

HealthSpring True Choice (PPO) Formulary Addendum for 2026

Vermont State Colleges System
2026 Standard Drug List Addendum
H7787_801_MAPD1 A1

Medicare Broad Network

Please read: This document contains information about the policies and criteria and any additional coverage offered with your plan.

Please visit [HealthSpring.com/GroupMA](https://www.healthspring.com/GroupMA) view the comprehensive 2026 Standard Drug List. The drug list found on our website will be updated each month.



Are there any restrictions on my 2026 HealthSpring True Choice (PPO) coverage?

Some covered drugs may have additional requirements or limits on coverage. You can identify these by looking to the right of the name of the drug on the drug list located on our website. The requirements and limits for your plan are the following:

*	Opioid medication available as a 7-day supply or less for first time opioid user. For continued use this drug may only be available as a one-month supply.
^	This prescription drug has an administrative prior authorization requirement that is not waived. This drug may be covered under different benefits depending on circumstances.
+	This prescription drug is not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for this drug does not apply to your total drug costs (that is, the amount you pay does not help you qualify for catastrophic coverage). In addition, if you are receiving extra help to pay for your prescriptions, you will not get any extra help to pay for this drug.
B/D PA	This prescription drug has a Part B versus D administrative prior authorization requirement. This drug may be covered under Medicare Part B or D depending on circumstances.
HRM	This high-risk medication requires prior authorization.
LA	Limited Availability. This prescription may be available only at certain pharmacies. For more information, please call Customer Service.
V	This vaccine is provided to adults at no cost when used based on recommendations by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP).
PA	This drug requires prior authorization.
QL	This drug has quantity limits.
ST	This drug has step therapy requirements.

Where can I find a Drug List for my plan?

You can visit [HealthSpring.com/GroupMA](https://www.healthspring.com/GroupMA) to view the current list of covered drugs for the **2026 Standard Drug List**. While there, you can also view documents that explain our prior authorization and step therapy restrictions as well as other useful plan information. To locate the drug list you need, simply visit the location above and search for the **2026 Standard Drug List**.

What additional coverage is available with my plan?

Your plan covers additional drugs not normally covered in a Medicare Prescription Drug Plan as indicated in the Formulary Drug List by the + symbol. Please see your 2026 formulary document for details. If a plan deductible applies, any non-Part D coverage added to the plan will not be subject to the plan deductible. The cost-share for these drugs is the same as the cost-shares in the initial coverage phase based on the drug classification. The cost-share you pay on these drugs do not count toward your annual True Out-of-Pocket (TrOOP).

Covered Supplemental Coverage:

- **Prescription Vitamins** - Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- **Sexual Dysfunction/Lifestyle Drugs[^]** - drugs used for erectile dysfunction and female sexual dysfunction
- **Cough and Cold Drugs** - Drugs used for symptomatic relief of cough and colds
- **Courtesy Drugs/DESI Buy Up - Courtesy Drugs:** Drugs normally covered under commercial pharmacy plans but are excluded by CMS. DESI (Drug Efficacy Study Implementation) Drugs: Drugs that were introduced between 1938-1962 and approved for safety but not effectiveness. DESI drugs are not “grandfathered” or generally recognized as safe and effective (GRAS/E).

[^]Some drugs are subject to prior authorization and quantity limitations even though these limitations may be waived in other treatment categories. Please review your 2026 formulary 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. If your plan has a Part D deductible, this will apply even if you haven't paid your deductible. If your insulin is on a tier where cost-sharing is lower than \$35 you will pay the lower cost for your insulin.

Important Message About What You Pay for Vaccines

Our plan covers most Part D vaccines at no cost to you. If your plan has a Part D deductible, this will apply even if you haven't paid your deductible. Call Customer Service for more information.

Covered Diabetic Test Strips and Meters

You will not pay more than \$0 for Preferred Products.

Covered Diabetic Lancets and Control Solutions

You will not pay more than \$0 for this benefit.

State Mandated Coverage

You live in a state that requires insurance companies to provide additional coverage. That coverage is outlined below, and the lists of covered drugs and supplies are found in the pages that follow.

