated fee schedule on covered services (annual maximum still applies).<br><br>Use the HumanaDental Medicare network for the Mandatory Supplemental Dental. The provider locator can be found at **Humana.com** > Find a Doctor > from the Search Type drop down select Dental > under Coverage Type select All Dental Networks > enter zip code > from the network drop down select HumanaDental Medicare. |
| **Vision** | • Medicare-covered vision services: **$35** copay<br>• Medicare-covered diabetic eye exam: **$0** copay<br>• Medicare-covered glaucoma screening: **$0** copay<br>• Medicare-covered eyewear (post-cataract): **$0** copay<br><br>**Routine vision:**<br>In-Network:<br>**VIS733**<br>• **$0** copay for routine exam up to 1 per year.<br>• **$300** maximum benefit coverage amount per year for contact lenses or eyeglasses-lenses and frames, fitting for eyeglasses-lenses and frames.<br>• Eyeglass lens options may be available with the maximum benefit coverage amount up to 1 pair per year.<br>• Maximum benefit coverage amount is limited to one time use per year.<br><br>The provider locator for routine vision can be found at **Humana.com** > Find a Doctor > select Vision care icon > Vision coverage through Medicare Advantage plans. |
| **Mental health services** | **Inpatient:**<br>• **$225** copay per day for days 1-6<br>• **$0** copay per day for days 7-90<br>• Your plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital.<br>**Outpatient** (group and individual therapy visits): **$20** copay |

*You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.*

## Covered Medical and Hospital Benefits (cont.)

| | |
|---|---|
| **Skilled nursing facility (SNF)** | • **$0** copay per day for days 1-20<br>• **$188** copay per day for days 21-50<br>• **$0** copay per day for days 51-100<br>• Your plan covers up to 100 days in a SNF |
| **Physical Therapy** | • **$30** copay |
| **ADDITIONAL BENEFITS** | |
| **Ambulance** | **$290** copay per date of service |
| **Transportation** | **$0** copay for plan approved location up to 24 one-way trip(s) per year. This benefit is not to exceed 125 miles per trip.<br><br>The member *must* contact transportation vendor to arrange transportation and should contact Customer Care to be directed to their plan's specific transportation provider. |
| **Medicare Part B drugs** | • Chemotherapy drugs: **20%** of the cost<br>• Other Part B drugs: **20%** of the cost |

## Prescription Drug Benefits

**PRESCRIPTION DRUGS**

**Important Message About What You Pay for Vaccines**
Our plan covers most Part D vaccines at no cost to you, no matter what cost-sharing tier it's on.

**Important Message About What You Pay for Insulin**
You won't pay more than $35 for a one-month (up to 30-day) supply of each Part D insulin product covered by our plan, no matter what cost-sharing tier it's on. This applies to all Part D covered insulins, including the Select Insulins covered under the Insulin Savings Program as described below. If you receive "Extra Help", you will still pay no more than $35 for a one-month supply for each Part D covered insulin. Please see your Prescription Drug Guide to find all Part D insulins covered by your plan.

**If you don't receive Extra Help for your drugs, you'll pay the following:**
**Deductible** This plan does not have a deductible.

**Initial coverage**
You pay the following until your total yearly drug costs reach **$4,660**. Total yearly drug costs are the total drug costs paid by both you and our plan. Once you reach this amount, you will enter the Coverage Gap.

*You do not need a referral to receive covered services from plan providers. Certain procedures, services and drugs may need advance approval from your plan. This is called a "prior authorization" or "preauthorization." Please contact your PCP or refer to the Evidence of Coverage (EOC) for services that require a prior authorization from the plan.*

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| Mail Order Cost-Sharing | | | | |
|---|---|---|---|---|
| **Pharmacy options** | **Standard** Walmart Mail, PillPack Other pharmacies are available in our network. To find pharmacy mail order options go to **Humana.com/pharmacyfinder** | | **Preferred** CenterWell Pharmacy™ | |
| | **30-day supply** | **90-day supply*** | **30-day supply** | **90-day supply*** |
| **Tier 1:** Preferred Generic | $10 | $30 | $0 | $0 |
| **Tier 2:** Generic | $20 | $60 | $5 | $0 |
| **Tier 3:** Preferred Brand | $47 | $141 | $45 | $90 |
| **Tier 4:** Non-Preferred Drug | $100 | $300 | $95 | $190 |
| **Tier 5:** Specialty Tier | 33% | N/A | 33% | N/A |

| Retail Cost-Sharing | | |
|---|---|---|
| **Pharmacy options** | **Retail** All network retail pharmacies. To find the retail pharmacies near you, go to **Humana.com/pharmacyfinder** | |
| | **30-day supply** | **90-day supply*** |
| **Tier 1:** Preferred Generic | $0 | $0 |
| **Tier 2:** Generic | $5 | $15 |
| **Tier 3:** Preferred Brand | $45 | $135 |
| **Tier 4:** Non-Preferred Drug | $95 | $285 |
| **Tier 5:** Specialty Tier | 33% | N/A |

Your plan participates in the Insulin Savings Program. You will pay no more than $35 for a one-month (up to a 30-day) supply for Select Insulins, no matter what cost-sharing tier it's on. To identify which Select Insulins are included within the Insulin Savings Program, look for the ***ISP*** indicator in your Prescription Drug Guide. You are not eligible for this program if you receive "Extra Help".

Your plan also provides enhanced insulin coverage which means you will pay no more than $35 for a one-month (up to 30-day) supply for all Part D insulins covered by our plan, including Select Insulins, no matter what cost-sharing tier it's on. The enhanced insulin coverage is available, even if you receive "Extra Help".

**Your share of the cost for Select Insulins:**

| Mail Order Cost-Sharing for Select Insulins | | | | |
|---|---|---|---|---|
| **Pharmacy options** | **Standard**<br>Walmart Mail, PillPack<br>Other pharmacies are available in our network. To find pharmacy mail order options, go to **Humana.com/pharmacyfinder** | | **Preferred**<br>CenterWell Pharmacy™ | |
| | **30-day supply** | **90-day supply*** | **30-day supply** | **90-day supply*** |
| **Tier 3:** Preferred Brand | **$35** | **$105** | **$35** | **$70** |

| Retail Cost-Sharing for Select Insulins | | |
|---|---|---|
| **Pharmacy options** | **Retail**<br>All network retail pharmacies. To find the retail pharmacies near you, go to **Humana.com/pharmacyfinder** | |
| | **30-day supply** | **90-day supply*** |
| **Tier 3:** Preferred Brand | **$35** | **$105** |

**If you receive Extra Help for your drugs, you'll pay the following:**
**Deductible** This plan does not have a deductible.

| Pharmacy cost-sharing | | |
|---|---|---|
| **For generic drugs** (including brand drugs treated as generic), either: | **30-day supply**<br>**$0** copay; or<br>**$1.45** copay; or<br>**$4.15** copay ; or<br>**15%** of the cost | **90-day supply***<br>**$0** copay; or<br>**$1.45** copay; or<br>**$4.15** copay ; or<br>**15%** of the cost |
| **For all other drugs,** either: | **$0** copay; or<br>**$4.30** copay; or<br>**$10.35** copay ; or<br>**15%** of the cost | **$0** copay; or<br>**$4.30** copay; or<br>**$10.35** copay ; or<br>**15%** of the cost |

Other pharmacies are available in our network.
*Some drugs are limited to a 30-day supply

| ADDITIONAL DRUG COVERAGE | |
|---|---|
| **Erectile dysfunction (ED) drugs** | Covered at Tier 1 cost-share amount. |
| **Anti-Obesity drugs** | Covered at Tier 2 cost-share amount. |

Cost sharing may change depending on the pharmacy you choose, when you enter another phase of the Part D benefit and if you qualify for "Extra Help." To find out if you qualify for "Extra Help," please contact the Social Security Office at 1-800-772-1213 Monday — Friday, 7 a.m. — 7 p.m. TTY users should call

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1-800-325-0778. For more information on your prescription drug benefit, please call us or access your "Evidence of Coverage" online.

If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

You may get drugs from an out-of-network pharmacy but may pay more than you pay at an in-network pharmacy.

**Coverage Gap**

After you enter the coverage gap, you pay **25 percent** of the plan's cost for covered brand name drugs and **25 percent** of the plan's cost for covered generic drugs until your out-of-pocket costs total **$7,400** — which is the end of the coverage gap. Not everyone will enter the coverage gap.

Under this plan, **you may pay even less** for the following:

**Tier 1** (Preferred Generic) - All Drugs

**Tier 2** (Generic) - All Drugs

**Tier 3** (Preferred Brand) - Select Insulin Drugs

For more information on cost sharing in the coverage gap, please call us or access your Evidence of Coverage online.

**Catastrophic Coverage**

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

- **5%** of the cost, or
- **$4.15** copay for generic (including brand drugs treated as generic) and a **$10.35** copay for all other drugs

## Additional Benefits

| | |
|---|---|
| **Medicare-covered foot care (podiatry)** | **$35** copay |
| **Medicare-covered chiropractic services** | **$20** copay |
| **Medical equipment/ supplies** Cost share may vary depending on the service and where service is provided | • Durable medical equipment (like wheelchairs or oxygen): **20%** of the cost<br>• Medical supplies: **20%** of the cost<br>• Prosthetics (artificial limbs or braces): **20%** of the cost<br>• Diabetic monitoring supplies: **$0** copay or **10%** to **20%** of the cost |
| **Rehabilitation services** | • Occupational and speech therapy: **$30** copay<br>• Cardiac rehabilitation: **$20** copay<br>• Pulmonary rehabilitation: **$20** copay |
| **Telehealth services (in addition to Original Medicare)** | • Primary care provider (PCP): **$0** copay<br>• Specialist: **$35** copay<br>• Urgent care services: **$0** copay<br>• Substance abuse and behavioral health services: **$0** copay |

# More benefits with **your plan**

Enjoy some of these extra benefits included in your plan.
This is a summary of what we cover. It doesn't list every service that we cover or list every limitation or exclusion. The Evidence of Coverage (EOC) provides a complete list of coverage and services. Visit **Humana.com/medicare** to view a copy of the EOC or call **1-800-833-2364**.

**Humana Flex Allowance**
**$250** annual allowance on a prepaid card to use toward out of pocket costs for the plan's preventive and comprehensive dental, vision, or hearing services including copays.
Members can use this benefit at participating providers where the primary business is Dental Care, Vision Services, or Hearing Services and Visa® is accepted.
Cannot be used for procedures such as cosmetic dentistry and teeth whitening.
Unused amount expires at the end of the plan year.

Allowance amounts cannot be combined with other benefit allowances. Limitations and restrictions may apply.

**Over-the-Counter (OTC) Allowance**
**$75** maximum benefit coverage amount per quarter (3 months) for over-the-counter (OTC) prepaid card to purchase eligible OTC health and wellness products at participating retailers.

Unused amount expires at the end of the quarter.

Allowance amounts cannot be combined with other benefit allowances. Limitations and restrictions may apply.

**Humana Spending Account Card**
The allowances listed below will be loaded onto this prepaid card. Each allowance is separate from any other allowance listed. Allowances shown are accessed by using this card. Allowance amounts cannot be combined with other benefit allowances. Limitations and restrictions may apply.

*Humana Flex Allowance
*OTC Allowance

**HMO Travel Benefit**
Members can receive in-network benefits when services are received from a participating HMO National Network provider during their travels to other states and Puerto Rico.

**Chiropractic services**
Routine chiropractic:
**$20** copay per visit for up to 12 visits.

**Routine foot care**
**$0** copay per visit for up to 12 visits

**Humana Well Dine® Meal Program**
Humana's home delivered meal program for members following an inpatient stay in the hospital or nursing facility.

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**Personal Home Care**
**$0** copay for a minimum of 4 hours per day, up to a maximum of 80 hours per year for certain in-home support services to assist individuals with disabilities and/or medical conditions in performing activities of daily living (ADLs) and Instrumental Activities of Daily living (IADLs) within the home by a qualified aide. A member must be receiving assistance with a minimum of one ADL to receive assistance with any IADL.

Authorization may be required. Contact the plan for details.

**Rewards and Incentives**
Go365 by Humana® a Rewards and Incentive program for completing certain preventive health screenings and health and wellness activities.

**SilverSneakers® fitness program**
Basic fitness center membership including fitness classes.

# Find out **more**

You can see our plan's **provider and pharmacy directory** at our website at **humana.com/finder/search** or call us at the number listed at the beginning of this booklet and we will send you one.

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

To find out more about the coverage and costs of Original Medicare, look in the 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, seven days a week. TTY users should call 1-877-486-2048.

Telehealth services shown are in addition to the Original Medicare covered telehealth. Your cost may be different for Original Medicare telehealth.

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

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

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# Notes

# Notes

# Important

## At Humana, it is important you are treated fairly.

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

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

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

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

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## Multi-Language Insert

Multi-language Interpreter Services

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

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

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

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

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

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

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

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

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

Humana.

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

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

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

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

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

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

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

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

Humana Gold Plus H0028-025 (HMO)
H0028025002 ENG
North and South Colorado Area

Humana.com

Humana.

2023

# Prescription Drug Guide

## Humana Abbreviated Formulary

Partial list of covered drugs

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

Humana Community (HMO-POS)
Humana Gold Plus (HMO)
Humana Gold Plus (HMO-POS)

This abridged formulary was updated on 10/12/2022 and is not a complete list of drugs covered by our plan. For a complete listing, or other questions, please contact Humana with any questions at 1-800-457-4708 or for TTY users, 711, five days a week April 1 – September 30 or seven days a week October 1 – March 31 from 8 a.m. - 8 p.m. Our automated phone system is available after hours, weekends, and holidays. Our website is also available 24 hours a day 7 days a week, by visiting **Humana.com.**

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

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

Instructions for getting information about all covered drugs are inside.

For a complete list of Contract/PBP numbers this document relates to, please see the final page of this document.

