

Additional Drug Coverage

Lower-cost Medicare prescription drugs

Your plan covers some of your Medicare prescription drugs at a \$0 copay. The lower tier or copay will apply even if you have not yet met your annual prescription (Part D) deductible.

These drugs are part of your Medicare prescription drug coverage.¹

| Drug Name |
|------------------|
| Shingles Vaccine |

¹Information about the appeals and grievance process for these prescription drugs can be found in your Evidence of Coverage.

Bonus Drug List

The LGHIB offers a bonus drug list. The prescription drugs on this list are covered in addition to the drugs on the plan's drug list (formulary).

The drug tier for each prescription drug is shown on the list.

Although you pay the same copay for these drugs as shown in the Summary of Benefits and Evidence of Coverage, the amount you pay for these additional prescription drugs **does not apply to your Medicare Part D out-of-pocket costs**. Payments for these additional prescription drugs (made by you or the plan) are treated differently from payments made for other prescription drugs.

Coverage for the prescription drugs on the bonus drug list is in addition to your Part D drug coverage. Unlike your Part D drug coverage, you are unable to file a Medicare appeal or grievance for drugs on the bonus drug list. If you have questions, please call Customer Service using the information on the cover of this book.

If you get Extra Help from Medicare to pay for your prescription drugs, it will not apply to the drugs on this bonus drug list.

This is not a complete list of the prescription drugs available to you or the restrictions and limitations that may apply through the bonus drug list. If your drug has any coverage rules or limits, there will be code(s) in the "Coverage Rules or Limits on use" column of the chart. The codes and what they mean are shown below. If you have questions about drug coverage, please call Customer Service using the information on the cover of this book.

QL - Quantity limits

The plan only covers a certain amount of this drug for one copay or over a certain number of days. These limits may be in place to ensure safe and effective use of the drug.

MME - Morphine milligram equivalent

Additional quantity limits may apply across all drugs in the opioid class used for the treatment of pain. This additional limit is called a cumulative morphine milligram equivalent (MME), and is designed to monitor safe dosing levels of opioids for individuals who may be taking more than one opioid drug for pain management. If your doctor prescribes more than this amount or thinks the limit is not right for your situation, you or your doctor can ask the plan to cover the additional quantity.

7D - 7-Day limit

An opioid drug used for the treatment of acute pain may be limited to a 7-day supply for members with no recent history of opioid use. This limit is intended to minimize long-term opioid use. For members who are new to the plan, and have a recent history of using opioids, the limit may be overridden by having the pharmacy contact the plan.

DL - Dispensing limit

Dispensing limits apply to this drug. This drug is limited to a one-month supply per prescription.

| Drug Name | Drug Tier | Coverage Rules or Limits on use |
|---|------------------|--|
| Analgesics - drugs to treat pain, inflammation, and muscle and joint conditions | | |
| Inflammation | | |
| Salsalate | 1 | |
| Urinary Tract Pain | | |
| Phenazopyridine | 1 | |
| Anorexiant - drugs to promote weight loss | | |
| Phentermine | 1 | QL (maximum of 1 capsule/tablet per day) |
| Anticoagulants - drugs to prevent clotting | | |
| Heparin Lock Flush | 1 | |
| Dermatological agents - drugs to treat skin conditions | | |
| Dry, Itchy Scalp | | |
| Sulfacetamide Sodium Liquid Wash 10% | 1 | |
| Sulfacetamide Sodium w/Sulfur in Urea Emulsion 10-5% | 1 | |
| Dry Skin | | |
| Urea 50% Cream | 1 | |
| Gastrointestinal agents - drugs to treat bowel, intestine and stomach conditions | | |
| Hemorrhoids | | |
| Hydrocortisone Acetate Suppository 25 mg | 1 | |
| Lidocaine/Hydrocortisone Acetate | 1 | |
| Irritable Bowel or Ulcers | | |
| Clidinium & Chlordiazepoxide | 1 | |
| Hyoscyamine Sulfate | 1 | |
| Levbid | 3 | |
| Genitourinary agents - drugs to treat bladder, genital and kidney conditions | | |
| Erectile Dysfunction | | |

Bold type = Brand name drug Plain type = Generic drug

| Drug Name | Drug Tier | Coverage Rules or Limits on use |
|--|------------------|--|
| Edex | 3 | QL (maximum of 6 cartridges per month) |
| Sildenafil (25 mg, 50 mg, 100 mg) | 1 | QL (maximum of 6 tablets per month) |
| Tadalafil | 1 | QL (maximum of 6 tablets per month) |
| Vardenafil | 1 | QL (maximum of 6 tablets per month) |
| Sexual Desire Disorder | | |
| Addyi | 3 | QL (maximum of 1 tablet per day) |
| Urinary Tract Infection | | |
| Methenamine/Hyoscamine/Methyl Blue/Sod Phosphate/Phenyl Salicylate | 1 | |
| Methenamine/Hyoscamine/Methylene Blue/Sodium Phosphate | 1 | |
| Urinary Tract Spasm and Pain | | |
| Belladonna Alkaloids & Opium Suppositories | 1 | MME, 7D, DL |
| Hormonal agents - hormone replacement/modifying drugs | | |
| Thyroid Supplement | | |
| Armour Thyroid | 3 | |
| Nutritional supplements - drugs to treat vitamin & mineral deficiencies | | |
| Potassium Supplement | | |
| K-Phos Tab | 3 | |
| Potassium Bicarbonate Effervescent Tab 25 mEq | 1 | |
| Vitamins and Minerals | | |
| Cyanocobalamin Injection (Vitamin B12) | 1 | |
| Folic Acid 1 mg (Rx only) | 1 | |

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| Drug Name | Drug Tier | Coverage Rules or Limits on use |
|---|------------------|--|
| Folic Acid-Vitamin B6-Vitamin B12 Tablet 2.5-25-1 mg | 1 | |
| Phytonadione | 1 | |
| Renal Cap | 1 | |
| Vitamin D 50,000 unit (Rx only) | 1 | |
| Respiratory tract agents - drugs to treat allergies, cough, cold and lung conditions | | |
| Cough and Cold | | |
| Benzonatate (100 mg, 200 mg) | 1 | |
| Brompheniramine/Pseudoephedrine/ Dextromethorphan Syrup | 1 | |
| Guaifenesin/Codeine Syrup | 1 | DL |
| Hydrocodone Polst/Chlorpheniramine ER Susp (generic for Tussionex) | 1 | DL |
| Hydrocodone/Homatropine | 1 | DL |
| Promethazine/Codeine Syrup | 1 | DL |
| Promethazine/Dextromethorphan Syrup | 1 | |

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This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply.

Benefits and/or copayments/coinsurance may change each plan/benefit year.

The drug list may change at any time. You will receive notice when necessary.

This information is available for free in other languages. Please call our Customer Service number on the cover.

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