Prescriptions for insulin medications

Prescription Insulin drugs will not exceed \$100 per 30-day supply regardless of the amount, type, or number of insulin medications per person.

Drug Name	Drug Tier	Requirements / Limits
Sexual Dysfunction Supplemental Benefits		
ADDYI	2	+, QL 30/30
<i>avanafil 50 mg, 100 mg, 200 mg tablet</i>	1	+, QL 8/30
CAVERJECT VIALS	2	+, QL 6/30
CAVERJECT IMPULSE	2	+, QL 6/30
CIALIS 2.5 MG, 5 MG	2	+, PA, ^, QL 8/30
CIALIS 10 MG, 20 MG	2	+, PA, ^, QL 8/30
EDEX 10 MCG, 20 MCG, 40 MCG CARTRIDGES	2	+, QL 6/30
IFE-BIMIX 30/1 150-5 MG/5 ML	2	+
MUSE 250 MCG, 500 MCG, 1000 MCG URETHRAL SUPPOSITORY	2	+, QL 6/30
<i>sildenafil 25 mg, 50 mg, 100 mg tablets (generic Viagra)</i>	1	+, QL 8/30
STENDRA 50 MG, 100 MG, 200 MG TABLETS	2	+, QL 8/30
<i>tadalafil 2.5 mg, 5 mg (generic Cialis)</i>	1	+, PA, ^, QL 8/30
<i>tadalafil 10 mg, 20 mg (generic Cialis)</i>	1	+, PA, ^, QL 8/30
TRI-MIX 150 MG-5 MG-50 MCG VL	2	+
<i>varденаfil 2.5 mg, 5 mg, 10 mg, 20 mg tablets</i>	1	+, QL 8/30
<i>varденаfil 10 mg odt</i>	1	+, QL 8/30
VIAGRA 25 MG, 50 MG, 100 MG	2	+, QL 8/30
VYLEESI 1.75 MG/0.3 ML AUTOINJ	2	+

Drug Name	Drug Tier	Requirements / Limits
Cough and Cold Supplemental Benefits		
<i>benzonatate 100mg, 150 mg, 200mg capsule</i>	1	+
<i>benzonatate pearle 100 mg capsule</i>	1	+
BROMFED DM 2-30-10 MG/5 ML SYRINGE	2	+
<i>bromphen-pse-dm 2-30-10 mg/5ml syringe</i>	1	+
CAPCOF LIQUID	2	+
<i>codeine-guaifen 10-100 mg/5 ml</i>	1	+
CODITUSSIN AC LIQUID	2	+
CODITUSSIN DAC LIQUID	2	+
<i>g tussin ac liquid</i>	1	+
<i>guaiatussin ac liquid</i>	1	+
<i>guaifen-codeine 100-10mg/5ml</i>	1	+
GUAIFEN-COD 100-10MG/ML, 200-20MG/10ML	2	+
<i>guaifenesin ac cough syrup</i>	1	+
<i>guaifenesin dac oral solution</i>	1	+
<i>guaifenesin-codeine syrup (generics)</i>	1	+
HISTEX-AC SYRUP	2	+
HYCODAN 5 MG-1.5 MG TABLET	2	+
HYCODAN 5 MG-1.5 MG/5 ML CUP	2	+
HYCODAN 5 MG-1.5 MG/5 ML SOLUTION	2	+
<i>hydrocodone-chlorphen er suspension</i>	1	+
HYDROCODONE-HOMATROP 5 ML CUP	2	+
<i>hydrocodone-homatropine 5-1.5</i>	1	+
<i>hydrocodone-homatropine solution</i>	1	+
<i>hydromet 5mg-1.5mg/5ml solution</i>	1	+
MAR-COF BP LIQUID	2	+
MAR-COF CG LIQUID	2	+
<i>maxi-tuss ac liquid</i>	1	+
MAXI-TUSS CD LIQUID	2	+
<i>m-clear wc liquid</i>	1	+

