





Effective: 7/1/2022

WELCOME TOWN OF NORTH READING

GET THE MOST OUT OF YOUR PLAN







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BLUE CARE ELECT \$2,000 DEDUCTIBLE

Town of North Reading

Plan-Year Deductible: \$2,000/\$4,000

UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:







ID CARD

Sign in

Download the app, or create an account at bluecrossma.org.





YOUR CHOICE

Your Deductible

Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for most benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductible is \$2,000 per member (or \$4,000 per family) for in-network and out-of-network services combined.

When You Choose Preferred Providers

You receive the highest level of benefits under your health care plan when you obtain covered services from preferred providers. These are called your "in-network" benefits. See the charts for your cost share.

Note: If a preferred provider refers you to another provider for covered services (such as a lab or specialist), make sure the provider is a preferred provider in order to receive benefits at the in-network level. If the provider you use is not a preferred provider, you're still covered, but your benefits, in most situations, will be covered at the out-of-network level, even if the preferred provider refers you.

How to Find a Preferred Provider

To find a preferred provider:

- Look up a provider on Find a Doctor at bluecrossma.com/findadoctor. If you need a copy of your directory or help choosing a provider, call the Member Service number on your ID card.
- Visit the Blue Cross Blue Shield of Massachusetts website at bluecrossma.org

When You Choose Non-Preferred Providers

You can also obtain covered services from non-preferred providers, but your out-of-pocket costs are higher. These are called your "out-of-network" benefits. See the charts for your cost share.

Payments for out-of-network benefits are based on the Blue Cross Blue Shield allowed charge as defined in your subscriber certificate. You may be responsible for any difference between the allowed charge and the provider's actual billed charge (this is in addition to your deductible and/or your coinsurance).

Your Out-of-Pocket Maximum

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments, and coinsurance for covered services. Your out-of-pocket maximum for medical benefits is \$5,000 per member (or \$10,000 per family) for in-network and out-of-network services combined. Your out-of-pocket maximum for prescription drug benefits is \$1,000 per member (or \$2,000 per family).

Emergency Room Services

In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call **911** (or the local emergency phone number). After meeting your deductible, you pay a copayment per visit for in-network or out-of-network emergency room services. The copayment is waived if you are admitted to the hospital or for an observation stay. See the chart for your cost share.

Telehealth Services

Telehealth services are covered when the same in-person service would be covered by the health plan and the use of telehealth is appropriate. Your health care provider will work with you to determine if a telehealth visit is medically appropriate for your health care needs or if an in-person visit is required. For a list of telehealth providers, visit the Blue Cross Blue Shield of Massachusetts website at bluecrossma.org, consult Find a Doctor, or call the Member Service number on your ID card.

Utilization Review Requirements

Certain services require pre-approval/prior authorization through Blue Cross Blue Shield of Massachusetts for you to have benefit coverage; this includes non-emergency and non-maternity hospitalization and may include certain outpatient services, therapies, procedures, and drugs. You should work with your health care provider to determine if pre-approval is required for any service your provider is suggesting. If your provider, or you, don't get pre-approval when it's required, your benefits will be denied, and you may be fully responsible for payment to the provider of the service. Refer to your subscriber certificate for requirements and the process you should follow for Utilization Review, including Pre-Admission Review, Pre-Service Approval, Concurrent Review and Discharge Planning, and Individual Case Management.

Dependent Benefits

This plan covers dependents until the end of the calendar month in which they turn age 26, regardless of their financial dependency, student status, or employment status. See your subscriber certificate (and riders, if any) for exact coverage details.

Covered Services	Your Cost In-Network	Your Cost Out-of-Network
Preventive Care		
Well-child care exams, including routine tests, according to age-based schedule as follows: 10 visits during the first year of life Three visits during the second year of life (age 1 to age 2) Two visits for age 2 One visit per calendar year for age 3 and older	Nothing , no deductible	20% coinsurance after deductible
Routine adult physical exams, including related tests (one per calendar year)	Nothing, no deductible	20% coinsurance after deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible	20% coinsurance after deductible
Routine hearing exams, including routine tests	Nothing, no deductible	20% coinsurance after deductible
Hearing aids (up to \$2,000 per ear every 36 months for a member age 21 or younger)	All charges beyond the maximum, no deductible	20% coinsurance after deductible and all charges beyond the maximum
Routine vision exams (one every 24 months)	Nothing, no deductible	20% coinsurance after deductible
Family planning services—office visits	Nothing, no deductible	20% coinsurance after deductible
Outpatient Care		
Emergency room visits	\$150 per visit after deductible (copayment waived if admitted or for an observation stay)	\$150 per visit after deductible (copayment waived if admitted or for an observation stay)
Office or health center visits, when performed by: • A family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, limited services clinic, multi-specialty provider group, or by a physician assistant or nurse practitioner designated as primary care • Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	\$30 per visit, no deductible \$45 per visit, no deductible	20% coinsurance after deductible 20% coinsurance after deductible
Mental health or substance use treatment	\$30 per visit, no deductible	20% coinsurance after deductible
Outpatient telehealth services • With a covered provider • With the designated telehealth vendor	Same as in-person visit \$30 per visit, no deductible	Same as in-person visit Not applicable
Chiropractors' office visits	\$45 per visit, no deductible	20% coinsurance after deductible
Acupuncture visits (up to 12 visits per calendar year)	\$45 per visit, no deductible	20% coinsurance after deductible
Short-term rehabilitation therapy—physical and occupational (up to 100 visits per calendar year*)	\$45 per visit, no deductible	20% coinsurance after deductible
Speech, hearing, and language disorder treatment—speech therapy	\$45 per visit, no deductible	20% coinsurance after deductible
Diagnostic X-rays and lab tests, including CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	Nothing after deductible	20% coinsurance after deductible
Home health care and hospice services	Nothing after deductible	20% coinsurance after deductible
Oxygen and equipment for its administration	Nothing after deductible	20% coinsurance after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds	20% coinsurance after deductible**	40% coinsurance after deductible**
Prosthetic devices	20% coinsurance after deductible	40% coinsurance after deductible
Surgery and related anesthesia in an office or health center, when performed by: • A family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, multi-specialty provider group, or by a physician assistant or nurse practitioner designated as primary care	\$30 per visit***, no deductible	20% coinsurance after deductible
Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	\$45 per visit***, no deductible	20% coinsurance after deductible
Surgery and related anesthesia in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	Nothing after deductible	20% coinsurance after deductible
Inpatient Care (including maternity care)		
General or chronic disease hospital care (as many days as medically necessary)	Nothing after deductible	20% coinsurance after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	Nothing after deductible	20% coinsurance after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing after deductible	20% coinsurance after deductible
Skilled nursing facility care (up to 100 days per calendar year)	Nothing after deductible	20% coinsurance after deductible
* No. 25 Period and the control of t		

^{*} No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or for the treatment of autism spectrum disorders.