Humana®

# Welcome to Humana!

**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 Humana. This document includes a partial list of the drugs (formulary) for our plan which is current as of January 1, 2023. For a complete, updated formulary, please contact us on our website at **Humana.com/PlanDocuments** or you can call the number below to request a paper copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages. You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1 of each year, and from time to time during the year.

**What is the abridged Humana Medicare formulary?**
A formulary is the entire list of covered drugs or medicines selected by Humana. The terms formulary and Drug List may be used interchangeably throughout communications regarding changes to your pharmacy benefits. Humana 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. Humana will generally cover the drugs listed in the formulary as long as the drug is medically necessary, the prescription is filled at a Humana network pharmacy, and other plan rules are followed. For more information on how to fill your medicines, please review your Evidence of Coverage.

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

For help or a complete list of covered drugs, please contact Humana Customer Care with any questions at 1-800-457-4708 **(TTY: 711)**. five days a week April 1 – September 30 or seven days a week October 1 – March 31 from 8 a.m. - 8 p.m. (EST). 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**.

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

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

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

changes based on new clinical guidelines. If we remove drugs from our formulary, or add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 30-day supply of the drug.

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

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

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

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

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

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

Please contact Humana Customer Care with any questions at **1-800-457-4708 (TTY: 711)**, five days a week April 1- September 30 or seven days a week October 1 – March 31 from 8 a.m. – 8 p.m. (EST). 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**.

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

**Medical condition**
The formulary starts on page 12. 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 12. Then look under the category name for your drug. The formulary also lists the Tier and Utilization Management Requirements for each drug (see page 6 for more information on Utilization Management Requirements).

**Alphabetical listing**
If you are not sure about your drug's group, you should look for your drug in the Index that begins on page 28. The Index is an alphabetical list of all of the drugs included in this document. Both brand-name drugs and generic drugs are listed. Look in the Index to search for your drug. Next to each drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of the drug in the first column of the list.

Prescription drugs are grouped into one of five tiers.
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 cost less than brand-name drugs.

- **Tier 1 - Preferred Generic:** Generic or brand drugs that are available at the lowest cost share for the plan
- **Tier 2 - Generic:** Generic or brand drugs that the plan offers at a higher cost to you than Tier 1 Preferred Generic drugs
- **Tier 3 - Preferred Brand:** Generic or brand drugs that the plan offers at a lower cost to you than Tier 4 Non-Preferred drugs
- **Tier 4 - Non-Preferred Drug:** Generic or brand drugs that the plan offers at a higher cost to you than Tier 3 Preferred Brand drugs
- **Tier 5 - Specialty Tier:** Some injectables and other high-cost drugs

**How much will I pay for covered drugs?**
Humana 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 Customer Care to find out what your costs are.**

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

- **Prior Authorization (PA):** Humana requires you to get prior authorization for certain drugs to be covered under your plan. This means that you will need to get approval from Humana before you fill your prescriptions. If you do not get approval, Humana may not cover the drug.
- **Quantity Limits (QL):** For some drugs, Humana limits the amount of the drug that is covered. Humana 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, Humana requires that you first try certain drugs to treat your medical condition before coverage is available for another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, Humana may not cover Drug B unless you try Drug A first. If Drug A does not work for you, Humana will then cover Drug B.
- **Part B versus Part D (B vs D):** Some drugs may be covered under Medicare Part B or Part D depending upon the circumstances. Information may need to be submitted to Humana 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 Humana at **1-877-486-2621**. Representatives are available Monday - Friday, 8 a.m. - 8 p.m. (EST).

**Insulin Savings Program**
Your plan participates in the Insulin Savings Program which provides affordable, predictable copayments for Select Insulins through the first three drug payment stages (Deductible (if applicable), Initial Coverage, and Coverage Gap) of the Part D benefit. To find out more about the Insulin Savings Program, visit **Humana.com/insulin** or refer to your Evidence of Coverage for additional details.

To identify which Select Insulins are included within in the Insulin Savings Program, look for the ***ISP*** indicator in the Utilization Management column.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 12.

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

You can ask Humana to make an exception to these restrictions or limits. See the section "**How do I request an exception to the formulary?**" on page 7 for information about how to request an exception.

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

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

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

**What is a compounded drug?**
A compounded drug is used to provide drug therapies that are not commercially available as FDA-approved finished products in the same dose, formulation, and/or combination of ingredients, but are instead created by a pharmacist by combining or mixing ingredients to create a prescription medication customized to the needs of an individual patient. While some compounded drugs may be Part D eligible, most compounded drugs are non-formulary drugs (not covered) by your plan. You may need to ask for and receive an approved coverage determination from us to have your compounded drug covered.

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

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

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

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

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

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

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

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

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

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

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

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

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

For these changes in treatment settings, Humana 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. Humana 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**

Humana 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. CenterWell Pharmacy is the preferred cost-sharing mail order pharmacy for many Humana MAPD and prescription drug plans (PDP). You can have your maintenance medicines, specialty medicines, or supplies mailed to a place that is most convenient for you. You should get your new prescription by mail in 7 – 10 days after CenterWell Pharmacy has received your prescription and all the necessary information. Refills should arrive within 5 – 7 days. 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 prescription drug coverage, please read your Evidence of Coverage (EOC) and other plan materials.

Please contact Humana Customer Care with any questions at **1-800-457-4708 (TTY: 711)**, five days a week April 1 – September 30 or seven days a week October 1 – March 31 from 8 a.m. – 8 p.m. (EST). 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**.

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 Formulary

The formulary that begins on the next page provides coverage information about the drugs covered by Humana. If you have trouble finding your drug in the list, turn to the Index that begins on page 28.

**Remember: This is only a partial list of drugs covered by Humana.** If your prescription drug is not listed in this partial formulary, please visit our website at **Humana.com**.

Your Humana plan has additional coverage of some drugs. These drugs are not normally covered under Medicare Part D and are not subject to the Medicare appeals process. These drugs are listed separately on page 27.

**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:
**GC** - Tier 1 or Tier 2 drugs that are covered in the gap
**DL** - Dispensing Limit; Drugs that may be limited to a 30 day supply, regardless of tier placement.
**MO** - Drugs that are typically available through mail-order. Please contact your mail-order pharmacy to make sure your drug is available.
**LA** - Limited Access; The health plan has authorized certain pharmacies to dispense this medicine, as it requires extra handling, doctor coordination or patient education. Please call the number on the back of your ID card for additional information.

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

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

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

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| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| *metronidazole 500 mg TABLET* **GC,MO** | 2 | |
| *nitrofurantoin monohyd/m-cryst 100 mg CAPSULE* **MO** | 3 | |
| NUZYRA 150 MG TABLET **DL** | 5 | QL(30 per 14 days) |
| SIVEXTRO 200 MG RECON SOLUTION **DL** | 5 | QL(6 per 28 days) |
| SIVEXTRO 200 MG TABLET **DL** | 5 | QL(6 per 28 days) |
| *sulfacetamide sodium 10 % OINTMENT* **MO** | 3 | |
| *sulfamethoxazole-trimethoprim 800-160 mg TABLET* **GC,MO** | 1 | |
| **Anticonvulsants** | | |
| EPIDIOLEX 100 MG/ML SOLUTION **DL** | 5 | PA |
| *gabapentin 100 mg, 300 mg, 400 mg CAPSULE* **GC,MO** | 2 | QL(270 per 30 days) |
| *gabapentin 600 mg, 800 mg TABLET* **GC,MO** | 2 | QL(180 per 30 days) |
| *lamotrigine 100 mg, 200 mg TABLET* **GC,MO** | 1 | |
| *levetiracetam 500 mg TABLET* **GC,MO** | 2 | |
| *primidone 50 mg TABLET* **GC,MO** | 2 | |
| **Antidementia Agents** | | |
| *donepezil 10 mg TABLET* **GC,MO** | 1 | QL(60 per 30 days) |
| *donepezil 5 mg TABLET* **GC,MO** | 1 | QL(30 per 30 days) |
| *memantine 10 mg, 5 mg TABLET* **GC,MO** | 2 | PA,QL(60 per 30 days) |
| NAMZARIC 14-10 MG, 21-10 MG, 28-10 MG, 7-10 MG CAPSULE ER SPRINKLE 24 HR. **MO** | 3 | QL(30 per 30 days) |
| NAMZARIC 7/14/21/28 MG-10 MG CAPSULE ER SPRINKLE 24 HR. **MO** | 3 | QL(28 per 28 days) |
| **Antidepressants** | | |
| *amitriptyline 25 mg TABLET* **GC,MO** | 2 | |
| *bupropion hcl 150 mg TABLET, ER 24 HR.* **MO** | 3 | QL(90 per 30 days) |
| *bupropion hcl 150 mg TABLET, SR 12 HR.* **MO** | 3 | QL(90 per 30 days) |
| *bupropion hcl 300 mg TABLET, ER 24 HR.* **MO** | 3 | QL(60 per 30 days) |
| *citalopram 10 mg, 40 mg TABLET* **GC,MO** | 1 | QL(30 per 30 days) |
| *citalopram 20 mg TABLET* **GC,MO** | 1 | QL(60 per 30 days) |
| *duloxetine 20 mg, 60 mg CAPSULE, DR/EC* **GC,MO** | 2 | QL(60 per 30 days) |
| *duloxetine 30 mg CAPSULE, DR/EC* **GC,MO** | 2 | QL(90 per 30 days) |
| *escitalopram oxalate 10 mg TABLET* **GC,MO** | 1 | QL(45 per 30 days) |
| *escitalopram oxalate 20 mg, 5 mg TABLET* **GC,MO** | 1 | QL(30 per 30 days) |
| *fluoxetine 20 mg CAPSULE* **GC,MO** | 1 | QL(120 per 30 days) |
| *fluoxetine 40 mg CAPSULE* **GC,MO** | 1 | QL(60 per 30 days) |
| *imipramine hcl 10 mg TABLET* **MO** | 3 | |
| *mirtazapine 15 mg, 30 mg, 7.5 mg TABLET* **GC,MO** | 2 | |

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| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| *paroxetine hcl 20 mg TABLET* **GC,MO** | 1 | QL(30 per 30 days) |
| *sertraline 100 mg TABLET* **GC,MO** | 1 | QL(60 per 30 days) |
| *sertraline 25 mg, 50 mg TABLET* **GC,MO** | 1 | QL(90 per 30 days) |
| *trazodone 100 mg, 150 mg, 50 mg TABLET* **GC,MO** | 1 | |
| TRINTELLIX 10 MG, 20 MG, 5 MG TABLET **MO** | 4 | ST,QL(30 per 30 days) |
| *venlafaxine 150 mg CAPSULE, ER 24 HR.* **GC,MO** | 2 | QL(60 per 30 days) |
| *venlafaxine 75 mg CAPSULE, ER 24 HR.* **GC,MO** | 2 | QL(90 per 30 days) |
| **Antiemetics** | | |
| *meclizine 25 mg TABLET* **GC,MO** | 2 | |
| *ondansetron 4 mg TABLET, DISINTEGRATING* **GC,MO** | 2 | BvsD,QL(90 per 30 days) |
| *ondansetron hcl 4 mg TABLET* **GC,MO** | 2 | BvsD,QL(90 per 30 days) |
| *promethazine 25 mg TABLET* **MO** | 4 | |
| SANCUSO 3.1 MG/24 HOUR PATCH, WEEKLY **DL** | 5 | QL(4 per 30 days) |
| **Antifungals** | | |
| *clotrimazole-betamethasone 1-0.05 % CREAM* **MO** | 3 | QL(180 per 30 days) |
| *fluconazole 150 mg TABLET* **GC,MO** | 2 | |
| *ketoconazole 2 % CREAM* **MO** | 3 | QL(60 per 30 days) |
| *ketoconazole 2 % SHAMPOO* **GC,MO** | 2 | QL(120 per 30 days) |
| **Antigout Agents** | | |
| *allopurinol 100 mg, 300 mg TABLET* **GC,MO** | 1 | |
| MITIGARE 0.6 MG CAPSULE **MO** | 3 | |
| **Antimigraine Agents** | | |
| AIMOVIG AUTOINJECTOR 140 MG/ML AUTO-INJECTOR **MO** | 4 | PA,QL(1 per 30 days) |
| AIMOVIG AUTOINJECTOR 70 MG/ML AUTO-INJECTOR **MO** | 4 | PA,QL(2 per 30 days) |
| EMGALITY PEN 120 MG/ML PEN INJECTOR **MO** | 4 | PA,QL(2 per 30 days) |
| EMGALITY SYRINGE 120 MG/ML SYRINGE **MO** | 4 | PA,QL(2 per 30 days) |
| EMGALITY SYRINGE 300 MG/3 ML (100 MG/ML X 3) SYRINGE **MO** | 4 | PA,QL(3 per 30 days) |
| *rizatriptan 5 mg TABLET* **GC,MO** | 2 | QL(12 per 30 days) |
| *sumatriptan succinate 100 mg TABLET* **GC,MO** | 1 | QL(9 per 30 days) |
| *topiramate 50 mg TABLET* **GC,MO** | 2 | QL(120 per 30 days) |
| **Antineoplastics** | | |
| ALECENSA 150 MG CAPSULE **DL** | 5 | PA,QL(240 per 30 days) |
| ALUNBRIG 180 MG, 90 MG TABLET **DL** | 5 | PA,QL(30 per 30 days) |
| ALUNBRIG 30 MG TABLET **DL** | 5 | PA,QL(180 per 30 days) |
| ALUNBRIG 90 MG (7)- 180 MG (23) TABLET, DOSE PACK **DL** | 5 | PA,QL(30 per 30 days) |
| *anastrozole 1 mg TABLET* **GC,MO** | 1 | QL(30 per 30 days) |