Drug Name	Drug Tier	Requirements / Limits
M-END PE LIQUID	2	+
NINJACOF-XG LIQUID	2	+
OBREDON 2.5-200 MG/5 ML SOLUTION	2	+
<i>pcm la tablet</i>	1	+
<i>pe-guai drops</i>	1	+
POLY-TUSSIN AC LIQUID	2	+
<i>promethazine-codeine syrup, solution</i>	1	+
<i>promethazine-dm solution</i>	1	+
<i>promethazine-dm syrup 6.25-15mg/5ml</i>	1	+
<i>promethazine-pe-codeine syrup</i>	1	+
RESPA A.R. TABLET SA	2	+
<i>rydex liquid</i>	1	+
TUXARIN ER 8-54.3 MG TABLET	2	+
TUZISTRA XR 14.7-2.8 MG/5 ML	2	+
<i>virtussin ac 10-100 MG/5 ml liquid</i>	1	+
<i>virtussin ac w-alc 10-100 MG/5</i>	1	+
<i>virtussin dac liquid</i>	1	+

Drug Name	Drug Tier	Requirements / Limits
Prescription Vitamins Supplemental Benefits		
ACCRUFER 30 MG CAPSULE	2	+
ALTRIXA OB PRENATAL TABLET	2	+
AQUASOL A 100,000 UNITS/2ML VIAL	2	+
ASCOR 25,000 MG/ML BULK VIAL	2	+
<i>ascorbic acid 500 mg/ml vial</i>	1	+
AZESCO TABLET	2	+
<i>bal-care dha combo pack</i>	2	+
BAL-CARE DHA ESSENTIAL PACK	2	+
<i>b-complex 100 injection</i>	1	+
<i>calcitriol 0.25 mcg, 0.5 mcg capsule</i>	1	+
<i>calcitriol 1 mcg/ml ampule</i>	1	+
<i>calcitriol 1 mcg/ml solution</i>	1	+
<i>calcitriol 1 mcg/ml vial</i>	1	+
CITRANATAL 90 DHA COMBO PACK	2	+
CITRANATAL ASSURE COMBO PACK	2	+
CITRANATAL B-CALM COMBO PACK	2	+
CITRANATAL BLOOM TABLET	2	+
CITRANATAL DHA PACK	2	+
CITRANATAL HARMONY CAPSULE	2	+
CITRANATAL MEDLEY SOFTGEL	2	+
CITRANATAL RX TABLET	2	+
<i>c-nate dha softgel</i>	2	+
<i>complete natal dha</i>	2	+
CONCEPT DHA CAPSULE	2	+
CONCEPT OB CAPSULE	2	+
<i>cyanocobalamin 1,000 mcg/ml, 10,000 mcg/10 ml, 30,000 mcg/30 ml</i>	1	+
<i>cyanocobalamin 500 mcg spray</i>	1	+
DERMACINRX PRENATRIX CAPLET	2	+

Drug Name	Drug Tier	Requirements / Limits
DERMACINRX PRENATRYL CAPLET	2	+
DERMACINRX PRETRATE CAPLET	2	+
<i>dodex 1,000 mcg/ml, 10,000 mcg/10 ml, 30,000 mcg/30ml</i>	1	+
DRISDOL 1.25 MG (50,000 UNIT)	2	+
DUET DHA 400 COMBO PACK, BALANCED	2	+
<i>elite-ob caplet</i>	2	+
ENBRACE HR SOFTGEL	2	+
FERAHEME 510 MG/17 ML VIAL	2	+
FERRLECIT 62.5 MG/5 ML VIAL	2	+
FERUMOXYTOL 510 MG/17 ML VIAL	2	+
<i>folic acid 1 mg tablet</i>	1	+
<i>folic acid 5 mg/ml, 50 mg/10 ml vial</i>	1	+
<i>folivane-ob capsule</i>	2	+
<i>hydroxocobalamin 1,000 mcg/ml</i>	1	+
INFED 100 MG/2ML VIAL	2	+
INFUVITE ADULT, PEDIATRIC	2	+
INJECTAFER 100 MG/2 ML VIAL	2	+
INJECTAFER 750 MG/15 ML VIAL	2	+
KOSHER PRENATAL PLUS IRON TAB	2	+
<i>m.v.i. adult vial</i>	1	+
MARNATAL-F CAPSULE	2	+
MATERNACEL PRENATAL TABLET	2	+
MEPHYTON 5 MG TABLET	2	+
METHYLCOBALAMIN 10,000 MCG VIAL	2	+
<i>m-natal plus tablet</i>	2	+
MONOFERRIC 1,000 MG/10 ML VIAL	2	+
MULTI-MAC TABLET	2	+
<i>mynatal capsule</i>	1	+
<i>mynatal plus captab</i>	1	+
<i>mynatal ultracaplet</i>	2	+
<i>mynatal-z captab</i>	1	+

