

PRESCRIPTION DRUG BENEFIT SUMMARY

Humana Benefit Plan of IL provides our members with comprehensive prescription drug benefits through local area pharmacies. Present your ID card at any participating pharmacy nationwide.

UP TO 30 DAY SUPPLY

GENERIC DRUG EQUIVALENTS

100% after a \$10 copayment.

PREFERRED NAME BRAND DRUGS WHEN NO GENERIC DRUG IS AVAILABLE

100% after a \$20 copayment.

NON-PREFERRED NAME BRAND DRUGS WHEN NO GENERIC DRUG IS AVAILABLE

100% after a \$40 copayment.

PREFERRED OR NON-PREFERRED NAME BRAND DRUGS WHEN REQUESTED BY THE MEMBER OR PHYSICIAN WHEN A GENERIC DRUG IS AVAILABLE

100% after the \$10 copayment plus the price difference of brand name over generic equivalent.

31 – 90 DAY SUPPLY

Please contact Humana for information on 90-day pharmacies.

GENERIC DRUG EQUIVALENTS

100% after a \$20 copayment.

PREFERRED NAME BRAND DRUGS WHEN NO GENERIC DRUG IS AVAILABLE

100% after a \$40 copayment.

NON-PREFERRED NAME BRAND DRUGS WHEN NO GENERIC DRUG IS AVAILABLE

100% after a \$80 copayment.

PREFERRED OR NON-PREFERRED NAME BRAND DRUGS WHEN REQUESTED BY THE MEMBER OR PHYSICIAN WHEN A GENERIC DRUG IS AVAILABLE

100% after the \$20 copayment plus the price difference of brand name over generic equivalent.

EXCLUSIONS

This outpatient prescription drug rider does not cover the following:

- Nicotine products for smoking cessation.
- Anorexics, including but not limited to, amphetamines and non-amphetamines containing phenteramine or diethylpropion (Drugs for weight loss).
- Any drugs used for cosmetic purposes.
- Any drugs labeled, “caution: limited by federal law to investigational use”, which Humana determines are in a testing stage or in early field trials on animals or humans, or those drugs which do not have required final federal regulatory approval for commercial distribution for the specific indications and methods of use assessed.
- Any charge for the administration of a prescription drug.
- Drugs or medications which do not require a prescription.
- Devices and supplies (except insulin needles and syringes) of any type, including but not limited to therapeutic devices, artificial appliances, support garments, and blood glucose test meters.
- Immunization agents, biological sera, blood or blood plasma, except as set forth under the covered services section of the applicable evidence of coverage.
- Total parenteral nutrition (TPN).
- Injectables, except for insulin.
- Prescription drugs new to the market until approved by Humana’s medical management.
- Prescription drugs which are not medically necessary.
- Replacement of lost or stolen prescription drugs.
- Prescription drugs which are covered under another plan, any worker’s compensation or occupational disease law or any drug for which there is no charge to the member.
- Contraceptive drugs including pills, fluids, and other devices.
- Prescription drugs which are used in the treatment of infertility (unless infertility rider is purchased).
- Growth hormones.