

# HumanaHMO Rx4 Prescription Drug Coverage

Level One - \$5, Level Two - \$15, Level Three - \$35, Level Four - 25%

## How the Rx4 structure works

Covered prescription drugs are assigned to one of four different levels with corresponding copayment amounts. The levels are organized as follows:

- **Level One:** lowest copayment for low cost generic and brand-name drugs.
- **Level Two:** higher copayment for higher cost generic and brand-name drugs.
- **Level Three:** higher copayment than Level Two for higher cost, brand-name drugs that may have generic or brand-name alternatives on Levels One or Two.
- **Level Four:** highest copayment for high-technology drugs (certain brand-name drugs, biotechnology drugs and self-administered injectable medications).
- If you request a brand-name drug when a generic equivalent is available, you pay the applicable Level One or Level Two generic copayment, plus the cost difference between the brand-name and generic drugs. If your doctor indicates that a generic drug cannot be substituted by writing “Dispense as Written” on your prescription, you can only receive that specific drug, even if a generic equivalent is available. As a result, you will be charged the applicable brand-name copayment. In this case, you will not be responsible for the cost difference between the brand and generic. If you discover at the pharmacy that your doctor gave you a “Dispense as Written” prescription, you can ask the pharmacist to contact your doctor for approval of a generic equivalent.

Prescription drug products, or classes of certain prescription drug products, are generally reviewed on an ongoing basis by a Humana Pharmacy and Therapeutics committee which is composed of physicians and pharmacists. Drugs are reviewed for safety, effectiveness and cost-effectiveness prior to assignment or a change in assignment to one of the levels. Coverage of a prescription drug or placement of the drug within a level are subject to change throughout the year. In the event drugs are moved to categories with higher member cost, advance notice is provided based on past usage. Always discuss prescription drugs with your physician to determine appropriateness or clinical effectiveness with respect to you or any specific illness.

Some drugs in all levels may be subject to dispensing limitations, based on age, gender, duration or quantity. Additionally, some drugs may need prior authorization in order to be covered. In these cases, your physician should contact Humana Clinical Pharmacy Review at 1-800-555-CLIN (2546).

Members can visit Humana’s Website, [www.humana.com](http://www.humana.com), to obtain information about their prescription drug and corresponding benefits and for possible lower cost alternatives, or they can call Humana’s Customer Service with questions or to request a partial Humana Rx4 Drug List by mail.

For a complete listing of participating pharmacies, please refer to our Website or your participating provider directory.

## Coverage at participating pharmacies

When you present your membership card at a participating pharmacy, you are required to make a copayment for each prescription based on the current assigned level of the drug.

Drugs assigned to:	Copayment per prescription or refill
Level One:	\$5
Level Two:	\$15
Level Three:	\$35
Level Four:	25%* of the total required payment to the dispensing pharmacy per prescription or refill.

\* The total maximum out-of-pocket copayment costs for drugs in Level Four is limited to \$2,500 per calendar year, per member.

- If the dispensing pharmacy’s charge is less than the corresponding copayment, you will only be responsible for the lower amount.
- Your copayments for covered prescription drugs are made on a per prescription or refill basis and will not change if Humana receives any retrospective volume discounts or prescription drug rebates.
- If you use a nonparticipating pharmacy, there is no coverage, except for prescriptions required during an emergency for treatment of an emergency medical condition.

There are no claim forms to file if you use a participating pharmacy and present your membership card with each prescription.

**Coverage specifics**

Your coverage includes the following:

- A 30-day supply or the amount prescribed, whichever is less, for each prescription or refill.
- Contraceptives.
- For Arizona, coverage also includes FDA approved contraceptive devices.
- Certain self-administered injectable drugs and related supplies approved by Humana.
- Certain drugs, medicines or medications that, under federal or state law, may be dispensed only by prescription from a physician.

**Mail-order benefit**

For your convenience, you may receive a maximum 90-day supply per prescription or refill through the mail (maximum 30-day supply for self-administered injectable drugs). The same requirements apply when purchasing medications through a participating mail-order pharmacy as apply when purchasing in person at a pharmacy. Members can call Customer Service or visit our Website for more information, including mail-order forms.

**Definition of terms**

- Drug List: a list of prescription drugs, medicines, medications and supplies specified by Humana. This list identifies drugs as Level One, Level Two, Level Three or Level Four and indicates applicable dispensing limits and/or any prior authorization requirements. (This list is subject to change.)
- Copayment: the amount to be paid by the member toward the cost of each separate prescription or refill of a covered drug when dispensed by a pharmacy.
- Participating pharmacy: a pharmacy that has signed a direct agreement with us as an independent contractor or has been designated by us as an independent contractor to provide services to all covered persons
- Nonparticipating pharmacy: a pharmacy that has not been designated by us to provide services to covered persons.

**Limitations and exclusions**

Unless specifically stated otherwise, no benefit will be provided for or on account of the following items:

- Any drug prescribed for a sickness or bodily injury not covered under the master group contract.
- Any drug, medicine or medication labeled “Caution-Limited by Federal Law to Investigational Use” or any experimental drug, medicine or medication, even though a charge is made to you. {WI – This does not apply to those investigational drugs which are approved by the FDA for treatment of HIV infection or a medical condition arising from or related to, and that has completed a Phase III clinical investigation.}
- Anorectic or any drug used for the purpose of weight control.
- Any drug used for cosmetic purposes, including but not limited to:
  - Tretinoin, e.g. Retin A, except if you are under the age of 45 or are diagnosed as having adult acne;
  - Dermatologicals or hair growth stimulants; or
  - Pigmenting or de-pigmenting agents, e.g. Solaquin.
- Any drug or medicine that is:
  - Lawfully obtainable without a prescription (over the counter drugs), except insulin {LA – insulin covered under diabetes benefit}; or
  - Available in prescription strength without a prescription.
- Abortifacients (drugs used to induce abortions).
- Infertility services including medications. {IL – This exclusion is removed.} {OH – Medications for infertility services.} {TX – Fertility medications.}
- Any drug prescribed for impotence and/or sexual dysfunction, e.g. Viagra.
- Any drug for which prior authorization is required, as determined by us, and not obtained.
- Any service, supply or therapy to eliminate or reduce a dependency on, or addiction to tobacco and tobacco products, including but not limited to nicotine withdrawal therapies, programs, services or medications.
- Treatment for onychomycosis (nail fungus).
- Any portion of a prescription or refill that exceeds a 30-day supply (or a 90-day supply for a prescription or refill that is received from a mail order pharmacy).
- Legend drugs which are not recommended and not deemed necessary by a health care practitioner.
- Prescriptions filled at a non-network pharmacy except for prescriptions required during an emergency.
- More than one prescription for the same drug or therapeutic equivalent medication prescribed by one or more health care practitioners and dispensed by one or more pharmacies until you have used, or should have used, at least 75 percent of the previous prescription, unless the drug or therapeutic equivalent medication is purchased through a mail order pharmacy, in which case you have used, or should have used 66 percent of the previous prescription. (Based on the dosage schedule prescribed by the health care practitioner.)

**This is only a partial list of limitations and exclusions. Please refer to the Certificate of Coverage for complete details regarding prescription drug coverage.**



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Please refer to your Benefit Plan Document (Certificate of Coverage/Insurance) for more information on the company providing your benefits.