** In-network cost share waived for one breast pump per birth (20% coinsurance after deductible out-of-network).

*** Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.

Covered Services	Your Cost In-Network	Your Cost Out-of-Network
Prescription Drug Benefits*		
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)**	No deductible \$20 for Tier 1 \$40 for Tier 2 \$60 for Tier 3	Not covered
Through the designated mail order pharmacy (up to a 90-day formulary supply for each prescription or refill)**	No deductible \$40 for Tier 1 \$80 for Tier 2 \$120 for Tier 3	Not covered

Generally, Tier 1 refers to generic drugs; Tier 2 refers to preferred brand-name drugs; Tier 3 refers to non-preferred brand-name drugs.

Get the Most from Your Plan: Visit us at bluecrossma.org or call 1–800–831–8730 to learn about discounts, savings, resources, and special programs available to you, like those listed below.

available to you, like those listed below.	
Wellness Participation Program Fitness Reimbursement: a program that rewards participation in qualified fitness programs or equipment (See your subscriber certificate for details.)	\$150 per calendar year per policy
Weight Loss Reimbursement: a program that rewards participation in a qualified weight loss program (See your subscriber certificate for details.)	\$150 per calendar year per policy

24/7 Nurse Line: Speak to a registered nurse, day or night, to get immediate guidance and advice. Call 1-888-247-BLUE (2583). No additional charge.

QUESTIONS?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-831-8730, or visit us online at bluecrossma.org.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your subscriber certificate and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the subscriber certificate and riders will govern. Some of the services not covered are: cosmetic surgery; custodial care; most dental care; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your subscriber certificate and riders.

Cost share may be waived for certain covered drugs and supplies. Retail drugs are available in a 90-day supply at three times the standard retail cost share.

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Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services **Blue Care Elect \$2000 Deductible:**

Town of North Reading

Coverage Period: on or after 07/01/2022 Coverage for: Individual and Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, see bluecrossma.org/coverage-info. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at bluecrossma.org/sbcglossary or call 1-800-831-8730 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$2,000 member / \$4,000 family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. In-network preventive and prenatal care, most office visits, mental health visits, therapy visits, and prescription drugs.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	For medical benefits, \$5,000 member / \$10,000 family; and for prescription drug benefits, \$1,000 member / \$2,000 family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limits</u> has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a <u>network provider</u> ?	Yes. See bluecrossma.com/findadoctor or call the Member Service number on your ID card for a list of network providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

		What You	ı Will Pay	
Common Medical Event	Services You May Need	In-Network (You will pay the least)	Out-of-Network (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	\$30 / visit	20% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of- network; family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric <u>specialist</u> , nurse midwife, limited services clinic, multi- specialty <u>provider</u> group, or by a physician assistant or nurse practitioner designated as primary care; a telehealth <u>cost share</u> may be applicable
If you visit a health care provider's office or clinic	<u>Specialist</u> visit	\$45 / visit; \$45 / chiropractor visit; \$45 / acupuncture visit	20% <u>coinsurance;</u> 20% <u>coinsurance</u> / chiropractor visit; 20% <u>coinsurance</u> / acupuncture visit	Deductible applies first for out-of- network; includes physician assistant or nurse practitioner designated as specialty care; limited to 12 acupuncture visits per calendar year; a telehealth cost share may be applicable
	Preventive care/screening/immunization	No charge	20% <u>coinsurance</u>	Deductible applies first for out-of- network; limited to age-based schedule and / or frequency; a telehealth cost share may be applicable. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	<u>Deductible</u> applies first; <u>pre-</u> <u>authorization</u> may be required
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	<u>Deductible</u> applies first; <u>pre-</u> <u>authorization</u> may be required

		What You Will Pay			
Common Medical Event	Services You May Need	In-Network (You will pay the least)	Out-of-Network (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Generic drugs	\$20 / retail supply or \$40 / mail order supply	Not covered	Up to 30-day retail (90-day mail order)	
If you need drugs to treat your illness or condition More information about	Preferred brand drugs	\$40 / retail supply or \$80 / mail order supply	Not covered	supply; <u>cost share</u> may be waived for certain covered drugs and supplies; <u>pre-authorization</u> required for certain	
prescription drug coverage is available at bluecrossma.org/medicatio n	Non-preferred brand drugs	\$60 / retail supply or \$120 / mail order supply	Not covered	drugs	
	Specialty drugs	Applicable <u>cost share</u> (generic, preferred, non-preferred)	Not covered	When obtained from a designated specialty pharmacy; pre-authorization required for certain drugs	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	<u>Deductible</u> applies first; <u>pre-</u> <u>authorization</u> required for certain services	
	Physician/surgeon fees	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-</u> <u>authorization</u> required for certain services	
	Emergency room care	\$150 / visit	\$150 / visit	<u>Deductible</u> applies first; <u>copayment</u> waived if admitted or for observation stay	
If you need immediate medical attention	Emergency medical transportation	No charge	No charge	<u>Deductible</u> applies first	
medical attention	<u>Urgent care</u>	\$45 / visit	20% <u>coinsurance</u>	<u>Deductible</u> applies first for out-of- network; a telehealth <u>cost share</u> may be applicable	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	<u>Deductible</u> applies first; <u>pre-</u> <u>authorization</u> required	
	Physician/surgeon fees	No charge	20% coinsurance	<u>Deductible</u> applies first; <u>pre-</u> <u>authorization</u> required	

		What You Will Pay			
Common Medical Event	Services You May Need	In-Network (You will pay the least)	Out-of-Network (You will pay the most)	Limitations, Exceptions, & Other Important Information	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 / visit	20% coinsurance	<u>Deductible</u> applies first for out-of- network; a telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services	
	Inpatient services	No charge	20% coinsurance	<u>Deductible</u> applies first; <u>pre-</u> <u>authorization</u> required for certain services	
	Office visits	No charge	20% coinsurance	Deductible applies first except for in-	
	Childbirth/delivery professional services	No charge	20% coinsurance	network prenatal care; cost sharing	
If you are pregnant	Childbirth/delivery facility services	No charge	20% coinsurance	does not apply for in-network <u>preventive services</u> ; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); a telehealth <u>cost</u> <u>share</u> may be applicable	