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| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| CABOMETYX 20 MG, 40 MG, 60 MG TABLET **DL** | 5 | PA,QL(30 per 30 days) |
| ERIVEDGE 150 MG CAPSULE **DL** | 5 | PA,QL(28 per 28 days) |
| ERLEADA 60 MG TABLET **DL** | 5 | PA,QL(120 per 30 days) |
| *exemestane 25 mg TABLET* **MO** | 4 | QL(60 per 30 days) |
| IBRANCE 100 MG, 125 MG, 75 MG CAPSULE **DL** | 5 | PA,QL(21 per 28 days) |
| IBRANCE 100 MG, 125 MG, 75 MG TABLET **DL** | 5 | PA,QL(21 per 28 days) |
| IMBRUVICA 140 MG CAPSULE **DL** | 5 | PA,QL(90 per 30 days) |
| IMBRUVICA 420 MG, 560 MG TABLET **DL** | 5 | PA,QL(28 per 28 days) |
| IMBRUVICA 70 MG CAPSULE **DL** | 5 | PA,QL(28 per 28 days) |
| NUBEQA 300 MG TABLET **DL** | 5 | PA,QL(120 per 30 days) |
| VERZENIO 100 MG, 150 MG, 200 MG, 50 MG TABLET **DL** | 5 | PA,QL(60 per 30 days) |
| XTANDI 40 MG CAPSULE **DL** | 5 | PA,QL(120 per 30 days) |
| XTANDI 40 MG TABLET **DL** | 5 | PA,QL(120 per 30 days) |
| XTANDI 80 MG TABLET **DL** | 5 | PA,QL(60 per 30 days) |
| **Antiparasitics** | | |
| *hydroxychloroquine 200 mg TABLET* **GC,MO** | 2 | |
| *nitazoxanide 500 mg TABLET* **DL** | 5 | QL(40 per 30 days) |
| **Antiparkinson Agents** | | |
| *carbidopa-levodopa 25-100 mg TABLET* **GC,MO** | 2 | |
| KYNMOBI 10 MG, 15 MG, 20 MG, 25 MG, 30 MG FILM **DL** | 5 | PA,QL(150 per 30 days) |
| RYTARY 23.75-95 MG CAPSULE, ER **MO** | 4 | ST,QL(360 per 30 days) |
| **Antipsychotics** | | |
| ABILIFY MAINTENA 300 MG, 400 MG SUSPENSION, ER, RECON **DL** | 5 | QL(1 per 28 days) |
| ABILIFY MAINTENA 300 MG, 400 MG SUSPENSION, ER, SYRINGE **DL** | 5 | QL(1 per 28 days) |
| ARISTADA 1,064 MG/3.9 ML SUSPENSION, ER, SYRINGE | 5 | QL(3.9 per 56 days) |
| ARISTADA 441 MG/1.6 ML SUSPENSION, ER, SYRINGE **DL** | 5 | QL(1.6 per 28 days) |
| ARISTADA 662 MG/2.4 ML SUSPENSION, ER, SYRINGE **DL** | 5 | QL(2.4 per 28 days) |
| ARISTADA 882 MG/3.2 ML SUSPENSION, ER, SYRINGE **DL** | 5 | QL(3.2 per 28 days) |
| ARISTADA INITIO 675 MG/2.4 ML SUSPENSION, ER, SYRINGE **DL** | 5 | QL(2.4 per 42 days) |
| INVEGA HAFYERA 1,092 MG/3.5 ML SYRINGE | 5 | QL(3.5 per 180 days) |
| INVEGA HAFYERA 1,560 MG/5 ML SYRINGE | 5 | QL(5 per 180 days) |
| INVEGA SUSTENNA 117 MG/0.75 ML, 234 MG/1.5 ML, 78 MG/0.5 ML SYRINGE **DL** | 5 | QL(1.5 per 28 days) |
| INVEGA SUSTENNA 156 MG/ML SYRINGE **DL** | 5 | QL(1 per 28 days) |
| INVEGA SUSTENNA 39 MG/0.25 ML SYRINGE **MO** | 4 | QL(1.5 per 28 days) |
| INVEGA TRINZA 273 MG/0.88 ML SYRINGE | 5 | QL(0.88 per 90 days) |

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| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| INVEGA TRINZA 410 MG/1.32 ML SYRINGE | 5 | QL(1.32 per 90 days) |
| INVEGA TRINZA 546 MG/1.75 ML SYRINGE | 5 | QL(1.75 per 90 days) |
| INVEGA TRINZA 819 MG/2.63 ML SYRINGE | 5 | QL(2.63 per 90 days) |
| PERSERIS 120 MG, 90 MG SUSPENSION, ER, SYRINGE **DL** | 5 | QL(1 per 28 days) |
| *quetiapine 100 mg TABLET* **GC,MO** | 2 | QL(90 per 30 days) |
| *quetiapine 25 mg, 50 mg TABLET* **GC,MO** | 2 | QL(120 per 30 days) |
| RISPERDAL CONSTA 12.5 MG/2 ML, 25 MG/2 ML SUSPENSION, ER, RECON **MO** | 4 | QL(2 per 28 days) |
| RISPERDAL CONSTA 37.5 MG/2 ML, 50 MG/2 ML SUSPENSION, ER, RECON **DL** | 5 | QL(2 per 28 days) |
| **Antispasticity Agents** | | |
| *baclofen 10 mg TABLET* **GC,MO** | 2 | |
| *dantrolene 100 mg, 50 mg CAPSULE* **MO** | 4 | |
| *dantrolene 25 mg CAPSULE* **MO** | 3 | |
| *tizanidine 2 mg, 4 mg TABLET* **GC,MO** | 1 | |
| **Antivirals** | | |
| *acyclovir 400 mg TABLET* **GC,MO** | 2 | |
| DESCOVY 200-25 MG TABLET **DL** | 5 | QL(30 per 30 days) |
| EPCLUSA 150-37.5 MG PELLETS IN PACKET **DL** | 5 | PA,QL(28 per 28 days) |
| EPCLUSA 200-50 MG PELLETS IN PACKET **DL** | 5 | PA,QL(56 per 28 days) |
| EPCLUSA 200-50 MG, 400-100 MG TABLET **DL** | 5 | PA,QL(28 per 28 days) |
| GENVOYA 150-150-200-10 MG TABLET **DL** | 5 | QL(30 per 30 days) |
| HARVONI 33.75-150 MG PELLETS IN PACKET **DL** | 5 | PA,QL(28 per 28 days) |
| HARVONI 45-200 MG PELLETS IN PACKET **DL** | 5 | PA,QL(56 per 28 days) |
| HARVONI 90-400 MG TABLET **DL** | 5 | PA,QL(28 per 28 days) |
| ISENTRESS HD 600 MG TABLET **DL** | 5 | QL(60 per 30 days) |
| *ledipasvir-sofosbuvir 90-400 mg TABLET* **DL** | 5 | PA,QL(28 per 28 days) |
| ODEFSEY 200-25-25 MG TABLET **DL** | 5 | QL(30 per 30 days) |
| *valacyclovir 1 gram, 500 mg TABLET* **MO** | 3 | |
| VOSEVI 400-100-100 MG TABLET **DL** | 5 | PA,QL(28 per 28 days) |
| XOFLUZA 40 MG TABLET **MO** | 4 | QL(10 per 365 days) |
| XOFLUZA 80 MG TABLET **MO** | 4 | QL(5 per 365 days) |
| **Anxiolytics** | | |
| *alprazolam 0.25 mg, 0.5 mg, 1 mg TABLET* **DL,GC** | 2 | QL(120 per 30 days) |
| *buspirone 10 mg, 15 mg, 5 mg TABLET* **GC,MO** | 1 | |
| *clonazepam 0.5 mg, 1 mg TABLET* **DL** | 3 | |
| *diazepam 10 mg TABLET* **DL** | 3 | QL(120 per 30 days) |
| *diazepam 5 mg TABLET* **DL** | 3 | QL(90 per 30 days) |

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|---|---|---|
| *hydroxyzine hcl 25 mg TABLET* **MO** | 3 | |
| *lorazepam 0.5 mg, 1 mg TABLET* **DL,GC** | 2 | QL(90 per 30 days) |
| **Blood Glucose Regulators** | | |
| BAQSIMI 3 MG/ACTUATION SPRAY, NON-AEROSOL **MO** | 3 | |
| BYDUREON BCISE 2 MG/0.85 ML AUTO-INJECTOR **MO** | 4 | QL(3.4 per 28 days) |
| FARXIGA 10 MG TABLET **MO** | 4 | QL(30 per 30 days) |
| FIASP FLEXTOUCH U-100 INSULIN 100 UNIT/ML (3 ML) INSULIN PEN **MO** | 3 | ISP |
| FIASP PENFILL U-100 INSULIN 100 UNIT/ML (3 ML) CARTRIDGE **MO** | 3 | ISP |
| FIASP U-100 INSULIN 100 UNIT/ML SOLUTION **MO** | 3 | ISP |
| *glimepiride 2 mg, 4 mg TABLET* **GC,MO** | 1 | |
| *glipizide 10 mg TABLET, ER 24 HR.* **GC,MO** | 1 | |
| *glipizide 10 mg, 5 mg TABLET* **GC,MO** | 1 | |
| GLYXAMBI 10-5 MG, 25-5 MG TABLET **MO** | 3 | QL(30 per 30 days) |
| GVOKE 1 MG/0.2 ML SOLUTION **MO** | 3 | |
| GVOKE HYPOPEN 2-PACK 0.5 MG/0.1 ML, 1 MG/0.2 ML AUTO-INJECTOR **MO** | 3 | |
| GVOKE PFS 1-PACK SYRINGE 0.5 MG/0.1 ML, 1 MG/0.2 ML SYRINGE **MO** | 3 | |
| INVOKAMET 150-1,000 MG, 150-500 MG, 50-1,000 MG, 50-500 MG TABLET **MO** | 3 | 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 | QL(60 per 30 days) |
| INVOKANA 100 MG, 300 MG TABLET **MO** | 3 | QL(30 per 30 days) |
| JANUMET 50-1,000 MG TABLET **MO** | 3 | QL(60 per 30 days) |
| JANUMET XR 100-1,000 MG TABLET, ER 24 HR., MULTIPHASE **MO** | 3 | QL(30 per 30 days) |
| JANUMET XR 50-1,000 MG TABLET, ER 24 HR., MULTIPHASE **MO** | 3 | QL(60 per 30 days) |
| JANUVIA 100 MG, 25 MG, 50 MG TABLET **MO** | 3 | QL(30 per 30 days) |
| JARDIANCE 10 MG, 25 MG TABLET **MO** | 3 | QL(30 per 30 days) |
| JENTADUETO 2.5-1,000 MG, 2.5-500 MG, 2.5-850 MG TABLET **MO** | 3 | QL(60 per 30 days) |
| JENTADUETO XR 2.5-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC **MO** | 3 | QL(60 per 30 days) |
| JENTADUETO XR 5-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC **MO** | 3 | QL(30 per 30 days) |
| KOMBIGLYZE XR 2.5-1,000 MG TABLET, ER 24 HR., MULTIPHASE **MO** | 4 | QL(60 per 30 days) |
| KOMBIGLYZE XR 5-1,000 MG TABLET, ER 24 HR., MULTIPHASE **MO** | 4 | QL(30 per 30 days) |
| LANTUS SOLOSTAR U-100 INSULIN 100 UNIT/ML (3 ML) INSULIN PEN **MO** | 3 | ISP |
| LANTUS U-100 INSULIN 100 UNIT/ML SOLUTION **MO** | 3 | ISP |
| LEVEMIR FLEXTOUCH U-100 INSULN 100 UNIT/ML (3 ML) INSULIN PEN **MO** | 3 | ISP |
| LEVEMIR U-100 INSULIN 100 UNIT/ML SOLUTION **MO** | 3 | ISP |
| *metformin 1,000 mg, 500 mg TABLET* **GC,MO** | 1 | |

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|---|---|---|
| *metformin 500 mg TABLET, ER 24 HR.* **GC,MO** | 1 | QL(120 per 30 days) |
| NOVOLIN 70-30 FLEXPEN U-100 100 UNIT/ML (70-30) INSULIN PEN **MO** | 3 | ISP |
| NOVOLIN 70/30 U-100 INSULIN 100 UNIT/ML (70-30) SUSPENSION **MO** | 3 | ISP |
| NOVOLIN N FLEXPEN 100 UNIT/ML (3 ML) INSULIN PEN **MO** | 3 | ISP |
| NOVOLIN N NPH U-100 INSULIN 100 UNIT/ML SUSPENSION **MO** | 3 | ISP |
| NOVOLOG FLEXPEN U-100 INSULIN 100 UNIT/ML (3 ML) INSULIN PEN **MO** | 3 | ISP |
| NOVOLOG MIX 70-30 U-100 INSULN 100 UNIT/ML (70-30) SOLUTION **MO** | 3 | ISP |
| NOVOLOG MIX 70-30FLEXPEN U-100 100 UNIT/ML (70-30) INSULIN PEN **MO** | 3 | ISP |
| NOVOLOG PENFILL U-100 INSULIN 100 UNIT/ML CARTRIDGE **MO** | 3 | ISP |
| NOVOLOG U-100 INSULIN ASPART 100 UNIT/ML SOLUTION **MO** | 3 | ISP |
| ONGLYZA 2.5 MG, 5 MG TABLET **MO** | 4 | QL(30 per 30 days) |
| OZEMPIC 0.25 MG OR 0.5 MG(2 MG/1.5 ML) PEN INJECTOR **MO** | 3 | QL(1.5 per 28 days) |
| OZEMPIC 1 MG/DOSE (4 MG/3 ML), 2 MG/DOSE (8 MG/3 ML) PEN INJECTOR **MO** | 3 | QL(3 per 28 days) |
| *pioglitazone 15 mg, 30 mg TABLET* **GC,MO** | 1 | QL(30 per 30 days) |
| RYBELSUS 14 MG, 3 MG, 7 MG TABLET **MO** | 3 | QL(30 per 30 days) |
| SOLIQUA 100/33 100 UNIT-33 MCG/ML INSULIN PEN **MO** | 3 | QL(15 per 24 days),ISP |
| SYNJARDY 12.5-1,000 MG, 12.5-500 MG, 5-1,000 MG, 5-500 MG TABLET **MO** | 3 | QL(60 per 30 days) |
| SYNJARDY XR 10-1,000 MG, 25-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC **MO** | 3 | QL(30 per 30 days) |
| SYNJARDY XR 12.5-1,000 MG, 5-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC **MO** | 3 | QL(60 per 30 days) |
| TOUJEO MAX U-300 SOLOSTAR 300 UNIT/ML (3 ML) INSULIN PEN **MO** | 3 | ISP |
| TOUJEO SOLOSTAR U-300 INSULIN 300 UNIT/ML (1.5 ML) INSULIN PEN **MO** | 3 | ISP |
| TRADJENTA 5 MG TABLET **MO** | 3 | QL(30 per 30 days) |
| TRESIBA FLEXTOUCH U-100 100 UNIT/ML (3 ML) INSULIN PEN **MO** | 3 | ISP |
| TRESIBA U-100 INSULIN 100 UNIT/ML SOLUTION **MO** | 3 | ISP |
| TRIJARDY XR 10-5-1,000 MG, 25-5-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC **MO** | 3 | 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 | 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** | 3 | QL(2 per 28 days) |
| VICTOZA 3-PAK 0.6 MG/0.1 ML (18 MG/3 ML) PEN INJECTOR **MO** | 3 | QL(9 per 30 days) |
| XIGDUO XR 10-1,000 MG, 10-500 MG TABLET, IR/ER 24 HR., BIPHASIC **MO** | 4 | QL(30 per 30 days) |
| XULTOPHY 100/3.6 100 UNIT-3.6 MG /ML (3 ML) INSULIN PEN **MO** | 3 | QL(15 per 30 days),ISP |
| ZEGALOGUE AUTOINJECTOR 0.6 MG/0.6 ML AUTO-INJECTOR **MO** | 3 | |
| ZEGALOGUE SYRINGE 0.6 MG/0.6 ML SYRINGE **MO** | 3 | |