Drug Name	Drug Tier	Requirements / Limits
NASCOBAL 500 MCG NASAL SPRAY	2	+
NATACHEW TABLET	2	+
NATAL PNV TABLET	2	+
NEEVODHA CAPSULE	2	+
NEONATAL COMPLETE TABLET	2	+
NEONATAL FE TABLET	2	+
NEONATAL PLUS VITAMIN TABLET	2	+
NEONATAL-DHA COMBO PACK	2	+
<i>neo-vital rx tablet</i>	2	+
NESTABS ABC PRENATAL COMBO PACK	2	+
NESTABS DHA COMBO PACK	2	+
NESTABS ONE SOFTGEL	2	+
NESTABS TABLET	2	+
<i>newgen tablet</i>	1	+
NEXA PLUS SOFTGEL	2	+
OB COMPLETE CAPLET	2	+
OB COMPLETE ONE SOFTGEL	2	+
OB COMPLETE PETITE SOFTGEL	2	+
OB COMPLETE PREMIER TABLET	2	+
OB COMPLETE WITH DHA SOFTGEL	2	+
<i>obstetrix dha combo pak</i>	2	+
OBSTETRIX EC CAPLET	2	+
OBTREX DHA PRENATAL VITAMIN	2	+
PHYSICIANS EZ USE B-12 KIT	2	+
PHYTONADIONE 1 MG/0.5 ML SYRINGE	2	+
PHYTONADIONE 1 MG/0.5 ML VIAL	2	+
<i>phytonadione 10 mg/ml ampul</i>	1	+
<i>phytonadione 10 mg/ml vial</i>	1	+
<i>phytonadione 5mg tablet</i>	1	+
<i>pnv 29-1 tablet</i>	2	+
<i>pnv prenatal plus multivit tablet</i>	2	+

Drug Name	Drug Tier	Requirements / Limits
PNV TABS 20-1 TABLET	2	+
<i>pnv-dha + docusate softgel</i>	2	+
<i>pnv-dha softgel</i>	2	+
<i>pnv-omega softgel</i>	2	+
<i>pnv-select tablet</i>	2	+
POTABA 500 MG CAPSULE	2	+
<i>pr natal 400 combo pack, ec combo pack</i>	2	+
<i>pr natal 430 combo pack, ec combo pack</i>	2	+
PREGEN DHA SOFTGEL	2	+
PREGENNA TABLET	2	+
<i>prena1 chew tablet</i>	1	+
<i>prena1 pearl softgel</i>	1	+
<i>prena1 true combo pack</i>	1	+
<i>prenaissance capsule</i>	2	+
<i>prenaissance plus softgel</i>	2	+
PRENATA CHEWABLE TABLET	2	+
<i>prenatabs fa, rx tablet</i>	1	+
PRENATAL 19 CHEWABLE TABLET	2	+
PRENATAL 19 TABLET	2	+
<i>prenatal plus iron tablet</i>	2	+
PRENATAL PLUS VITAMIN-MINERAL	2	+
PRENATAL PLUS-DHA COMBO PACK	2	+
<i>prenatal vitamin plus low iron</i>	2	+
<i>prenatal-u capsule</i>	1	+
PRENATE AM TABLET	2	+
PRENATE CHEWABLE TABLET	2	+
PRENATE DHA SOFTGEL	2	+
PRENATE ELITE TABLET	2	+
PRENATE ENHANCE SOFTGEL	2	+
PRENATE ESSENTIAL SOFTGEL	2	+
PRENATE MINI SOFTGEL	2	+