		What You Will Pay		
Common Medical Event	Services You May Need	In-Network (You will pay the least)	Out-of-Network (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Home health care	No charge	20% coinsurance	<u>Deductible</u> applies first; <u>pre-</u> <u>authorization</u> required
If you need help recovering or have other special health needs	Rehabilitation services	\$45 / visit for outpatient services; No charge for inpatient services	20% <u>coinsurance</u> for outpatient services; 20% <u>coinsurance</u> for inpatient services	Deductible applies first except for innetwork outpatient services; limited to 100 outpatient visits per calendar year (other than for autism, home health care, and speech therapy); limited to 60 days per calendar year for inpatient admissions; a telehealth cost share may be applicable; preauthorization required for certain services
	Habilitation services	\$45 / visit	20% <u>coinsurance</u>	Deductible applies first for out-of- network; outpatient rehabilitation therapy coverage limits apply; cost share and coverage limits waived for early intervention services for eligible children; a telehealth cost share may be applicable
	Skilled nursing care	No charge	20% coinsurance	Deductible applies first; limited to 100 days per calendar year; pre- authorization required
	Durable medical equipment	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Deductible</u> applies first; in-network <u>cost share</u> waived for one breast pump per birth (20% <u>coinsurance</u> for out-of-network)
	Hospice services	No charge	20% coinsurance	<u>Deductible</u> applies first; <u>pre-</u> <u>authorization</u> required for certain services

		What You Will Pay		
Common Medical Event	Services You May Need	In-Network (You will pay the least)	Out-of-Network (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Children's eye exam	No charge	20% coinsurance	<u>Deductible</u> applies first for out-of- network; limited to one exam every 24 months
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	No charge for members with a cleft palate / cleft lip condition	20% <u>coinsurance</u> for members with a cleft palate / cleft lip condition	<u>Deductible</u> applies first for out-of- network; limited to members under age 18

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Children's glasses
- Cosmetic surgery

- Dental care (Adult)
- Long-term care

• Private-duty nursing

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (12 visits per calendar year)
- Bariatric surgery
- Chiropractic care
- Hearing aids (\$2,000 per ear every 36 months for members age 21 or younger)
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Routine eye care adult (one exam every 24 months)
- Routine foot care (only for patients with systemic circulatory disease)
- Weight loss programs (\$150 per calendar year per policy)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Your state insurance department might also be able to help. If you are a Massachusetts resident, you can contact the Massachusetts Division of Insurance at 1-877-563-4467 or www.mass.gov/doi. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. For more information about possibly buying individual coverage through a state exchange, you can contact your state's marketplace, if applicable. If you are a Massachusetts resident, contact the Massachusetts Health Connector by visiting www.mahealthconnector.org. For more information on your rights to continue your employer coverage, contact your pull-nember sponsor is usually the member's employer or organization that provides group health coverage to the member.)

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, call 1-800-472-2689 or contact your <u>plan</u> sponsor. (A <u>plan</u> sponsor is usually the member's employer or organization that provides group health coverage to the member.) You may also contact The Office of Patient Protection at 1-800-436-7757 or <u>www.mass.gov/hpc/opp</u>.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Disclaimer: This document contains only a partial description of the benefits, limitations, exclusions and other provisions of this health care <u>plan</u>. It is not a policy. It is a general overview only. It does not provide all the details of this coverage, including benefits, exclusions and policy limitations. In the event there are discrepancies between this document and the policy, the terms and conditions of the policy will govern.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network prenatal care and a hospital delivery)

■The <u>plan</u> 's overall <u>deductible</u>	\$2,000
■ Delivery fee <u>copay</u>	\$0
■Facility fee copay	\$0
■ Diagnostic tests copay	\$0

This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost	\$12,700

In this example, Peg would pay:

Oost onanny	
<u>Deductibles</u>	\$2,000
Copayments	\$10
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,070

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■The <u>plan</u> 's overall <u>deductible</u>	\$2,000
■Specialist visit copay	\$45
■Primary care visit copay	\$30
■ Diagnostic tests copay	\$0

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (including disease education)
Diagnostic tests (blood work)

Prescription drugs

<u>Durable medical equipment</u> (glucose meter)

Total Example Cost \$5,600

In this example, Joe would pay:

Cost Sharing			
<u>Deductibles</u>	\$100		
Copayments	\$1,300		
Coinsurance	\$0		
What isn't covered			
Limits or exclusions \$2			
The total Joe would pay is	\$1,420		

Mia's Simple Fracture

(in-network emergency room visit and follow-up care)

■The <u>plan</u> 's overall <u>deductible</u>	\$2,000
■Specialist visit copay	\$45
■Emergency room <u>copay</u>	\$150
■ Amhulance services conav	0.2

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

Total Example Cost

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

In this example, Mia would pay:

in the example, and treata pay.		
Cost Sharing		
<u>Deductibles</u>	\$1,900	
<u>Copayments</u>	\$200	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$2,100	

\$2.800







This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect January 1, 2014, as part of the Massachusetts Health Care Reform Law.



PREFERRED PROVIDER ORGANIZATION (PPO)

IMPORTANT INFORMATION ABOUT YOUR PLAN

Your health plan lets you get care from providers who participate in the Blue Cross Blue Shield PPO Network (preferred), as well as from providers who are out of our network. You'll pay lower out-of-pocket costs for care when you see in-network providers, and higher out-of-pocket costs when you see out-of-network providers.



HOW TO ACCESS IMPORTANT RESOURCES

We're committed to your health—that's why we offer additional programs, benefits, and discounts beyond traditional health care coverage. Use these tools and resources to monitor your health and overall wellness.

Unlock the Power of Your Plan: MyBlue is your key to more features and savings. Plus, you can track your claims, medications, account balances, and more. Download the MyBlue app or create an account at **bluecrossma.org**.

Let Team Blue Lend a Hand: Your health plan comes with a special feature: a coordinated team, ready to spring into action whether you need help understanding your coverage or getting the care you need. Need answers, access, or advice? Just ask. Call 1-800-262-2583.

Get Exclusive Health and Wellness Deals: Blue365® offers great discounts and deals on sportswear, nutrition, travel, fitness equipment, and more. Explore available deals at **blue365deals.com**.

Need to Find a Doctor?

Go to bluecrossma.org
 Click Find a Doctor under Find Care
 Enter a provider or type of care, then select either the PPO or EPO network

ACCESSING CARE

Routine health checkups are one of the best ways you and your doctor can stay on top of your health. When selecting a doctor, consider the hospital where that doctor has admitting privileges.

Finding a Provider: You don't have to choose a primary care provider (PCP) to help manage your care, but you should see in-network doctors to pay the lowest out-of-pocket costs. You can also see out-of-network doctors, but you'll pay higher out-of-pocket costs.

Seeing a Specialist: You don't need a referral from your PCP to see a specialist. However, you should talk with your doctor about the specialty care you may need.

Telehealth Visits: When appropriate, you can choose to have phone or video visits with covered medical and mental health care providers. Ask your provider if they offer telehealth.