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| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| **Blood Products And Modifiers** | | |
| BRILINTA 60 MG, 90 MG TABLET **MO** | 3 | QL(60 per 30 days) |
| *clopidogrel 75 mg TABLET* **GC,MO** | 1 | QL(30 per 30 days) |
| ELIQUIS 2.5 MG TABLET **MO** | 3 | QL(60 per 30 days) |
| ELIQUIS 5 MG TABLET **MO** | 3 | QL(74 per 30 days) |
| ELIQUIS DVT-PE TREAT 30D START 5 MG (74 TABS) TABLET, DOSE PACK **MO** | 3 | QL(74 per 30 days) |
| NIVESTYM 300 MCG/0.5 ML SYRINGE **DL** | 5 | PA,QL(7 per 30 days) |
| NIVESTYM 300 MCG/ML SOLUTION **DL** | 5 | PA,QL(14 per 30 days) |
| NIVESTYM 480 MCG/0.8 ML SYRINGE **DL** | 5 | PA,QL(11.2 per 30 days) |
| NIVESTYM 480 MCG/1.6 ML SOLUTION **DL** | 5 | PA,QL(22.4 per 30 days) |
| PROCRIT 10,000 UNIT/ML SOLUTION **MO** | 4 | PA,QL(14 per 30 days) |
| RETACRIT 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML, 40,000 UNIT/ML SOLUTION **MO** | 4 | PA,QL(14 per 30 days) |
| UDENYCA 6 MG/0.6 ML SYRINGE **DL** | 5 | PA,QL(1.2 per 28 days) |
| *warfarin 5 mg TABLET* **GC,MO** | 1 | |
| XARELTO 1 MG/ML SUSPENSION FOR RECONSTITUTION **MO** | 3 | ST,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 SYRINGE **DL** | 5 | PA,QL(7 per 30 days) |
| ZARXIO 480 MCG/0.8 ML SYRINGE **DL** | 5 | PA,QL(11.2 per 30 days) |
| **Cardiovascular Agents** | | |
| *amiodarone 200 mg TABLET* **GC,MO** | 2 | |
| *amlodipine 10 mg, 2.5 mg, 5 mg TABLET* **GC,MO** | 1 | |
| *atenolol 25 mg, 50 mg TABLET* **GC,MO** | 1 | |
| *atorvastatin 10 mg, 20 mg, 40 mg, 80 mg TABLET* **GC,MO** | 1 | |
| *bumetanide 1 mg TABLET* **GC,MO** | 2 | |
| *carvedilol 12.5 mg, 25 mg, 3.125 mg, 6.25 mg TABLET* **GC,MO** | 1 | |
| *chlorthalidone 25 mg TABLET* **GC,MO** | 2 | |
| *clonidine hcl 0.1 mg TABLET* **GC,MO** | 1 | |
| CORLANOR 5 MG, 7.5 MG TABLET **MO** | 4 | PA,QL(60 per 30 days) |
| *digoxin 125 mcg (0.125 mg) TABLET* **GC,MO** | 2 | QL(30 per 30 days) |
| *diltiazem hcl 120 mg, 180 mg, 240 mg CAPSULE, ER 24 HR.* **GC,MO** | 2 | QL(60 per 30 days) |
| ENTRESTO 24-26 MG, 49-51 MG, 97-103 MG TABLET **MO** | 3 | QL(60 per 30 days) |
| *ezetimibe 10 mg TABLET* **GC,MO** | 1 | QL(30 per 30 days) |

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| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| *fenofibrate 160 mg TABLET* **GC,MO** | 2 | QL(30 per 30 days) |
| *fenofibrate nanocrystallized 145 mg TABLET* **MO** | 3 | QL(30 per 30 days) |
| *furosemide 20 mg, 40 mg TABLET* **GC,MO** | 1 | |
| *guanfacine 1 mg TABLET* **GC,MO** | 2 | |
| *hydralazine 25 mg, 50 mg TABLET* **GC,MO** | 2 | |
| *hydrochlorothiazide 12.5 mg CAPSULE* **GC,MO** | 1 | |
| *hydrochlorothiazide 12.5 mg, 25 mg TABLET* **GC,MO** | 1 | |
| *irbesartan 300 mg TABLET* **GC,MO** | 1 | QL(30 per 30 days) |
| *isosorbide mononitrate 30 mg, 60 mg TABLET, ER 24 HR.* **GC,MO** | 1 | |
| *lisinopril 10 mg, 2.5 mg, 20 mg, 40 mg, 5 mg TABLET* **GC,MO** | 1 | |
| *lisinopril-hydrochlorothiazide 10-12.5 mg, 20-12.5 mg, 20-25 mg TABLET* **GC,MO** | 1 | |
| *losartan 100 mg, 25 mg, 50 mg TABLET* **GC,MO** | 1 | QL(60 per 30 days) |
| *losartan-hydrochlorothiazide 100-12.5 mg, 100-25 mg, 50-12.5 mg TABLET* **GC,MO** | 1 | QL(60 per 30 days) |
| *lovastatin 20 mg, 40 mg TABLET* **GC,MO** | 1 | |
| *metoprolol succinate 100 mg, 50 mg TABLET, ER 24 HR.* **GC,MO** | 1 | QL(60 per 30 days) |
| *metoprolol succinate 25 mg TABLET, ER 24 HR.* **GC,MO** | 1 | QL(90 per 30 days) |
| *metoprolol tartrate 100 mg, 25 mg, 50 mg TABLET* **GC,MO** | 1 | |
| MULTAQ 400 MG TABLET **MO** | 3 | QL(60 per 30 days) |
| NEXLETOL 180 MG TABLET **MO** | 3 | PA,QL(30 per 30 days) |
| NEXLIZET 180-10 MG TABLET **MO** | 3 | PA,QL(30 per 30 days) |
| *nitroglycerin 0.4 mg SUBLINGUAL TABLET* **MO** | 3 | |
| *olmesartan 40 mg TABLET* **GC,MO** | 1 | QL(30 per 30 days) |
| *pravastatin 10 mg, 20 mg, 40 mg, 80 mg TABLET* **GC,MO** | 1 | |
| REPATHA PUSHTRONEX 420 MG/3.5 ML WEARABLE INJECTOR **MO** | 3 | PA,QL(3.5 per 28 days) |
| REPATHA SURECLICK 140 MG/ML PEN INJECTOR **MO** | 3 | PA,QL(3 per 28 days) |
| REPATHA SYRINGE 140 MG/ML SYRINGE **MO** | 3 | PA,QL(3 per 28 days) |
| *rosuvastatin 10 mg, 20 mg, 40 mg, 5 mg TABLET* **GC,MO** | 1 | |
| *simvastatin 10 mg, 20 mg, 40 mg TABLET* **GC,MO** | 1 | |
| *spironolactone 25 mg, 50 mg TABLET* **GC,MO** | 1 | |
| *torsemide 20 mg TABLET* **GC,MO** | 2 | |
| *triamterene-hydrochlorothiazid 37.5-25 mg TABLET* **GC,MO** | 1 | |
| *valsartan 160 mg TABLET* **GC,MO** | 1 | QL(60 per 30 days) |
| VASCEPA 0.5 GRAM CAPSULE **MO** | 3 | QL(240 per 30 days) |
| VASCEPA 1 GRAM CAPSULE **MO** | 3 | QL(120 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** | 5 | PA,QL(120 per 30 days) |
| AUSTEDO 6 MG TABLET **DL** | 5 | PA,QL(60 per 30 days) |
| BETASERON 0.3 MG KIT **DL** | 5 | PA,QL(15 per 30 days) |
| COPAXONE 20 MG/ML SYRINGE **DL** | 5 | PA,QL(30 per 30 days) |
| GILENYA 0.5 MG CAPSULE **DL** | 5 | PA,QL(30 per 30 days) |
| KESIMPTA PEN 20 MG/0.4 ML PEN INJECTOR **DL** | 5 | PA,QL(1.2 per 28 days) |
| *pregabalin 100 mg, 150 mg, 50 mg, 75 mg CAPSULE* **MO** | 3 | QL(90 per 30 days) |
| SAVELLA 100 MG, 12.5 MG, 25 MG, 50 MG TABLET **MO** | 3 | QL(60 per 30 days) |
| SAVELLA 12.5 MG (5)-25 MG(8)-50 MG(42) TABLET, DOSE PACK **MO** | 3 | QL(55 per 28 days) |
| VUMERITY 231 MG CAPSULE, DR/EC **DL** | 5 | PA,QL(120 per 30 days) |
| **Dental & Oral Agents** | | |
| *chlorhexidine gluconate 0.12 % MOUTHWASH* **GC,MO** | 1 | |
| *triamcinolone acetonide 0.1 % PASTE* **MO** | 3 | |
| **Dermatological Agents** | | |
| ENSTILAR 0.005-0.064 % FOAM **MO** | 4 | QL(120 per 30 days) |
| *erythromycin with ethanol 2 % SOLUTION* **MO** | 4 | QL(120 per 30 days) |
| *mupirocin 2 % OINTMENT* **GC,MO** | 2 | |
| OTEZLA 30 MG TABLET **DL** | 5 | PA,QL(60 per 30 days) |
| OTEZLA STARTER 10 MG (4)-20 MG (4)-30 MG (47) TABLET, DOSE PACK **DL** | 5 | PA,QL(55 per 28 days) |
| REGRANEX 0.01 % GEL **DL** | 5 | PA |
| **Electrolytes/minerals/metals/vitamins** | | |
| *calcium acetate(phosphat bind) 667 mg CAPSULE* **MO** | 3 | |
| ISOLYTE S PH 7.4 PARENTERAL SOLUTION **MO** | 4 | |
| PLASMA-LYTE 148 PARENTERAL SOLUTION **MO** | 4 | |
| PLASMA-LYTE A PARENTERAL SOLUTION **MO** | 4 | |
| *potassium chloride 10 meq CAPSULE, ER* **GC,MO** | 2 | |
| *potassium chloride 10 meq, 20 meq TABLET ER* **GC,MO** | 2 | |
| *potassium chloride 10 meq, 20 meq TABLET, ER PARTICLES/CRYSTALS* **GC,MO** | 2 | |
| VELTASSA 16.8 GRAM, 25.2 GRAM, 8.4 GRAM POWDER IN PACKET **MO** | 3 | QL(30 per 30 days) |
| **Gastrointestinal Agents** | | |
| CLENPIQ 10 MG-3.5 GRAM -12 GRAM/160 ML SOLUTION **MO** | 3 | |
| *dicyclomine 10 mg CAPSULE* **GC,MO** | 2 | |
| *dicyclomine 20 mg TABLET* **GC,MO** | 2 | |
| *esomeprazole magnesium 40 mg CAPSULE, DR/EC* **MO** | 3 | QL(60 per 30 days) |
| *famotidine 20 mg, 40 mg TABLET* **GC,MO** | 2 | |