Drug Name	Drug Tier	Requirements / Limits
PRENATE PIXIE SOFTGEL	2	+
PRENATE RESTORE SOFTGEL	2	+
PRENATE STAR TABLET	2	+
<i>preplus ca-fe 27 mg-fa 1 mg tb</i>	2	+
<i>pretab 29 mg-1 mg tablet</i>	2	+
PRIMACARE SOFTGEL	2	+
PROVIDA OB CAPSULE	2	+
<i>pyridoxine 100 mg/ml vial</i>	1	+
R-NATAL OB SOFTGEL	2	+
ROLCALTROL 0.25 MCG, 0.5 MCG CAPSULE	2	+
ROCALTROL 1 MCG/ML ORAL SOLN	2	+
SELECT-OB + DHA PACK	2	+
SELECT-OB CHEWABLE CAPLET	2	+
<i>se-natal 19 chewable tablet</i>	2	+
<i>se-natal 19 tablet</i>	2	+
<i>sod fer gluc cplx 62.5 mg/5 ml</i>	1	+
<i>taron-c dha capsule</i>	2	+
<i>taron-prex prenatal dha cap</i>	2	+
<i>thiamine 200 mg/2 ml vial</i>	1	+
THIAMINE 500 MG/100ML-0.9%NACL	2	+
THRIVITE RX TABLET	2	+
TRICARE PRENATAL TABLET	2	+
TRIFERIC 27.2 MG/5 ML AMPULE	2	+
TRIFERIC 272 MG POWDER PACKET	2	+
<i>trinatal rx 1 tablet</i>	1	+
<i>trinate tablet</i>	1	+
TRINAZ TABLET	2	+
TRISTART DHA SOFTGEL	2	+
VENOFER 100 MG/5 ML VIAL	2	+
VENOFER 200 MG/10 ML VIAL	2	+

Drug Name	Drug Tier	Requirements / Limits
VENOFER 50 MG/2.5 ML VIAL	2	+
<i>virt-c dha softgel</i>	2	+
<i>virt-nate dha softgel</i>	2	+
<i>virt-pn dha softgel</i>	2	+
<i>virt-pn plus softgel</i>	2	+
VITAFOL FE PLUS SOFTGEL	2	+
VITAFOL GUMMIES	2	+
VITAFOL NANO TABLET	2	+
VITAFOL ULTRA SOFTGEL	2	+
VITAFOL-OB CAPLET	2	+
VITAFOL-OB+DHA COMBO PACK	2	+
VITAFOL-ONE CAPSULE	2	+
VITALARA PRENATAL TABLET	2	+
VITALIPID N INFANT AMPULE	2	+
VITAMEDMD ONE RX SOFTGEL	2	+
VITAMEDMD REDICHEW RX TAB CHEW	2	+
<i>vitamin D2 1.25mg (50,000 unit)</i>	1	+
<i>vitamin K-1 1mg/0.5ml, 10 mg/ml ampule</i>	1	+
VITAPEARL SOFTGEL	2	+
VITATRUE COMBO PACK	2	+
VITLIPID N ADULT, INFANT AMPULE	2	+
VP-PNV-DHA SOFTGEL	2	+
<i>wescap-c dha softgel</i>	2	+
<i>wescap-pn dha capsule</i>	2	+
<i>westnatal dha complete</i>	2	+
<i>wesnate dha softgel</i>	2	+
<i>westab plus tablet</i>	2	+
<i>westgel dha softgel</i>	2	+
ZALVIT TABLET	2	+
<i>zatean pn dha capsule</i>	1	+
<i>zatean pn plus softgel</i>	1	+

Drug Name	Drug Tier	Requirements / Limits
<i>zingiber tablet</i>	1	+
ZIPHEX TABLET	2	+