24/7 Nurse Line: Speak to a registered nurse, right when you need to, day or night. Call **1-888-247-BLUE** (**2583**).

UNDERSTANDING PRIOR AUTHORIZATION

To make sure you only get care that's medically necessary and covered by your plan, your doctor needs to obtain prior authorization, or approval, from us for certain services, procedures, or medications. Without prior authorization, your care may not be covered, and you may have to pay the full cost. Be sure to ask your doctor if prior authorization is needed before you receive care.

ABOUT YOUR ID CARD

Show your member ID card every time you get care. Your ID card includes important information, such as your ID number, copay amounts, and if you have pharmacy coverage.* You can also download the MyBlue app and use it to email a digital version of your card to your doctor, or order a new ID card.

*As of January 1, 2022, your ID card will also include information about the maximum deductible and out-of-pocket costs for your plan.

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).

ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: 711).



HMO BLUE NEW ENGLAND BASIC COPAYMENT

Town of North Reading

Plan-Year Deductible: \$2,000/\$4,000

UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:







DIGITAL ID CARD

Sign in

Download the app, or create an account at bluecrossma.org.





YOUR CARE

Your Primary Care Provider (PCP)

When you enroll in this health plan, you must choose a primary care provider. Be sure to choose a PCP who can accept you and your family members and who participates in the network of providers in New England. For children, you may choose a participating network pediatrician as the PCP.

For a list of participating PCPs or OB/GYN physicians, visit the Blue Cross Blue Shield of Massachusetts website at **bluecrossma.org**; consult Find a Doctor at **bluecrossma.com/findadoctor**; or call the Member Service number on your ID card.

If you have trouble choosing a doctor, Member Service can help. They can give you the doctor's gender, the medical school the doctor attended, and whether there are languages other than English spoken in the office.

Referrals

Your PCP is the first person you call when you need routine or sick care. If your PCP decides that you need to see a specialist for covered services, your PCP will refer you to an appropriate network specialist, who is likely affiliated with your PCP's hospital or medical group.

You will not need prior authorization or referral to see an HMO Blue New England network provider who specializes in OB/GYN services. Your providers may also work with Blue Cross Blue Shield of Massachusetts regarding referrals and Utilization Review Requirements, including Pre-Admission Review, Concurrent Review and Discharge Planning, Prior Approval for Certain Outpatient Services, and Individual Case Management. For detailed information about Utilization Review, see your subscriber certificate.

Your Deductible

Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for most benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductible is \$2,000 per member (or \$4,000 per family).

Your Out-of-Pocket Maximum

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments, and coinsurance for covered services. Your out-of-pocket maximum for medical benefits is \$5,000 per member (or \$10,000 per family). Your out-of-pocket maximum for prescription drug benefits is \$1,000 per member (or \$2,000 per family).

Emergency Room Services

In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call 911 (or the local emergency phone number). After meeting your deductible, you pay a copayment per visit for emergency room services. This copayment is waived if you're admitted to the hospital or for an observation stay. See the chart for your cost share.

Telehealth Services

Telehealth services are covered when the same in-person service would be covered by the health plan and the use of telehealth is appropriate. Your health care provider will work with you to determine if a telehealth visit is medically appropriate for your health care needs or if an in-person visit is required. For a list of telehealth providers, visit the Blue Cross Blue Shield of Massachusetts website at **bluecrossma.org**, consult Find a Doctor, or call the Member Service number on your ID card.

Service Area

The plan's service area includes all cities and towns in the Commonwealth of Massachusetts, State of Rhode Island, State of Vermont, State of Connecticut, State of New Hampshire, and State of Maine.

When Outside the Service Area

If you're traveling outside the service area and you need urgent or emergency care, you should go to the nearest appropriate health care facility. You are covered for the urgent or emergency care visit and one follow-up visit while outside the service area. Any additional follow-up care must be arranged by your PCP. See your subscriber certificate for more information.

Dependent Benefits

This plan covers dependents until the end of the calendar month in which they turn age 26, regardless of their financial dependency, student status, or employment status. See your subscriber certificate (and riders, if any) for exact coverage details.

Covered Services	Your Cost
Preventive Care	
Well-child care exams	Nothing, no deductible
Preventive dental care for children under age 12 (one visit each six months)	Nothing, no deductible
Routine adult physical exams, including related tests	Nothing, no deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible
Routine hearing exams, including routine tests	Nothing, no deductible
Hearing aids (up to \$2,000 per ear every 36 months for a member age 21 or younger)	All charges beyond the maximum, no deductible
Routine vision exams (one every 24 months)	Nothing, no deductible
Family planning services—office visits	Nothing, no deductible
Outpatient Care	
Emergency room visits	\$750 per visit after deductible (copayment waived if admitted or for observation stay)
Office or health center visits, when performed by: Your PCP, OB/GYN physician, nurse midwife, limited services clinic, or by a physician assistant or nurse practitioner designated as primary care Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	\$30 per visit, no deductible \$45 per visit, no deductible
Mental health or substance use treatment	\$30 per visit, no deductible
Outpatient telehealth services • With a covered provider • With the designated telehealth vendor	Same as in-person visit \$30 per visit, no deductible
Chiropractors' office visits	\$45 per visit, no deductible
Acupuncture visits (up to 12 visits per calendar year)	\$45 per visit, no deductible
Short-term rehabilitation therapy—physical and occupational (up to 60 visits per calendar year*)	\$45 per visit after deductible
Speech, hearing, and language disorder treatment—speech therapy	\$45 per visit after deductible
Diagnostic tests • X-rays • Lab tests • CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	\$25 per service date after deductible \$25 per service date after deductible \$1,000 per category per service date after deductible
Home health care and hospice services	Nothing after deductible
Oxygen and equipment for its administration	Nothing after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds	20% coinsurance after deductible**
Prosthetic devices	20% coinsurance after deductible
 Surgery and related anesthesia in an office or health center, when performed by: Your PCP, OB/GYN physician, nurse midwife, or by a physician assistant or nurse practitioner designated as primary care Other covered providers, including a physician assistant or nurse practitioner designated as specialty care 	\$30 per visit***, no deductible \$45 per visit***, no deductible
Surgery and related anesthesia in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	\$1,000 per admission after deductible
Inpatient Care (including maternity care)	
General or chronic disease hospital care (as many days as medically necessary)	\$1,000 per admission after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	\$1,000 per admission after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	\$1,000 per admission after deductible
Skilled nursing facility care (up to 100 days per calendar year)	\$1,000 per admission after deductible
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* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or for the treatment of autism spectrum disorders.