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| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| *lactulose 10 gram/15 ml SOLUTION* **GC,MO** | 2 | |
| LINZESS 145 MCG, 290 MCG, 72 MCG CAPSULE **MO** | 3 | QL(30 per 30 days) |
| *misoprostol 200 mcg TABLET* **MO** | 3 | |
| MOVANTIK 12.5 MG, 25 MG TABLET **MO** | 3 | QL(30 per 30 days) |
| *omeprazole 20 mg, 40 mg CAPSULE, DR/EC* **GC,MO** | 1 | QL(60 per 30 days) |
| *pantoprazole 20 mg, 40 mg TABLET, DR/EC* **GC,MO** | 1 | QL(60 per 30 days) |
| PYLERA 140-125-125 MG CAPSULE **MO** | 4 | QL(120 per 30 days) |
| *sucralfate 1 gram TABLET* **GC,MO** | 2 | |
| XIFAXAN 200 MG TABLET **DL** | 5 | PA,QL(9 per 30 days) |
| XIFAXAN 550 MG TABLET **DL** | 5 | PA,QL(84 per 28 days) |
| **Genetic/enzyme/protein Disorder: Replacement, Modifiers, Treatment** | | |
| CERDELGA 84 MG CAPSULE **DL** | 5 | PA |
| CREON 24,000-76,000 -120,000 UNIT CAPSULE, DR/EC **MO** | 3 | |
| PROLASTIN-C 1,000 MG RECON SOLUTION **DL** | 5 | PA |
| ZENPEP 25,000-79,000- 105,000 UNIT CAPSULE, DR/EC **MO** | 4 | |
| **Genitourinary Agents** | | |
| *finasteride 5 mg TABLET* **GC,MO** | 1 | QL(30 per 30 days) |
| GEMTESA 75 MG TABLET **MO** | 4 | QL(30 per 30 days) |
| MYRBETRIQ 25 MG, 50 MG TABLET, ER 24 HR. **MO** | 3 | QL(30 per 30 days) |
| MYRBETRIQ 8 MG/ML SUSPENSION, ER, RECON **MO** | 3 | QL(300 per 30 days) |
| *oxybutynin chloride 10 mg, 5 mg TABLET, ER 24 HR.* **GC,MO** | 2 | QL(60 per 30 days) |
| *oxybutynin chloride 5 mg TABLET* **GC,MO** | 2 | |
| *tamsulosin 0.4 mg CAPSULE* **GC,MO** | 2 | |
| **Hormonal Agents, Stimulant/replacement/modifying (adrenal)** | | |
| *methylprednisolone 4 mg TABLET, DOSE PACK* **GC,MO** | 2 | |
| *prednisone 10 mg, 20 mg, 5 mg TABLET* **GC,MO** | 1 | BvsD |
| *triamcinolone acetonide 0.1 % CREAM* **GC,MO** | 2 | |
| **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** | 5 | PA |
| OMNITROPE 5.8 MG RECON SOLUTION **DL** | 5 | PA |
| **Hormonal Agents, Stimulant/replacement/modifying (sex Hormones/modifiers)** | | |
| DUAVEE 0.45-20 MG TABLET **MO** | 4 | PA,QL(30 per 30 days) |
| OSPHENA 60 MG TABLET **MO** | 3 | PA |
| PREMARIN 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG TABLET **MO** | 4 | |
| PREMARIN 0.625 MG/GRAM CREAM **MO** | 3 | |

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| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| **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* **GC,MO** | 1 | |
| *liothyronine 25 mcg, 5 mcg, 50 mcg TABLET* **MO** | 3 | |
| **Hormonal Agents, Suppressant (pituitary)** | | |
| LUPRON DEPOT-PED 11.25 MG KIT **DL** | 5 | PA,QL(1 per 28 days) |
| ORGOVYX 120 MG TABLET **DL** | 5 | PA,QL(32 per 30 days) |
| **Immunological Agents** | | |
| COSENTYX 75 MG/0.5 ML SYRINGE **DL** | 5 | PA,QL(2 per 28 days) |
| COSENTYX (2 SYRINGES) 150 MG/ML SYRINGE **DL** | 5 | PA,QL(8 per 28 days) |
| COSENTYX PEN (2 PENS) 150 MG/ML PEN INJECTOR **DL** | 5 | PA,QL(8 per 28 days) |
| DUPIXENT PEN 200 MG/1.14 ML PEN INJECTOR **DL** | 5 | PA,QL(3.42 per 28 days) |
| DUPIXENT PEN 300 MG/2 ML PEN INJECTOR **DL** | 5 | PA,QL(8 per 28 days) |
| DUPIXENT SYRINGE 100 MG/0.67 ML SYRINGE **DL** | 5 | PA,QL(1.34 per 28 days) |
| DUPIXENT SYRINGE 200 MG/1.14 ML SYRINGE **DL** | 5 | PA,QL(3.42 per 28 days) |
| DUPIXENT SYRINGE 300 MG/2 ML SYRINGE **DL** | 5 | PA,QL(8 per 28 days) |
| ENBREL 25 MG (1 ML) RECON SOLUTION **DL** | 5 | PA,QL(8 per 28 days) |
| ENBREL 25 MG/0.5 ML (0.5), 50 MG/ML (1 ML) SYRINGE **DL** | 5 | PA,QL(8 per 28 days) |
| ENBREL 25 MG/0.5 ML SOLUTION **DL** | 5 | PA,QL(8 per 28 days) |
| ENBREL MINI 50 MG/ML (1 ML) CARTRIDGE **DL** | 5 | PA,QL(8 per 28 days) |
| ENBREL SURECLICK 50 MG/ML (1 ML) PEN INJECTOR **DL** | 5 | PA,QL(8 per 28 days) |
| ENVARSUS XR 0.75 MG, 1 MG TABLET, ER 24 HR. **MO** | 4 | PA |
| GAMUNEX-C 1 GRAM/10 ML (10 %) SOLUTION **DL** | 5 | PA |
| HUMIRA 40 MG/0.8 ML SYRINGE KIT **DL** | 5 | PA,QL(6 per 28 days) |
| HUMIRA PEN 40 MG/0.8 ML PEN INJECTOR KIT **DL** | 5 | PA,QL(6 per 28 days) |
| HUMIRA PEN CROHNS-UC-HS START 40 MG/0.8 ML PEN INJECTOR KIT **DL** | 5 | PA,QL(6 per 28 days) |
| HUMIRA PEN PSOR-UVEITS-ADOL HS 40 MG/0.8 ML PEN INJECTOR KIT **DL** | 5 | PA,QL(6 per 28 days) |
| HUMIRA(CF) 10 MG/0.1 ML SYRINGE KIT **DL** | 5 | PA,QL(2 per 28 days) |
| HUMIRA(CF) 20 MG/0.2 ML, 40 MG/0.4 ML SYRINGE KIT **DL** | 5 | PA,QL(6 per 28 days) |
| HUMIRA(CF) PEDI CROHNS STARTER 80 MG/0.8 ML, 80 MG/0.8 ML-40 MG/0.4 ML SYRINGE KIT **DL** | 5 | PA,QL(6 per 28 days) |
| HUMIRA(CF) PEN 40 MG/0.4 ML, 80 MG/0.8 ML PEN INJECTOR KIT **DL** | 5 | PA,QL(6 per 28 days) |
| HUMIRA(CF) PEN CROHNS-UC-HS 80 MG/0.8 ML PEN INJECTOR KIT **DL** | 5 | PA,QL(6 per 28 days) |
| HUMIRA(CF) PEN PEDIATRIC UC 80 MG/0.8 ML PEN INJECTOR KIT **DL** | 5 | 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** | 5 | PA,QL(6 per 28 days) |

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|---|---|---|
| KEVZARA 150 MG/1.14 ML, 200 MG/1.14 ML PEN INJECTOR **DL** | 5 | PA,QL(2.28 per 28 days) |
| KEVZARA 150 MG/1.14 ML, 200 MG/1.14 ML SYRINGE **DL** | 5 | PA,QL(2.28 per 28 days) |
| *methotrexate sodium 2.5 mg TABLET* **GC,MO** | 2 | BvsD |
| RINVOQ 15 MG, 30 MG TABLET, ER 24 HR. **DL** | 5 | PA,QL(30 per 30 days) |
| RINVOQ 45 MG TABLET, ER 24 HR. **DL** | 5 | PA,QL(56 per 365 days) |
| SHINGRIX (PF) 50 MCG/0.5 ML SUSPENSION FOR RECONSTITUTION **DL,GC** | 1 | |
| SKYRIZI 150 MG/ML PEN INJECTOR | 5 | PA,QL(6 per 365 days) |
| SKYRIZI 150 MG/ML SYRINGE | 5 | PA,QL(6 per 365 days) |
| SKYRIZI 150MG/1.66ML(75 MG/0.83 ML X2) SYRINGE KIT | 5 | PA,QL(6 per 365 days) |
| STELARA 45 MG/0.5 ML SOLUTION **DL** | 5 | PA,QL(1.5 per 84 days) |
| STELARA 45 MG/0.5 ML SYRINGE **DL** | 5 | PA,QL(1.5 per 84 days) |
| STELARA 90 MG/ML SYRINGE **DL** | 5 | PA,QL(3 per 84 days) |
| TDVAX 2-2 LF UNIT/0.5 ML SUSPENSION **DL,GC** | 1 | |
| **Metabolic Bone Disease Agents** | | |
| *alendronate 70 mg TABLET* **GC,MO** | 1 | QL(4 per 28 days) |
| FORTEO 20 MCG/DOSE (600MCG/2.4ML) PEN INJECTOR **DL** | 5 | PA,QL(2.4 per 28 days) |
| PROLIA 60 MG/ML SYRINGE **MO** | 4 | QL(1 per 180 days) |
| RAYALDEE 30 MCG CAPSULE, ER 24 HR. **DL** | 5 | QL(60 per 30 days) |
| TYMLOS 80 MCG (3,120 MCG/1.56 ML) PEN INJECTOR **DL** | 5 | PA,QL(1.56 per 30 days) |
| **Miscellaneous Therapeutic Agents** | | |
| BD ALCOHOL SWABS PADS, MEDICATED **GC,MO** | 1 | |
| *butalbital-acetaminophen-caff 50-325-40 mg TABLET* **GC,MO** | 2 | QL(180 per 30 days) |
| RECTIV 0.4 % (W/W) OINTMENT **MO** | 4 | QL(30 per 30 days) |
| **Ophthalmic Agents** | | |
| ALPHAGAN P 0.1 % DROPS **MO** | 3 | |
| *azelastine 0.05 % DROPS* **MO** | 3 | |
| *brimonidine 0.2 % DROPS* **GC,MO** | 1 | |
| COMBIGAN 0.2-0.5 % DROPS **MO** | 3 | QL(5 per 25 days) |
| *dorzolamide-timolol 22.3-6.8 mg/ml DROPS* **GC,MO** | 1 | |
| DUREZOL 0.05 % DROPS **MO** | 3 | |
| *erythromycin 5 mg/gram (0.5 %) OINTMENT* **GC,MO** | 2 | QL(3.5 per 28 days) |
| EYSUVIS 0.25 % DROPS, SUSPENSION **MO** | 3 | QL(16.6 per 30 days) |
| ILEVRO 0.3 % DROPS, SUSPENSION **MO** | 3 | QL(3 per 30 days) |
| *ketorolac 0.5 % DROPS* **GC,MO** | 2 | QL(10 per 30 days) |
| *latanoprost 0.005 % DROPS* **GC,MO** | 1 | QL(5 per 25 days) |
| *levobunolol 0.5 % DROPS* **GC,MO** | 1 | |

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|---|---|---|
| LOTEMAX SM 0.38 % DROPS, GEL **MO** | 4 | |
| LUMIGAN 0.01 % DROPS **MO** | 3 | QL(2.5 per 25 days) |
| *moxifloxacin 0.5 % DROPS* **MO** | 3 | |
| *prednisolone acetate 1 % DROPS, SUSPENSION* **MO** | 3 | |
| RESTASIS 0.05 % DROPPERETTE **MO** | 3 | QL(60 per 30 days) |
| RESTASIS MULTIDOSE 0.05 % DROPS **MO** | 3 | QL(5.5 per 25 days) |
| RHOPRESSA 0.02 % DROPS **MO** | 3 | ST,QL(2.5 per 25 days) |
| ROCKLATAN 0.02-0.005 % DROPS **MO** | 3 | ST,QL(2.5 per 25 days) |
| *timolol maleate 0.5 % DROPS* **GC,MO** | 1 | |
| VYZULTA 0.024 % DROPS **MO** | 4 | QL(5 per 30 days) |
| ZERVIATE 0.24 % DROPPERETTE **MO** | 4 | QL(60 per 30 days) |
| **Respiratory Tract/pulmonary Agents** | | |
| ADEMPAS 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG TABLET **DL,LA** | 5 | PA,QL(90 per 30 days) |
| ADVAIR DISKUS 100-50 MCG/DOSE, 250-50 MCG/DOSE, 500-50 MCG/DOSE BLISTER WITH DEVICE **MO** | 3 | QL(60 per 30 days) |
| ADVAIR HFA 115-21 MCG/ACTUATION, 230-21 MCG/ACTUATION, 45-21 MCG/ACTUATION HFA AEROSOL INHALER **MO** | 3 | QL(12 per 30 days) |
| *albuterol sulfate 90 mcg/actuation HFA AEROSOL INHALER* **MO** | 3 | QL(36 per 30 days) |
| ARNUITY ELLIPTA 100 MCG/ACTUATION, 200 MCG/ACTUATION, 50 MCG/ACTUATION BLISTER WITH DEVICE **MO** | 3 | QL(30 per 30 days) |
| *azelastine 137 mcg (0.1 %) AEROSOL SPRAY* **MO** | 3 | QL(30 per 25 days) |
| BEVESPI AEROSPHERE 9-4.8 MCG HFA AEROSOL INHALER **MO** | 4 | QL(10.7 per 30 days) |
| BREO ELLIPTA 100-25 MCG/DOSE, 200-25 MCG/DOSE BLISTER WITH DEVICE **MO** | 3 | QL(60 per 30 days) |
| BREZTRI AEROSPHERE 160-9-4.8 MCG/ACTUATION HFA AEROSOL INHALER **MO** | 3 | QL(10.7 per 30 days) |
| COMBIVENT RESPIMAT 20-100 MCG/ACTUATION MIST **MO** | 4 | QL(4 per 20 days) |
| FASENRA PEN 30 MG/ML AUTO-INJECTOR **DL** | 5 | PA,QL(1 per 28 days) |
| FLOVENT DISKUS 250 MCG/ACTUATION, 50 MCG/ACTUATION BLISTER WITH DEVICE **MO** | 3 | QL(60 per 30 days) |
| FLOVENT HFA 220 MCG/ACTUATION HFA AEROSOL INHALER **MO** | 3 | QL(24 per 30 days) |
| FLOVENT HFA 44 MCG/ACTUATION HFA AEROSOL INHALER **MO** | 3 | QL(10.6 per 30 days) |
| *fluticasone propion-salmeterol 250-50 mcg/dose BLISTER WITH DEVICE* **MO** | 3 | QL(60 per 30 days) |
| *fluticasone propionate 50 mcg/actuation SPRAY, SUSPENSION* **GC,MO** | 2 | QL(16 per 30 days) |
| *hydroxyzine pamoate 25 mg CAPSULE* **MO** | 3 | |
| *levocetirizine 5 mg TABLET* **GC,MO** | 1 | QL(30 per 30 days) |
| *montelukast 10 mg TABLET* **GC,MO** | 1 | QL(30 per 30 days) |

Need more information about the indicators displayed by the drug names? Please go to page 11. Need more information about the utilization management requirements? Please go to page 6.