2026 Diabetic Glucose Testing Supplies

Drug Name	Medical Benefit	Requirements/Limits
BLOOD GLUCOSE MONITORING DEVICES & SUPPLIES		
PREFERRED DIABETIC METERS		
DEXCOM G6 RECEIVER	Part B \$0 Copay	QL (1 EA/ 2 years)
DEXCOM G6 SENSOR	Part B \$0 Copay	QL (3 UNITS/ 30 day fill)
DEXCOM G6 TRANSMITTER	Part B \$0 Copay	
DEXCOM G7 RECEIVER	Part B \$0 Copay	QL (1 EA/ 2 years)
DEXCOM G7 SENSOR	Part B \$0 Copay	QL (3 UNITS/ 30 day fill)
DEXCOM RECEIVER KIT	Part B \$0 Copay	QL (1 EA/ 2 years)
FREESTYLE GLUCOSE METER	Part B \$0 Copay	QL (1 EA/ 2 years)
FREESTYLE FREEDOME LITE METER	Part B \$0 Copay	QL (1 EA/ 2 years)
FREESTYLE LIBRE 14 DAY SENSOR	Part B \$0 Copay	QL (3 UNITS/ 30 day fill)
FREESTYLE LIBRE 14 DAY READER	Part B \$0 Copay	QL (1 EACH /2 years)
FREESTYLE LIBRE 2 PLUS SENSOR	Part B \$0 Copay	QL (3 UNITS/ 30 day fill)
FREESTYLE LIBRE 2 SENSOR	Part B \$0 Copay	QL (3 UNITS/ 30 day fill)
FREESTYLE LIBRE 2 READER	Part B \$0 Copay	QL (1 EACH/ 2 years)
FREESTYLE LIBRE 3 PLUS SENSOR	Part B \$0 Copay	QL (3 UNITS/ 30 day fill)
FREESTYLE LIBRE 3 SENSOR	Part B \$0 Copay	QL (3 UNITS/ 30 day fill)
FREESTYLE LIBRE 3 READER	Part B \$0 Copay	QL (1 EACH/ 2 years)
FREESTYLE LITE GLUCOSE METER	Part B \$0 Copay	QL (1 EACH/ 2 years)
FREESTYLE PRECISION NEO METER	Part B \$0 Copay	QL (1 EACH/ 2 years)
PREFERRED DIABETIC GLUCOSE TEST STRIPS		
FREESTYLE LITE GLUCOSE TEST STRIPS	Part B \$0 Copay	QL (200 STRIPS/ 30 day fill)
FREESTYLE PREC NEO TEST STRIPS	Part B \$0 Copay	QL (200 STRIPS/ 30 day fill)
FREESTYLE TEST STRIPS	Part B \$0 Copay	QL (200 STRIPS/ 30 day fill)

2026 Covered Diabetic Lancets and Control Solutions

All lancing devices, lancets, and control solutions for diabetic blood sugar monitoring are covered. Below are examples of products available at the time the list was created.

Drug Name	Medical Benefit	Requirements/Limits
DIABETIC SUPPLIES MISCELLANEOUS		
CONTROL SOLUTIONS (EXAMPLES)		
FREESTYLE CONTROL SOLUTIONS	Part B \$0 Copay	
LANCETS AND LANCING DEVICES (EXAMPLES)		
ACTI-LANCE LANCETS	Part B \$0 Copay	
ACCU-CHEK LANCETS	Part B \$0 Copay	
BD LANCETS DEVICES	Part B \$0 Copay	
BD LANCETS	Part B \$0 Copay	
E-Z JECT LANCETS	Part B \$0 Copay	
FREESTYLE LANCETS	Part B \$0 Copay	
LANCING DEVICES	Part B \$0 Copay	
LANCETS	Part B \$0 Copay	
MEDLANCE PLUS LANCETS	Part B \$0 Copay	
TECHLITE LANCETS	Part B \$0 Copay	



1-888-281-7867 (TTY 711)

October 1 - March 31, 8 a.m. - 8 p.m. local time, 7 days a week. April 1 - September 30, 8 a.m. - 8 p.m. local time, Monday - Friday. Our automated phone system may answer your call during weekends, federal holidays and after hours. Customer service also has free language interpreter services available for non-English speakers.



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