** Cost share waived for one breast pump per birth.

*** Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.

Covered Services	Your Cost
Prescription Drug Benefits*	
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)**	No deductible \$20 for Tier 1 \$40 for Tier 2 \$60 for Tier 3
Through the designated mail order pharmacy (up to a 90-day formulary supply for each prescription or refill)**	No deductible \$40 for Tier 1 \$80 for Tier 2 \$120 for Tier 3

Generally, Tier 1 refers to generic drugs; Tier 2 refers to preferred brand-name drugs; Tier 3 refers to non-preferred brand-name drugs.

Get the Most from Your Plan: Visit us at bluecrossma.org or call 1–800–831–8730 to learn about discounts, savings, resources, and special programs available to you, like those listed below.

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Wellness Participation Program Fitness Reimbursement: a program that rewards participation in qualified fitness programs or equipment (See your subscriber certificate for details.)	\$150 per calendar year per policy
Weight Loss Reimbursement: a program that rewards participation in a qualified weight loss program (See your subscriber certificate for details.)	\$150 per calendar year per policy

24/7 Nurse Line: Speak to a registered nurse, day or night, to get immediate guidance and advice. Call 1-888-247-BLUE (2583). No additional charge.

QUESTIONS?

For questions about Blue Cross Blue Shield of Massachusetts, call 1-800-831-8730, or visit us online at bluecrossma.org.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your subscriber certificate and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the subscriber certificate and riders will govern. Some of the services not covered are: cosmetic surgery; custodial care; most dental care; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your subscriber certificate and riders.

Cost share may be waived for certain covered drugs and supplies. Retail drugs are available in a 90-day supply at three times the standard retail cost share.

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Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services **HMO Blue New England Basic Copayment:**

Town of North Reading

Coverage Period: on or after 07/01/2022 Coverage for: Individual and Family | Plan Type: HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, see bluecrossma.org/coverage-info. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at bluecrossma.org/sbcglossary or call 1-800-831-8730 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$2,000 member / \$4,000 family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> , prenatal care, <u>prescription drugs</u> , most office visits, and mental health visits.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	For medical benefits, \$5,000 member / \$10,000 family; and for prescription drug benefits, \$1,000 member / \$2,000 family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limits</u> has been met.
What is not included in the <u>out-of-pocket limit?</u>	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See bluecrossma.com/findadoctor or call the Member Service number on your ID card for a list of network providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .

All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

		What You Will Pay		
Common Medical Event	Services You May Need	In-Network (You will pay the least)	Out-of-Network (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	\$30 / visit	Not covered	A telehealth <u>cost share</u> may be applicable
If you visit a health care provider's office or clinic	Specialist visit	\$45 / visit; \$45 / chiropractor visit; \$45 / acupuncture visit	Not covered	Limited to 12 acupuncture visits per calendar year; a telehealth cost share may be applicable
	Preventive care/screening/immunization	No charge	Not covered	GYN exam limited to one exam per calendar year; a telehealth <u>cost share</u> may be applicable. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	\$25	Not covered	Deductible applies first; copayment applies per category of test / day; pre-authorization required for certain services
	Imaging (CT/PET scans, MRIs)	\$1,000	Not covered	Deductible applies first; copayment applies per category of test / day; pre-authorization required for certain services

		What You Will Pay			
Common Medical Event	Services You May Need	In-Network (You will pay the least)	Out-of-Network (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Generic drugs	\$20 / retail supply or \$40 / mail order supply	Not covered	Up to 30-day retail (90-day mail order)	
If you need drugs to treat your illness or condition More information about	Preferred brand drugs	\$40 / retail supply or \$80 / mail order supply	Not covered	supply; cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain	
prescription drug coverage is available at bluecrossma.org/medicatio n	Non-preferred brand drugs	\$60 / retail supply or \$120 / mail order supply	Not covered	drugs	
	Specialty drugs	Applicable <u>cost share</u> (generic, preferred, non-preferred)	Not covered	When obtained from a designated specialty pharmacy; pre-authorization required for certain drugs	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$1,000 / admission	Not covered	<u>Deductible</u> applies first; <u>pre-</u> <u>authorization</u> required for certain services	
	Physician/surgeon fees	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-</u> <u>authorization</u> required for certain services	
If you need immediate medical attention	Emergency room care	\$750 / visit	\$750 / visit	<u>Deductible</u> applies first; <u>copayment</u> waived if admitted or for observation stay	
	Emergency medical transportation	No charge	No charge	<u>Deductible</u> applies first	
	<u>Urgent care</u>	\$45 / visit	\$45 / visit	Out-of-network coverage limited to out of service area; a telehealth cost share may be applicable	

		What You Will Pay			
Common Medical Event	Services You May Need	In-Network (You will pay the least)	Out-of-Network (You will pay the most)	Limitations, Exceptions, & Other Important Information	
If you have a hearital atoy	Facility fee (e.g., hospital room)	\$1,000 / admission	Not covered	<u>Deductible</u> applies first; <u>pre-</u> <u>authorization</u> required	
If you have a hospital stay	Physician/surgeon fees	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-</u> <u>authorization</u> required	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 / visit	Not covered	A telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services	
	Inpatient services	\$1,000 / admission	Not covered	<u>Deductible</u> applies first; <u>pre-</u> <u>authorization</u> required for certain services	
	Office visits	No charge	Not covered	Deductible applies first except for	
	Childbirth/delivery professional services	No charge	Not covered	prenatal care; cost sharing does not	
If you are pregnant	Childbirth/delivery facility services	\$1,000 / admission	Not covered	apply for <u>preventive services</u> ; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); a telehealth <u>cost share</u> may be applicable	

		What You Will Pay		
Common Medical Event	Services You May Need	In-Network (You will pay the least)	Out-of-Network (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Home health care	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-</u> <u>authorization</u> required
If you need help recovering or have other special health needs	Rehabilitation services	\$45 / visit for outpatient services; \$1,000 / admission for inpatient services	Not covered	Deductible applies first; limited to 60 outpatient visits per calendar year (other than for autism, home health care, and speech therapy); limited to 60 days per calendar year for inpatient admissions; a telehealth cost share may be applicable; preauthorization required for certain services
	Habilitation services	\$45 / visit	Not covered	Deductible applies first; outpatient rehabilitation therapy coverage limits apply; cost share and coverage limits waived for early intervention services for eligible children; a telehealth cost share may be applicable; preauthorization required for certain services
	Skilled nursing care	\$1,000 / admission	Not covered	Deductible applies first; limited to 100 days per calendar year; pre- authorization required
	Durable medical equipment	20% coinsurance	Not covered	<u>Deductible</u> applies first; <u>cost share</u> waived for one breast pump per birth
	Hospice services	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-</u> <u>authorization</u> required for certain services
	Children's eye exam	No charge	Not covered	Limited to one exam every 24 months
If your child needs dental	Children's glasses	Not covered	Not covered	None
or eye care	Children's dental check-up	No charge	Not covered	Limited to children under age 12 (every 6 months) and under age 18 with a cleft palate / cleft lip condition