B vs D - Part B vs Part D • MO – Mail Order • PA - Prior Authorization • QL - Quantity Limit • ST - Step Therapy • DL – Dispensing Limit • GC- Gap Coverage • ISP – Insulin Savings Program • LA – Limited Access

| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| NUCALA 100 MG/ML AUTO-INJECTOR **DL** | 5 | PA,QL(3 per 28 days) |
| NUCALA 100 MG/ML SYRINGE **DL** | 5 | PA,QL(3 per 28 days) |
| OFEV 100 MG, 150 MG CAPSULE **DL,LA** | 5 | PA,QL(60 per 30 days) |
| OPSUMIT 10 MG TABLET **DL,LA** | 5 | PA,QL(30 per 30 days) |
| SPIRIVA RESPIMAT 1.25 MCG/ACTUATION, 2.5 MCG/ACTUATION MIST **MO** | 3 | QL(4 per 28 days) |
| SPIRIVA WITH HANDIHALER 18 MCG CAPSULE, W/INHALATION DEVICE **MO** | 3 | QL(30 per 30 days) |
| STIOLTO RESPIMAT 2.5-2.5 MCG/ACTUATION MIST **MO** | 3 | QL(4 per 28 days) |
| STRIVERDI RESPIMAT 2.5 MCG/ACTUATION MIST **MO** | 3 | QL(4 per 30 days) |
| SYMBICORT 160-4.5 MCG/ACTUATION, 80-4.5 MCG/ACTUATION HFA AEROSOL INHALER **MO** | 3 | QL(10.2 per 30 days) |
| TRELEGY ELLIPTA 100-62.5-25 MCG, 200-62.5-25 MCG BLISTER WITH DEVICE **MO** | 3 | QL(60 per 30 days) |
| VENTOLIN HFA 90 MCG/ACTUATION HFA AEROSOL INHALER **MO** | 3 | QL(36 per 30 days) |
| *zafirlukast 20 mg TABLET* **MO** | 4 | QL(60 per 30 days) |
| **Skeletal Muscle Relaxants** | | |
| *cyclobenzaprine 10 mg, 5 mg TABLET* **GC,MO** | 2 | |
| *methocarbamol 500 mg, 750 mg TABLET* **GC,MO** | 2 | |
| **Sleep Disorder Agents** | | |
| BELSOMRA 10 MG TABLET **MO** | 3 | QL(60 per 30 days) |
| BELSOMRA 15 MG, 20 MG TABLET **MO** | 3 | QL(30 per 30 days) |
| BELSOMRA 5 MG TABLET **MO** | 3 | QL(120 per 30 days) |
| *temazepam 15 mg, 30 mg CAPSULE* **DL** | 4 | QL(30 per 30 days) |
| *zolpidem 10 mg, 5 mg TABLET* **GC,MO** | 2 | QL(30 per 30 days) |

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| Humana Coverage of Additional Prescription Drugs<br>DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| **Erectile Dysfunction** | | |
| *sildenafil 100 mg, 25 mg, 50 mg TABLET* | 1 | QL(6 per 30 days) |
| **Weight Loss** | | |
| CONTRAVE 8-90 MG TABLET ER | 2 | PA,QL(120 per 30 days) |

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

B vs D - Part B vs Part D • MO – Mail Order • PA - Prior Authorization • QL - Quantity Limit • ST - Step Therapy • DL – Dispensing Limit • GC- Gap Coverage • ISP – Insulin Savings Program • LA – Limited Access

# Index

**W**



**X**



**Z**

# Important!

## At Humana, it is important you are treated fairly.

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

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

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

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

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

# Multi-Language Insert

Multi-language Interpreter Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# Notes

# Notes

# Notes

This abridged formulary was updated on 10/12/2022 and is not a complete list of drugs covered by our plan. For a complete listing, or other questions, please contact Humana with any questions at 1-800-457-4708 or, for TTY users, 711, five days a week April 1 – September 30 or seven days a week October 1– March 31 from 8 a.m. - 8 p.m. 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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H0028-014, 019, 024, 025, 029, 030, 046, 052, 053, 054; H2463-003; H4141-015, 017; H4623-001, 002; H5619-111, 152; H6622-032, 033

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# Your plan gives you $200 or more towards your cold medicine, vitamins and more

## Your over-the-counter allowance helps you care for your health

**Get an allowance to spend on approved over-the-counter items. These include:**

- Hormone replacement
- Weight loss items
- Fiber supplements
- First aid supplies
- Incontinence supplies
- Medicines
- Ointments and sprays with active medical ingredients that alleviate symptoms
- Topical sunscreen
- Supportive items for comfort
- Mouth care
- Minerals and vitamins

The over-the-counter allowance makes the things you need to support your health more affordable. Check your Summary of Benefits for your dollar amount, distribution timing and rollover options.

### Use your allowance—and save

Your allowance will be loaded onto your Humana Spending Account Card. You can use it to buy many over-the-counter items at participating retail locations throughout the year. You'll receive more information about participating locations when your card arrives in the mail.

**New for 2023**

### One card for all your plan allowances

Your over-the-counter allowance will automatically be loaded to your new Humana Spending Account Card, so you only have one card to keep track of for allowances included in your plan.


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# Important!

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

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

Humana is a Medicare Advantage HMO, HMO SNP, PPO, PPO SNP and PFFS organization with a Medicare contract. Humana is also a Coordinated Care plan with a Medicare contract and a contract with the state Medicaid program. Enrollment in any Humana plan depends on contract renewal. Allowance amounts cannot be combined. Limitations and restrictions may apply.

# Care and communication on your terms

Your privacy and well-being are important to us. There may be times when you want a family member or friend to talk to Humana on your behalf.

To make that possible, you must first complete a consent for release of protected health information form. This form will allow you to choose a trusted individual who can have access to your protected health information. We would consider this person to be your family or friend caregiver.

This is not a power of attorney (POA). To have someone help you enroll or to request account changes or updates, you must submit a POA or other authorization under state law to allow them to act on your behalf. You can submit POA and PHI consent forms together.

**If you complete the PHI form and grant authorization to someone, we will consider that individual your caregiver who can:**

- Speak to Humana on your behalf about the plan—but may not make or request any account changes or updates (unless they are your POA or have other legal authorization from the state to act on your behalf)
- Keep track of your benefits and claims
- Get answers to healthcare coverage questions
- Receive helpful information and advice on caregiving from Humana

**How to get started***

You have three options for completing and submitting your consent form.

1. If you have a MyHumana account or plan to create one after enrolling, you can complete a consent form online from the “Accounts & Settings” page.
2. Your agent can utilize one of our sales systems to help you complete a consent form electronically as part of your enrollment.
3. Complete the paper form included with this packet (after you have submitted your application and received your Humana member ID card).

You don’t need to use this consent form to authorize an individual if you are also submitting a POA or other legal authorization for the same individual.

* If you have previously submitted a consent form for this individual, you do not need to submit again at this time. We will notify you if your consent is due to expire.

Humana.

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# Consent for release of protected health information

**Member information** (person whose information will be released):

Name: _____ Date of birth: ____ / ____ / ____
First Middle Last Month Day Year

Address: _____
Street City State ZIP

Member ID: _____ Group # (if applicable): _____ Phone #: _____
❑ Home ❑ Cell*

**I understand that this authorization will allow Humana and its affiliates to use or disclose the protected health† information (PHI) described below:** (Please check only **one** box)

❑ Full Disclosure: Any protected health information Humana and its affiliates maintains, including mental health, HIV, health status or substance use or disorder records. This also includes sharing information on mail-order pharmacy, wellness products, and health programs with the person being authorized.

❑ Limited Disclosure: You specify what PHI to share, e.g., condition or treatment information, a specific date range, or product type. Unless you limit by product type, information will apply to all products and services. _____

If Limited Disclosure was selected please indicate which product(s) apply:

❑ **Medical and/or prescription coverage** ❑ **Vision** ❑ **Dental** ❑ **Centerwell Pharmacy™ (mail delivery)** ❑ **Go365®**

This information may be disclosed to, and used by, the following person or organization (such as nursing home, care provider, and care managers) to assist me with the Humana-owned products or services for which I am providing consent to disclose information:

Name: _____ Date of birth: ____ / ____ / ____
First Middle Last *Required Field* Month Day Year

Or if organization: _____
Name

Address: _____
Street City State ZIP

Email: _____ Phone #: _____
❑ Home ❑ Cell*

Relationship: ❑ Spouse ❑ Sibling ❑ Parent ❑ Child ❑ Agent/Broker ❑ Friend ❑ Organization

I understand:

- I am not required to fill out this consent and Humana cannot base decisions regarding treatment, payment, enrollment or eligibility for benefits on whether I submit it.
- Disclosures may include information from past, present, and/or future treating providers.
- This consent is valid until I cancel my Humana membership. For customers in the following states—CA, CT, GA, IL, MA, MD, MT, NC, NJ, NV, OH, OR, PR, VA—consents will expire in compliance with applicable state laws.‡ I can cancel my consent at any time through my MyHumana account, by calling customer service, or by submitting a written notice to Humana.
- If I cancel consent, it will not apply to any information previously released with this authorization. Once information is shared, Humana cannot prevent the person or organization who has access to it from sharing that information with others, and this information may not be protected by federal privacy regulations.

Member or Legal Representative signature _____ Date: ____ / ____ / ____

❑ Member ❑ Legal Representative

**Please note: Legal representatives must attach copies of authorization as required by law. Examples include healthcare power of attorney, healthcare surrogate, living will or guardianship papers.**

After you complete and sign the form, please fax it to **800-633-8188.** Or, if you prefer, mail your completed form to: **Humana Insurance Company, P.O. Box 14168, Lexington, KY 40512-4168**

Humana.

* By giving your cell phone number, you give Humana permission to make calls to your cell.
† Health includes Medical, Dental, Pharmacy, Behavioral Health, Vision, Long-Term Care.
‡ Expires in 12 months: CA, CT, GA, IL, MA, MD, NC, NJ, NV, OH, OR
Expires in 24 months: MT, VA & Puerto Rico



Humana will follow the more stringent of all federal and state laws and regulations.

For Humana Use Only

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- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.
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## Auxiliary aids and services, free of charge, are available to you. 877-320-1235 (TTY: 711)

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

# Scope of Sales Appointment Form

It's important for you to understand the type of products that you can choose to discuss before your appointment with a licensed Humana sales agent. The Centers for Medicare & Medicaid Services requires sales agents to document the scope of any personal/individual marketing appointment beforehand. All information provided on this form is confidential, and a separate form should be completed by each beneficiary or his/her legally authorized representative. We look forward to speaking with you.

## Stand-alone Medicare prescription drug plans (Part D)

**Medicare prescription drug plan (PDP) –**
A stand-alone drug plan that adds prescription drug coverage to Original Medicare and some other Medicare plans.

## Medicare Advantage plans (Part C)

A Medicare Advantage plan that provides all Original Medicare Part A and Part B health coverage and sometimes offers Part D prescription drug coverage and other additional benefits. There are different types of MA plans, such as:

**Health maintenance organization (HMO) plan –**
A Medicare Advantage plan that typically requires you to see only in-network providers and get referrals from a primary care doctor.

**Preferred provider organization (PPO) plan –**
A Medicare Advantage plan where in most cases you pay less if you use in-network doctors, and referrals from a primary care doctor are not required.

**Private fee-for-service (PFFS) plan –**
A Medicare Advantage plan in which you may go to any Medicare-approved doctor, hospital and provider that accepts the plan's payment, terms and conditions and agrees to treat you—not all providers will.

**Special Needs Plan (SNP) –** A Medicare Advantage plan that has a benefits package designed for people with special healthcare needs. Examples of groups served include people who have both Medicare and Medicaid, reside in nursing homes, and/or have certain chronic medical conditions.

## Medicare Supplement

Medicare Supplement plans are standardized plans that can be bought with varying coverage options to help supplement your Original Medicare plan. Medicare Supplement plans have no provider networks and help pay some of the costs that Original Medicare does not pay. Medicare supplement plans cannot be held with a Medicare Advantage plan, as they must be separate and distinct.

## Dental

Dental plans are available at varying levels of coverage at in-network and out-of-network providers.

## Vision

Vision plans are available at varying levels of coverage at in-network and out-of-network providers.

## Hospital indemnity

Hospital indemnity plans cover some of the costs associated with hospital stays that may not be covered by a primary health plan.

The licensed sales agent who will discuss the products with you is either employed or contracted by a Medicare plan. They do not work for the federal government. This licensed sales agent may also be paid based on your enrollment in a plan.

Signing this form does NOT obligate you to enroll in a plan, affect your current or future enrollment status, or automatically enroll you in a Medicare plan.

Humana.

# Scope of Sales Appointment

**In the space provided below, please initial next to the type of health product(s) you want the licensed sales agent to discuss.**

- ☐ Medicare Advantage plans (Part C)
- ☐ Stand-alone prescription drug plans (Part D)
- ☐ Medicare Supplement plans
- ☐ Dental plans
- ☐ Vision plans
- ☐ Hospital indemnity
- ☐ Other health products

_____

Name _____ Phone _____

Address (street, city, state, ZIP code) _____ Relationship to the beneficiary _____

_____ Medicare ID number (optional) _____

**By signing the form, you agree to a meeting with a licensed sales agent to discuss the types of products you initialed above. Signing this form does NOT obligate you to enroll in a plan, affect your current or future enrollment status, or automatically enroll you in a Medicare plan.**

Beneficiary or legally authorized representative signature and signature date**:**

Signature _____ Signature date _____/_____/_____

**To be completed by agent:** (Please print)

Agent name _____

Agent phone _____

Agent SAN _____

**Agent please mail this form to:**

MarketPoint
P.O. Box 14637
Lexington, KY 40512-4637
Or fax to: 877-889-9936

Agent signature _____ Agent signature date _____/_____/_____

Appointment date _____/_____/_____ Plan(s) the agent represented _____

Application No. – paper barcode, EHUB ID, Fast APP ID or recording ID _____

Date appointment completed _____/_____/_____

# Important

## At Humana, it is important you are treated fairly.

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

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
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### Multi-Language Insert

Multi-language Interpreter Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# 2023
# Enrollment Form

## Follow these easy steps to become a Humana Medicare member

### Have your Medicare card ready

Each individual applying must fill out a separate form.

### Sign and date the enrollment form

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

### Submit your enrollment form

You may fax the Member Services pages of this enrollment form to: **1-877-889-9936**. Or mail this enrollment form to:

Humana Medicare Enrollment
P.O. Box 14309
Lexington, KY
40512-4309

Please don't send in the same enrollment form or apply to the same plan more than once.

### Call us with questions

If you have questions, please call a licensed Humana sales agent at **1-800-833-2367 (TTY: 711)**. We're available seven days a week, 8 a.m. – 8 p.m.

However, please note that our automated phone system may answer your call on holidays and during weekends April 1 – September 30. Please leave your name and telephone number, and we'll call you back by the end of the next business day.

### Electronic enrollment options

Have you considered enrolling online at **Humana.com/Medicare** instead? It's a fast, secure and easy way to apply.

## Instructions

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

**Correct numbers and letters**


Humana®

# Additional Notes

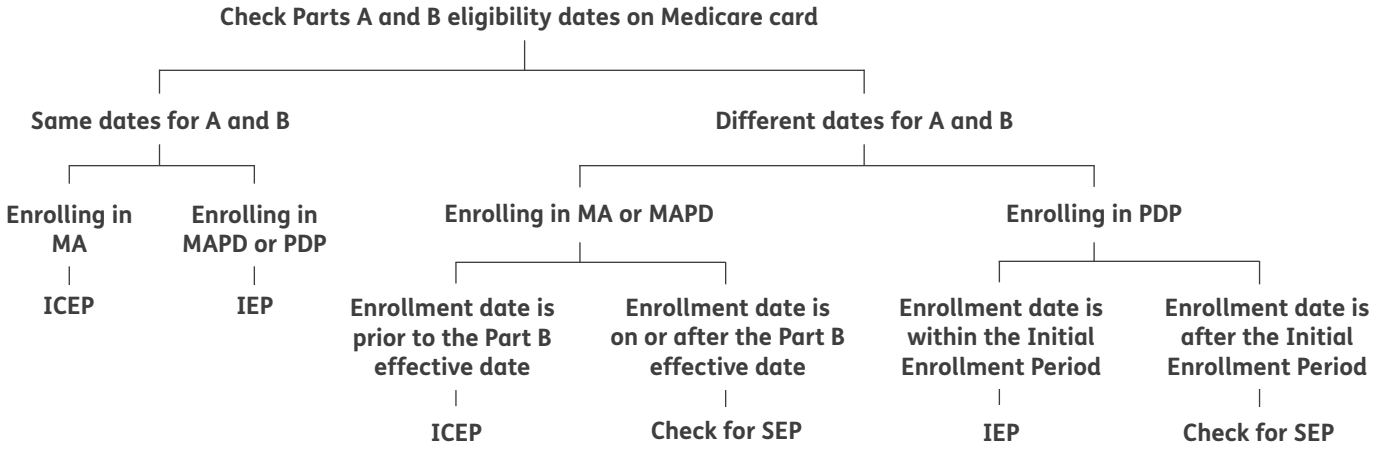
**Asterisks (*) indicate required fields**
Answering non-required fields is your choice. You can't be denied coverage if you don't complete them.

## Initial Enrollment Period (IEP) and Initial Coverage Election Period (ICEP)

- If Part A and Part B dates are the same, the election period spans 7 months: 3 months prior to the month you become eligible, the month you become eligible, and 3 months after the month you became eligible.
- If Part A and Part B dates are different, the election period spans 3 months: 3 months prior to the month of the later effective date (often Part B), only for enrollment into a Medicare Advantage (MA)-only plan or a Medicare Advantage prescription drug (MAPD) plan. If enrollment is for a prescription drug plan (PDP), check to see if the 7-month IEP may still be available.
- The coverage start date is based on factors such as Medicare entitlement and the submission of the completed enrollment form.

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

Enrollment periods may overlap. Ensure you mark any Special Election Period (SEP) oval that applies to you from the list of SEP statements on page 4 of the enrollment form. When enrolling specifically during an SEP, one of the SEP statements must be true to be eligible for an SEP. Agents, please refer to the Enrollment Options Job Aid (DMS-024) found in Humana MarketPoint University in Vantage if you do not see the SEP listed on page 4, or contact the Agent Support Unit for assistance.




## Scope Of Appointment (SOA) (Page 8)

Agents, please use one of the three-letter codes below for the appointment type field. Note: An SOA is not required for SEM—Seminar or GCS—Neighborhood Center Seminar. An SOA is also not required for enrollment forms taken at an informal event such as reported retail store hours e.g., Walmart.

F2F – Face to Face
GCS – Neighborhood Center Seminar
GCW – Neighborhood Center Walk-in
INH – In Home Appointment
OTH – Other
RET – Retail Partner
SEM – Seminar
WAL – Walmart
TEL – Telephonic

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

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

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

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

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

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

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

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

## PLEASE READ THIS IMPORTANT INFORMATION

**If you currently have health coverage from an employer or union, joining Humana could affect your employer or union healthcare benefits.** You could lose your employer or union health coverage if you join Humana.

**By completing this enrollment form, I agree to the following:**
If I am enrolling in a Medicare Advantage health plan that has a contract with the federal government, I will need to keep my Medicare Parts A and B to stay in the plan. I must continue to pay my Medicare Part B premium. If I am enrolling in a Medicare prescription drug plan, I will need to keep my Medicare Parts A or B coverage. It is my responsibility to inform Humana of any prescription drug coverage that I have or may get in the future. **I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.** With few exceptions, I can only be in one Medicare Advantage health plan or Medicare prescription drug plan at a time. I understand that my enrollment in my selected plan may end my enrollment in another Medicare Advantage health plan or prescription drug plan. Enrollment in my selected plan is generally for the entire year.

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

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

Once Humana has received my enrollment form, I may get a verification letter to make sure that I understand how my plan works and to confirm my intent to enroll. This is not a secondary plan to Medicare Parts A and B. Humana pays instead of Medicare, and I will be responsible for the amounts that Humana doesn't cover, such as copayments and coinsurances. Medicare Parts A and B won't pay for my healthcare while I am enrolled in Humana.

- If you are requesting membership in a **Private Fee For Service (PFFS)** plan, the following statement applies: I understand that this plan is a Medicare Advantage PFFS plan which may have prescription drug coverage built in. Before seeing a provider, I should verify that the provider will accept this plan before each visit. My doctor or hospital isn't required to agree to accept the plan's terms and conditions, and thus may choose not to treat me, except for emergencies. I understand that my healthcare providers have the right to choose whether to accept a PFFS plan's payment terms and conditions every time I see them. I understand that if my provider decides not to accept PFFS, I will need to find another provider that will. I understand that if my PFFS plan doesn't offer Medicare prescription drug coverage, I may obtain coverage from another Medicare prescription drug plan.
- If you are requesting membership in a **Chronic Condition Special Needs Plan (C-SNP)**, the following statement applies: I understand this plan is a chronic condition special needs plan. My ability to enroll is based on physician verification that I have the qualifying medical condition(s).
- If you are requesting membership in an **Institutional Special Needs Plan (I-SNP)**, the following statement applies: I understand this plan is an institutional special needs plan. My ability to enroll is based on verification that my condition makes it likely that either the length of stay or the need for an institutional level of care would be at least 90 days; or, I reside in the community and meet state requirements for institutional level of care.

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

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

**Release of Information:**

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

**Privacy Act Statement:**

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

**Individuals experiencing homelessness:**

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

# 2023 Humana Medicare Enrollment Form

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

**Print clearly. Use black ink.**
**Asterisks (*) indicate required fields.**

AGENT NUMBER (SAN)

DATE OF BIRTH* SEX*

M M – D D – Y Y Y Y ○ M ○ F

MEMBER ID NUMBER

H

(For current or past Humana members)

## MEDICARE HEALTH INSURANCE

LAST NAME*

FIRST NAME* MI

MEDICARE NUMBER*

N A E N – A E N – A A N N

IS ENTITLED TO EFFECTIVE DATE

HOSPITAL (PART A) M M – 0 1 – Y Y Y Y

MEDICAL (PART B) M M – 0 1 – Y Y Y Y

Please see your agent to complete these questions.

PROPOSED COVERAGE START DATE*

M M – 0 1 – 2 0 2 3

(Must be after the sign date on page 8)

○ ICEP MA or MAPD ○ IEP PDP or MAPD ○ AEP ○ OEP ○ OEP NEW ○ OEPI ○ SEP CODE†

(See Additional Notes page)

†Required if SEP selected. See page 4 for code.

RESIDENTIAL ADDRESS* P.O. Box not allowed. ○ Experiencing homelessness

APT or STE

CITY* ST* ZIP*

COUNTY*

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

APT or STE

CITY ST ZIP

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

TELEPHONE

( ) –

TELEPHONE TYPE

○ Cellphone ○ Home (landline)

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

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

**Go paperless.** Many plan documents are now available in a digital format. See the enrollment book for a list of available communications and guidance on how to view your documents. To choose this option, please fill this oval. ○

We strongly recommend that all medical plan applicants include their primary care physician's (PCP) information below. If you are applying for an HMO plan, then you must complete this section. Please see your Summary of Benefits to determine if your plan requires a PCP.

PCP ID NUMBER

PRIMARY CARE PHYSICIAN (PCP)

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

**Asterisks (*) indicate required fields**

APPLICANT MEDICARE NUMBER*

N A E N – A E N – A A N N

Typically, you may enroll in a Medicare Advantage or prescription drug plan during the Annual Election Period (AEP) between October 15 and December 7 of each year. In addition, you can choose to change your Medicare Advantage plan once during the annual Open Enrollment Period (OEP) between January 1 and March 31 of each year, or immediately after enrolling in a plan during your IEP/ICEP (OEP NEW). Limitations on allowed plan changes during OEP apply. There are exceptions that may allow you to enroll outside of these periods. Please read the following statements carefully and mark the oval to the left of any statement that applies to you. By marking any of the following ovals you are certifying that, to the best of your knowledge, the text is a true statement about you. **If we later determine that this information is incorrect, you may be disenrolled.**

| | SEP Code | Special Election Period (SEP) statements |
|---|---|---|
| ○ | **LEC** | I am either losing/leaving coverage I had from an employer or union or lost this type of coverage within the last two months. |
| ○ | **MDE** | I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I **HAVEN'T** had a change. **Note: This SEP is only valid once per calendar quarter from January 1 through September 30.** |
| ○ | **NLS** | I had a change in my Extra Help paying for Medicare prescription drug coverage (newly got assistance, had a change in level or lost eligibility) within the last three months. |
| ○ | **MCD** | I had a change in my Medicaid status (newly got assistance, had a change in level or lost eligibility) within the last three months. |
| ○ | **MOV** | I am moving or have moved within the last two months. The move is either outside the service area for my current plan or this plan is a new option for me. |
| ○ | **SNP** | I have been notified that I no longer qualify for my Dual Eligible Special Needs Plan and am in a period of deemed continued eligibility or I was disenrolled from my Dual Eligible Special Needs Plan within the past three months due to a Medicaid change or loss. |
| ○ | **DST** | I was affected by a Federal Emergency Management Agency (FEMA) declared emergency/ disaster or a disaster or other emergency declaration issued by a federal, state or local government entity, and was unable to use another election period available to me due to it. Election Period Missed: _____ Emergency/Disaster Experienced: _____ |
| ○ | **NON** | My existing Medicare Advantage (MA) plan is non-renewing for the upcoming contract year. **Note: This SEP is only valid from December 8 through the last day of February.** |
| ○ | **OTH** | None of the above statements apply to me. However, I feel I have a special circumstance which allows me an exception to enroll. Humana will contact you to determine if an exception can be granted. **Must include the reason below.** |

Notes (if OTH):

**Asterisks (*) indicate required fields**

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

## Plan selection

Please provide the plan information below for the medical or prescription drug plan you'd like.
Plan information can be found in your Summary of Benefits.

CONTRACT* PBP* SEGMENT
0 0

Please provide the base monthly premium for this plan from the Summary of Benefits. This amount helps us identify the plan you would like and should not include any OSB options, late enrollment penalties or payments from other parties, like Medicaid.

BASE MONTHLY PREMIUM*
$ . 

Select one option below corresponding with the plan details you provided above.
Refer to your Summary of Benefits or your agent for assistance.