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Children's glasses
- Cosmetic surgery
- Dental care (Adult)

- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)

- Acupuncture (12 visits per calendar year)
- Bariatric surgery
- Chiropractic care
- Hearing aids (\$2,000 per ear every 36 months for members age 21 or younger)
- Infertility treatment
- Routine eye care adult (one exam every 24 months)
- Routine foot care (only for patients with systemic circulatory disease)
- Weight loss programs (\$150 per calendar year per policy)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Your state insurance department might also be able to help. If you are a Massachusetts resident, you can contact the Massachusetts Division of Insurance at 1-877-563-4467 or www.mass.gov/doi. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. For more information about possibly buying individual coverage through a state exchange, you can contact your state's marketplace, if applicable. If you are a Massachusetts resident, contact the Massachusetts Health Connector by visiting www.mahealthconnector.org. For more information on your rights to continue your employer coverage, contact your <a href="pull-new manage-pull-new mana

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, call 1-800-472-2689 or contact your <u>plan</u> sponsor. (A <u>plan</u> sponsor is usually the member's employer or organization that provides group health coverage to the member.) You may also contact The Office of Patient Protection at 1-800-436-7757 or <u>www.mass.gov/hpc/opp</u>.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Disclaimer: This document contains only a partial description of the benefits, limitations, exclusions and other provisions of this health care <u>plan</u>. It is not a policy. It is a general overview only. It does not provide all the details of this coverage, including benefits, exclusions and policy limitations. In the event there are discrepancies between this document and the policy, the terms and conditions of the policy will govern.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network prenatal care and a hospital delivery)

■The plan's overall deductible	\$2,000
■ Delivery fee <u>copay</u>	\$0
■Facility fee copay	\$1,000
■ Diagnostic tests copay	\$25

This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost \$12,700

In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$1,100
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,160

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■The plan's overall deductible	\$2,000
■Specialist visit copay	\$45
■ Primary care visit <u>copay</u>	\$30
■ Diagnostic tests copay	\$25

This EXAMPLE event includes services like:

Primary care physician office visits (including disease education)

Diagnostic tests (blood work)

Prescription drugs

<u>Durable medical equipment</u> (glucose meter)

Total Example Cost	\$5,600

In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$100
Copayments	\$1,300
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,420

Mia's Simple Fracture

(in-network emergency room visit and follow-up care)

■The plan's overall deductible	\$2,000
■Specialist visit copay	\$45
■Emergency room <u>copay</u>	\$750
■ Ambulance services conav	\$0

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

Total Example Cost \$2,800

In this example, Mia would pay:

in the example, and treata pay.	
Cost Sharing	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$200
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,200







This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect January 1, 2014, as part of the Massachusetts Health Care Reform Law.



HMO BLUE NEW ENGLAND

IMPORTANT INFORMATION ABOUT YOUR PLAN

Your health plan lets you get care from providers who participate in the **HMO Blue New England Network**. Under this plan, you're required to choose a primary care provider (PCP) to manage your care and refer you to specialists.



HOW TO ACCESS IMPORTANT RESOURCES

We're committed to your health—that's why we offer additional programs, benefits, and discounts beyond traditional health care coverage. Use these tools and resources to monitor your health and overall wellness.

Unlock the Power of Your Plan: MyBlue is your key to more features and savings. Plus, you can track your claims, medications, account balances, and more. To create an account, go to **bluecrossma.org** or download the MyBlue app.

Let Team Blue Lend a Hand: Your health plan comes with a special feature: a coordinated team, ready to spring into action whether you need help understanding your coverage or getting the care you need. Need answers, access, or advice? Just ask. Call 1-800-262-2583.

Get Exclusive Health and Wellness Deals: Blue 365® offers great discounts and deals on sportswear, nutrition, travel, fitness equipment, and more. Explore available deals at **blue 365 deals.com**.

Need to Find a Doctor?

Go to **bluecrossma.org** to use the **Find a Doctor** tool. To search for an in-network doctor, specialist, or hospital near you, select the network: **HMO Blue New England**.

ACCESSING CARE

The Importance of a Primary Care Provider: Routine health checkups with your PCP are one of the best ways you can stay on top of your health. Your PCP can also manage your care and refer you to specialists.

Choose a PCP for yourself and every member of your family covered under your plan. Everyone doesn't need to see the same PCP.

When selecting a PCP, consider the hospital where your PCP has admitting privileges. You can use the **Find a Doctor** tool to find this information.

Seeing a Specialist: If you need to see a specialist, your PCP must refer you for the care to be covered under your plan. Make sure your PCP has contacted the specialist's office and provided the referral.

Telehealth Visits: When appropriate, you can choose to have phone or video visits with covered medical and mental health care providers. Ask your provider if they offer telehealth.

24/7 Nurse Line: Speak to a registered nurse, right when you need to, day or night. Call 1-888-247-BLUE (2583).

UNDERSTANDING PRIOR AUTHORIZATION

To make sure you only get care that's medically necessary and covered by your plan, your doctor needs to obtain prior authorization, or approval, from us for certain services, procedures, or medications. Without prior authorization, your care may not be covered, and you may have to pay the full cost. Be sure to ask your doctor if prior authorization is needed before you receive care.

ABOUT YOUR ID CARD

You need to show your member ID card when you go to the doctor or a hospital. It includes important details, such as copay amounts and your member ID number.* If you have pharmacy coverage, this will be noted, too. You can use the MyBlue app to view, download, and email a digital version of your card.

Lost your ID card?

No problem, you can order another one through MyBlue.

*As of January 1, 2022, your ID card will also include information about the maximum deductible and out-of-pocket costs for your plan.

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).

ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: 711).



DENTAL BLUE° **PROGRAM 1**

Town of North Reading

UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:







ID CARD

Sign in

Download the app, or create an account at bluecrossma.org.



DENTAL BLUE PROGRAM 1

Preventive Benefit Group	Basic Benefit Group
No Deductible	\$50 Per Member/\$150 Per Family Calendar-Year Deductible
Full Coverage	80% Coverage

\$750 Per Member Calendar-Year Benefit Maximum

Diagnostic

- One complete initial oral exam, including initial dental history and charting of the teeth and supporting structures
- Full mouth X-rays, seven or more films, or panoramic X-ray with bitewing X-rays once each 60 months
- · Bitewing X-rays twice per calendar year
- Single tooth X-rays as needed
- · Study models and casts used in planning treatment once each 60 months
- Periodic or routine oral exams twice per calendar year
- · Emergency exams

Preventive

- · Routine cleaning, scaling, and polishing of the teeth twice per calendar year
- Fluoride treatment twice per calendar year (members under age 19)
- Sealants on permanent pre-molar and molar surfaces (members under age 14).
 Benefits are provided for one application per bicuspid or molar surface each 48 months.
- Space maintainers needed due to premature tooth loss (members under age 19)

Restorative

- Amalgam (silver) fillings (limited to one filling for each tooth surface in a 12-month period)
- Composite resin (tooth color) fillings (limited to one filling for each tooth surface in a 12-month period)
- · Pin retention for fillings
- Stainless steel crowns on baby teeth and on first permanent adult molars (members under age 16)

Oral Surgery

- Tooth extraction
- Root removal
- · Biopsies

Periodontics (gum and bone)

- Periodontal scaling and root planing once per quadrant each 24 months
- Periodontal surgery once per quadrant each 36 months
- Periodontal maintenance following active periodontal therapy once each three months

Endodontics (roots and pulp)

- · Root canal therapy (permanent teeth, once in a lifetime per tooth)
- Retreatment root canal therapy on permanent teeth, once in a lifetime for each tooth
- Therapeutic pulpotomy on primary or permanent teeth (members under age 16)
- · Other endodontic surgery to treat or remove the dental root

Prosthetic Maintenance

- Repair of partial or complete dentures, crowns, and bridges once each 12 months
- · Adding teeth to an existing complete or partial denture
- · Rebase or reline of dentures once each 36 months
- Recementing of crowns, inlays, onlays, and fixed bridgework once each 12 months

Other Services

- · Occlusal adjustments once each 24 months
- · Services to treat root sensitivity
- Emergency dental care to treat acute pain or to prevent permanent harm to a member
- General anesthesia when administered in conjunction with covered surgical services

WELCOME TO DENTAL BLUE,

A COMPREHENSIVE DENTAL PLAN PROVIDING BROAD NETWORK ACCESS TO MEET YOUR DENTAL CARE NEEDS.

Your Dentist

Dental Blue offers an extensive network of dentists. Over 90 percent of dentists in Massachusetts and Rhode Island participate with Blue Cross Blue Shield of Massachusetts. Dental Blue members also have access to participating dentists nationwide.

If you would like help choosing a dentist, or already have a dentist and want to know if they participate with your plan, you can call the dentist, look at the current dental provider directory, or call Member Service at the toll–free phone number shown on your Dental Blue ID card. You can also access the online dental provider directory at **bluecrossma.org**.

Your Benefits

The dental benefits your plan covers are subject to the calendar-year deductible and coinsurance (if applicable), and benefit maximum amounts shown in the chart. The calendar year begins on January 1 and ends on December 31 of each year. The chart also shows the percentage of costs your plan will pay for covered dental services. Many of the covered services have specific time or age limits.

Pre-Treatment Estimates

If your dentist expects that your dental treatment will involve covered services that will cost more than \$250, Blue Cross Blue Shield recommends that your dentist send a copy of the "treatment plan" to Blue Cross Blue Shield before services are provided. A treatment plan is a detailed description of the procedures that the dentist plans to perform and includes an estimate of the charge for each service. Once the treatment plan is reviewed, you and your dentist will be notified of the benefits available.

Remember, the payment estimate is based on your eligibility status and the amount of your calendar-year benefit maximum at the time the estimate is received and reviewed. (The actual payment may differ if your available calendar-year benefit maximum or eligibility status has changed.)

Multi-Stage Procedures

Your dental plan provides benefits for multi-stage procedures (procedures that require more than one visit, such as crowns, dentures and root canals) as long as you are enrolled in the plan on the date that the multi-stage procedure is completed. A participating dentist will send a claim for a multi-stage procedure to Blue Cross Blue Shield only after the completion date of the procedure. You will be responsible for all charges for multi-stage procedures if your plan has been cancelled before the completion date of the procedure.

How Dentists Are Paid - Participating Dentists

Dentists that participate with Blue Cross Blue Shield of Massachusetts, Blue Cross Blue Shield of Rhode Island, or participating out-of-area dentists accept the lesser of either the dentist's actual charge or the allowed charge as payment in full for covered services. You pay only your deductible and coinsurance (if applicable), and any allowed charges beyond your calendar-year benefit maximum.

In Massachusetts, benefits are usually only provided when covered services are received from a participating dentist. The exceptions are described in your plan description.

How Dentists Are Paid – Non-participating Dentists Outside of Massachusetts

Benefits for covered services by a non-participating dentist outside of Massachusetts are provided based on the dentist's actual charge. You are also responsible for your deductible and coinsurance (if applicable), and charges beyond your calendar-year benefit maximum.

When Coverage Begins

You are covered, without a waiting period, from the date you enroll in the plan.

Dependent Benefits

This plan covers dependents until the end of the calendar month in which they turn age 26, regardless of their financial dependency, student status, or employment status. See your plan description (and riders, if any) for exact coverage details.

Accumulated Maximum Rollover Benefits

This dental plan includes an Accumulated Maximum Rollover Benefit. This rollover benefit allows you to roll over a certain dollar amount of your unused annual dental benefits for use in the future. There are limits and restrictions on this benefit. Refer to the Accumulated Dental Maximum Rollover brochure for further information.

Enhanced Dental Benefits

Enhanced Dental Benefits for certain dental care services are available for members who have been diagnosed with qualifying conditions. To learn more about specific conditions included in this benefit, review your plan description (and riders, if any) on MyBlue at **bluecrossma.org**.

If You Have to File a Claim

Participating dentists will send claims directly to Blue Cross Blue Shield. All you have to do is show them your Dental Blue ID card. The payment will be sent directly to your dentist as long as the claims are received within one year of the completed service.

If you receive care from a non-participating dentist, you will typically need to submit the claim yourself. Before submitting your claim, get an Attending Dentist's Statement form from Member Service.

After your dentist fills out the form, send it and your original itemized bills to Blue Cross Blue Shield of Massachusetts, P. O. Box 986030, Boston, MA 02298. All member-submitted claims must be submitted within two years of the date of service.

If you have a grievance, see your plan description for instructions on how to file a grievance.

Other Information

Coordination of benefits applies to plan members who are covered by another plan for health care expenses. Coordination of benefits ensures that payments from other insurance or health care plans do not exceed the total charges billed for covered services.

Your plan description has a subrogation clause, which means that Blue Cross Blue Shield can recover payments if a member has already been paid for the same claim by a third party.

QUESTIONS?

For questions about Blue Cross Blue Shield of Massachusetts, call 800-262-2583, or visit us online at bluecrossma.org.

Limitations and Exclusions. These pages summarize the benefits of your dental plan. Your plan description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the plan description and riders will govern. For a complete list of limitations and exclusions, refer to your plan description and riders.