I would like **ONE** of the following options:*

- Humana Gold Plus® HMO
- Humana Value Plus HMO
- Humana Honor HMO
- Humana Gold Plus® HMO C-SNP (Additional Pre-Qualification Form Required)
- Humana Community HMO C-SNP (Additional Pre-Qualification Form Required)
- Humana Together in Health HMO I-SNP (Additional Attestation Form Required)
- Humana Senior Living Plan HMO I-SNP (Additional Attestation Form Required)
- Humana Community HMO
- Humana Community Select HMO
- Humana-Ochsner Network HMO
- Humana Cleveland Clinic Preferred HMO
- Humana LCMC Advantage HMO
- UC San Diego Health Humana HMO
- Humana FMOL Network HMO
- Humana BR Clinic-BR Gen HMO
- HumanaChoice® PPO
- Humana Value Plus PPO
- Humana Honor PPO
- HumanaChoice® PPO C-SNP (Additional Pre-Qualification Form Required)
- Humana Together in Health PPO I-SNP (Additional Attestation Form Required)
- HumanaChoice® Value PPO
- HumanaChoice® Partnered PPO
- Humana USAA Honor with Rx PPO
- Humana Basic Rx Plan (PDP)
- Humana Premier Rx Plan (PDP)
- Humana Walmart Value Rx Plan (PDP)
- Humana Gold Choice® PFFS

If selecting a Medicare Advantage HMO or PPO plan that does not include prescription drug coverage, a stand-alone prescription drug plan (PDP) cannot be carried at the same time.

**Asterisks (*) indicate required fields**

APPLICANT MEDICARE NUMBER*

N A E N – A E N – A A N N

OPTIONAL SUPPLEMENTAL BENEFIT (OSB) YOU ARE ENROLLING IN:

Please fill in the ovals for the OSBs you want to enroll in. If you're currently enrolled in an OSB, you **MUST** choose it on this form to continue receiving this benefit. Not all OSB offerings are available in all areas. **Please review the OSB options below and your Summary of Benefits to verify that yours are still offered and available.**

Enrollees must continue to pay the Medicare Part B premium and the Humana plan premium plus the OSB premium.

- MyOption℠ Platinum Dental
- MyOption℠ Dental – High
- MyOption℠ Total Dental
- MyOption℠ Total Dental Plus
- MyOption℠ Dental Enriched
- MyOption℠ DEN478
- MyOption℠ Enhanced Dental
- MyOption℠ Enhanced Dental Plus
- MyOption℠ Fitness
- MyOption℠ Plus
- MyOption℠ Vision
- MyOption℠ DEN204
- MyOption℠ DEN205
- MyOption℠ DEN206
- MyOption℠ DEN207
- MyOption℠ DEN432

---

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

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

NAME OF OTHER COVERAGE

ID NUMBER FOR THIS COVERAGE

GROUP NUMBER FOR THIS COVERAGE

---

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

---

Preferred Written Language (when available)

English Spanish Chinese Korean Other _____

Preferred Verbal Language

English Spanish Mandarin Cantonese

Korean Other _____

If an accessible format is needed, please select one option

Audio Large print Accessible screen reader PDF

Oral over the phone Braille

Please call a licensed Humana sales agent at **1-800-833-2367 (TTY: 711)** if you need information in another format or language.

---

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

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

What's your race? Select all that apply.

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

**Asterisks (*) indicate required fields**

APPLICANT MEDICARE NUMBER*

N A E N – A E N – A A N N

**PLEASE SELECT ONE PREMIUM PAYMENT OPTION.*** You may pay your monthly plan premium and/or late enrollment penalty via automatic deduction from your bank account (ACH), Social Security Administration (SSA) or Railroad Retirement Board (RRB) benefit check, or credit or debit card (CC/DC). You may also choose to pay by mail using a Coupon book. **If you do not select a payment option below, you may be defaulted to a Coupon book.**

○ **Automatic bank account deduction**
Bank account information (Only complete this section if you selected Automatic bank account deduction as your payment option).

○ Checking account ○ Savings account

BANK NAME

ROUTING NUMBER ACCOUNT NUMBER


Routing number Account number

○ **Social Security benefit check deduction** (Please see note below)

○ **Railroad Retirement Board benefit check deduction** (Please see note below)
You must currently be receiving a Railroad Retirement Board benefit check in order to qualify for this payment option.

**NOTE:** Due to processing timelines mandated by CMS (Medicare), your SSA or RRB deduction may be denied for your first premium payment. Humana will issue you an invoice for the initial payment and resubmit your request to CMS (Medicare) for SSA or RRB deduction to begin with your second month's premium. The deduction may take two or more benefit checks to begin. In most cases, if SSA or RRB accepts your request for automatic deduction, the first deduction from your benefit check will start with the month that SSA accepts the withholding. If SSA or RRB does not approve your request for automatic deduction, we will send you a Coupon book for your monthly premiums.

○ **Automatic credit or debit card deduction**
Credit or debit card information (Only complete this section if you selected Automatic credit or debit card deduction as your payment option).

○ Mastercard ○ Visa ○ Discover ○ American Express

CREDIT OR DEBIT CARD NUMBER EXPIRATION DATE

M M – 2 0 Y Y

○ **Coupon book**

You can visit **Humana.com/pay** to make your monthly premium payments online. If you have selected Coupon book as your payment option, you can pay as far in advance as you like. You can also log in to your secure MyHumana account (click Register if you haven't signed up yet) or download the MyHumana mobile app to take advantage of other premium-related services.

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

**Asterisks (*) indicate required fields**

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

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

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

SIGNATURE DATE*
M M – D D – 2 0 Y Y

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

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

LAST NAME FIRST NAME MI

STREET ADDRESS

CITY ST ZIP

TELEPHONE
( ) –

RELATIONSHIP TO APPLICANT

**AGENT USE ONLY**

APPOINTMENT TYPE

SCOPE OF APPOINTMENT ID NUMBER

WRITING AGENT NAME*

AGENT NUMBER (SAN)*

DATE*
M M – D D – 2 0 Y Y

AFFINITY PARTNER LOCATION CAMPAIGN

REFERRING AGENT NAME

REFERRING AGENT NUMBER (SAN)

ASK THE APPLICANT: Would you like to provide your Veteran status?*

Self Spouse Dependent I am not a Veteran Prefers not to answer

LEAD SOURCE*

Book of Business Event Marketing/Advertisement Third-Party Humana

Humana MyOption℠ Optional Supplemental Benefits (OSB) are only available to members of certain Humana Medicare Advantage (MA) plans. Members of Humana plans that offer OSBs may enroll in OSBs throughout the year. Benefits may change on January 1 each year.

Humana®

Humana.com

Y0040_SP_APP_FL_2023_C 06292022

GNHHUTSEN_2023

# Welcome to care that's all about you

Receipt of enrollment application in a Humana Medicare plan*

Member name

Humana licensed sales agent name

Application ID number

Plan name

Plan type

Proposed effective date

Primary care provider (PCP)

PCP phone number (if applicable)

Plan premium _____ Copayment PCP _____

Specialist _____ ER _____

❑ I have read and reviewed the Summary of Benefits.

**Optional supplemental benefits (OSB) you are enrolling in:**

- ❑ MyOption℠ Dental Enriched (DEN786)
- ❑ MyOption℠ Dental – High (DEN838)
- ❑ MyOption℠ Total Dental Plus (DEN152)
- ❑ MyOption℠ Enhanced Dental Plus (DEN151)
- ❑ MyOption℠ Fitness (FTP010)
- ❑ MyOption℠ Platinum Dental (DEN887)
- ❑ MyOption℠ Plus (VIS759/DEN843)
- ❑ MyOption℠ Total Dental (DEN983)
- ❑ MyOption℠ Total Dental (DEN984)
- ❑ MyOption℠ Vision (VIS757)
- ❑ MyOptionSM Enhanced Dental (DEN839)
- ❑ MyOption℠ Enhanced Dental (DEN840)
- ❑ MyOption℠ Enhanced Dental Plus (DEN153)
- ❑ MyOption℠ Total Dental Plus (DEN154)
- ❑ MyOption℠ Dental Enriched (DEN787)
- ❑ MyOption℠ DEN204
- ❑ MyOption℠ DEN205
- ❑ MyOption℠ DEN206
- ❑ MyOption℠ DEN207
- ❑ MyOption℠ DEN432
- ❑ MyOption℠ DEN478

**Please refer to the information below regarding the plan you have applied for until you receive your Humana member ID card.**

| | |
|---|---|
| Medicare Advantage prescription drug plan (MAPD) or prescription drug plans (PDP) (Part D) | PCN: 03200000 |
| | BIN: 015581 |
| Medicare Advantage plans (without drug coverage) | PCN: 03200004 |
| | BIN: 610649 |

RX plan –_____–_____

Processor control number (PCN) Bank identification number (BIN)

_____–_____ _____

Contract – Plan benefit package (PBP) Segment

_____ _____ _____ _____

Member signature Date Agent signature Date

Humana.

* Enrollment is pending review and final approval by Medicare and Humana. Humana will send a letter once processing is complete. You may use this form as temporary proof of coverage until you receive your Humana ID card. Please note, however, that if the application is not approved, claims may be denied.

**Humana Customer Care**
For questions about claims, benefits or anything else regarding your Humana coverage, visit **Humana.com/Help** or call **800-457-4708 (TTY: 711)**.

Oct. 15 – Dec. 7
Daily
8 a.m. – 8 p.m.

Dec. 8 – Oct. 14
Monday – Friday
8 a.m. – 8 p.m.

**24-hour authorization: 800-523-0023 (TTY: 711)**

Doctor and hospital: HMO and PPO plans require authorization for all non-emergency and non-urgent services. Notification is requested for PFFS plans. Providers can call **866-291-9714** for PFFS plan terms and conditions.

Humana MyOption optional supplemental benefits (OSB) are only available to members of certain Humana Medicare Advantage (MA) plans. Members of Humana plans that offer OSBs may enroll in OSBs throughout the year. Benefits may change on Jan. 1 each year. Enrollees must continue to pay the Medicare Part B premium, their Humana plan premium, and the OSB premium.

# Important!

## At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries comply with applicable Federal Civil Rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status or religion.

**English:** ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call **1-877-320-1235 (TTY: 711)**.

**Español (Spanish):** ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-320-1235 (TTY: 711)**.

**繁體中文 (Chinese):** 注意：如果您使用繁體中文 ，您可以免費獲得語言援助服務 。請致電 **1-877-320-1235 (TTY：711)** 。

# IMPORTANT INFORMATION:

## 2023 Medicare Star Ratings

Official U.S. Government Medicare Information

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Humana - H0028

**For 2023, Humana - H0028 received the following Star Ratings from Medicare:**

| | |
|---|---|
| **Overall Star Rating:** | ★★★★☆ |
| **Health Services Rating:** | ★★★★☆ |
| **Drug Services Rating:** | ★★★★☆ |

**Every year, Medicare evaluates plans based on a 5-star rating system.**

### Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

More stars mean a better plan – for example, members may get better care and better, faster customer service.

**The number of stars show how well a plan performs.**

★★★★★ EXCELLENT
★★★★☆ ABOVE AVERAGE
★★★☆☆ AVERAGE
★★☆☆☆ BELOW AVERAGE
★☆☆☆☆ POOR

### Get More Information on Star Ratings Online

Compare Star Ratings for this and other plans online at medicare.gov/plan-compare.

### Questions about this plan?

Contact Humana 7 days a week from 8:00 a.m. to 8:00 p.m. local time at 800-833-2364 (toll-free) or 711 (TTY), from October 1 to March 31. Our hours of operation from April 1 to September 30 are Monday through Friday from 8:00 a.m. to 8:00 p.m. local time. Current members please call 800-457-4708 (toll-free) or 711 (TTY).

# Important

## At Humana, it is important you are treated fairly.

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

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

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

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

# Multi-Language Insert

## Multi-language Interpreter Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# Important resources guide

Keep this resource guide handy so you can easily and quickly get answers to your questions after you enroll.

**Find a Doctor**
**Humana.com/FindADoctor**

**Go365 by Humana**
**Go365.com**

**Home care services**
**Humana.com/AtHome**

**Virtual visits**
**Humana.com/VirtualVisits**

**Pharmacy education**
**844-330-0816**

**SilverSneakers**
**888-423-4632 (TTY: 711)**

**Create a MyHumana account**
**MyHumana.com**

**Humana Neighborhood Centers**
**HumanaNeighborhoodCenter.com**

**Information on resources for food, transportation, loneliness, financial strain and housing**
**PopulationHealth.Humana.com**

## Humana Customer Care

For questions about claims, benefits or anything else regarding your Humana coverage, visit **Humana.com/Help** or call **800-457-4708 (TTY: 711)**.

Oct. 15 – Dec. 7
Daily
8 a.m. – 8 p.m.

Dec. 8 – Oct. 14
Monday – Friday
8 a.m. – 8 p.m.

Not all benefits and resources listed are available on all plans or in all areas. Consult your Evidence of Coverage or ask your licensed Humana sales agent to find out what benefits are included in your plan.

Humana.

# What's next

Once you complete your enrollment application and it is approved by the Centers for Medicare & Medicaid Services, we'll send you:

**A notice confirming your application is approved**

**Your Humana member identification (ID) card**

As a Humana member, you'll have access to MyHumana, your secure online account where you will be able to set up a personal profile to see your summary of benefits and costs, as well as ways you may be able to save money.

# Go paperless

Get the following information sent right to your MyHumana account:

- Summary of Benefits and Value Added Items and Services
- Annual Notice of Change
- SmartSummary—Explanation of Benefits (EOB)
- Health and wellness information
- Plan messages and notifications (Verification of Enrollment, Confirmation of Enrollment)
- Medication information and resources

Go to **Humana.com/LogOn** to
set up your MyHumana account.

Now you know how your plan works, including the extra benefits and services Humana provides.

So when the time comes, you can **make the most of your plan.**

**Let's talk**

Call your licensed Humana sales agent.

Humana is a Medicare Advantage HMO, PPO and PFFS organization with a Medicare contract. Humana is also a Coordinated Care plan with a Medicare contract and a contract with the state Medicaid program. Enrollment in any Humana plan depends on contract renewal.

Out-of-network/non-contracted providers are under no obligation to treat Humana 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.

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

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**English:** ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call **1-877-320-1235** (TTY: 711).

**Español (Spanish):** ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-320-1235** (TTY: 711).

**繁體中文 (Chinese):** 注意：如果您使用繁體中文 ，您可以免費獲得語言援助服務 。請致電 **1-877-320-1235** (TTY: 711)。

Humana Gold Plus
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Select Counties in CO
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ENGLISH