DENTAL BLUE® ACCUMULATED MAXIMUM ROLLOVER

At Blue Cross Blue Shield of Massachusetts, we know that oral health is a critical part of overall health. That's why we offer a dental benefit that will allow you to roll over a portion of your unused dental benefits from year to year.

HOW MAXIMUM ROLLOVER WORKS

Beginning 60 days after the last day of your benefit period, your rollover amount will be added to your maximum benefit amount, increasing it for you to use that year and beyond (see below for amounts and maximums).

There is no cost to you. You don't need to do anything. To figure out the amount of benefit dollars that are eligible to roll over, just use the chart below. Start by searching for your benefit period maximum in the first column. If Blue Cross

doesn't pay out more claims dollars on your behalf than the amount in the second column, your benefit maximum for the next year will increase by the amount in the third column.

And, your rollover amount keeps growing and is available for you to use as long as your employer offers this rollover benefit.* The last column will show you the total amount of additional benefit dollars you can earn. It's one more way we're working to improve health care for all our members.

You can accumulate benefit dollars to help offset higher out-of-pocket costs for complex procedures. This benefit applies to you automatically if:

- You receive at least one service during the benefit period
- You remain a member of the plan throughout the benefit period
- You don't exceed the claim payment threshold in the benefit period

If your dental plan's annual maximum benefit amount is:	And if your total claims don't exceed this amount for the benefit period:*	We'll roll over this amount for you to use next year and beyond:*	However, rollover totals will be capped at this amount:*
\$500-\$749	\$200	\$150	\$500
\$750-\$999	\$300	\$200	\$500
\$1,000-\$1,249	\$500	\$350	\$1,000
\$1,250-\$1,499	\$600	\$450	\$1,250
\$1,500-\$1,999	\$700	\$500	\$1,250
\$2,000-\$2,499	\$800	\$600	\$1,500
\$2,500-\$2,999	\$900	\$700	\$1,500
\$3,000 or more	\$1,000	\$750	\$1,500

^{*}This is not a flexible spending account (FSA). The amount reflects your benefit maximum for a given year.

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ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).

ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: 711).





Exam-Plus Integrated Vision Plan: Insight Network

Blue 20/20 is administered by EyeMed Vision Care®, an independent company.

Vision care service	In-network member cost	Out-of-network reimbursement¹
Comprehensive eye exam	\$20 copay	up to \$50
Contact lens fit and follow-up ² • Standard • Premium Retinal imaging Enhanced Diabetes Eye Care Benefit ³	up to \$40 10% off retail price up to \$39	n/a n/a n/a
For members diagnosed with type 1 or type 2 diabetes	Paid in full: up to two diabetic eye exams and diagnostic testing every 12 months	n/a
Frames	\$130 allowance, then additional 20% off balance	up to \$74
Standard plastic lenses • Single vision • Bifocal • Trifocal • Lenticular • Standard progressive lens • Premium progressive lens tier 1-tier 3 tier 4	\$25 copay \$25 copay \$25 copay \$25 copay \$90 copay \$110-\$135 copay \$90 copay, then 80% of charge less \$120 allowance	up to \$42 up to \$78 up to \$130 up to \$130 up to \$140 up to \$196 up to \$196
Lens options ² • UV treatment • Tint (solid and gradient) • Standard plastic scratch coating • Standard polycarbonate • Standard polycarbonate for covered dependents under age 19 • Standard anti-reflective coating • Premium anti-reflective coating • Photochromic/Transitions® plastic • Polarized • Other add-ons	\$15 \$15 \$15 \$40 Paid in full \$45 \$57–\$68 \$75 20% off retail price 20% off retail price	n/a n/a n/a n/a up to \$26 n/a n/a n/a n/a
 Contact lenses⁴ Conventional Disposable Medically necessary 	\$130 allowance, then additional 15% off balance \$130 allowance Paid in full	up to \$104 up to \$104 up to \$210
Frequency • Exam • Lenses for frames or one order of contact lenses • Frames	once every 24 once every 12 once every 24	2 months

Additional in-network savings and discounts		
40 %	a complete second pair of glasses	
20 %	non-prescription sunglasses	
15 %	retail price or 5% off promotional price for laser vision correction through U.S. Laser Network	
Customer service: 1-855-875-6948 To locate an in-network provider, visit blue2020ma.com.* 'Registration not required to search for providers.		

Save on hearing exams and hearing aids

Offered by Amplifon Hearing, an independent company.

To learn more about the savings available, visit amplifonusa.com/blue2020.

Call **1-866-921-5367** to get started.

Choose from thousands of independent and retail providers including:

LENSCRAFTERS*

PEARLE OOVISION"



For costs and further details of the coverage, including exclusions, please refer to your member booklet.

- 1. Your actual expenses for covered services may exceed the stated out-of-network amount.
- 2. Indicates a service that is a discounted arrangement as part of your vision plan.
- 3. Consult with your eye care provider.
- 4. Discount applies to materials only and not fittings for contact lenses.

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call the EyeMed Network/Patient Services number on your ID card (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de EyeMed Network/Servicio al Paciente que figura en su tarjeta de identificación (TTY: 711).

ATENÇÃO: Se você não fala inglês, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para a EyeMed Network/Serviços ao Paciente usando o número no seu cartão de ID (TTV: 711)





MEDEX[®] 2

Town of North Reading

This Medex plan provides benefits for:

- Medicare Part A and B Deductibles and Coinsurances
- OBRA Benefits

This Medex plan does not provide benefits for:

Prescription Drugs

UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:



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COVERAGE AND BENEFITS

CLAIMS AND BALANCES

Sign in

Download the app, or create an account at bluecrossma.org.



QUESTIONS? CALL 800-258-2226. (TTY) 711.

The Member Service staff can assist you Monday through Friday, 8 a.m. to 6 p.m. Medicare Office Telephone Number in Massachusetts: 1-800-MEDICARE (1-800-633-4227)



This health plan, alone, does not meet Minimum Creditable Coverage standards and will not satisfy the individual mandate that you have health insurance; however, the Commonwealth of Massachusetts has stated that enrollment in Original Medicare (Medicare Part A and Medicare Part B) satisfies these standards.

YOUR MEDICAL BENEFITS

	Medicare Provides	Medex Provides
Inpatient Care		
Hospital care—including surgical services, X-rays and laboratory tests, anesthesia, drugs and medications, and intensive care services	 Coverage for days 1–60 per benefit period after Part A deductible Coverage for days 61–90 after daily Part A coinsurance Coverage for an additional 60 lifetime reserve days after daily Part A coinsurance 	 Full coverage of Medicare deductible and coinsurance Full coverage of lifetime reserve day coinsurance Full coverage up to a lifetime maximum of 365 additional hospital days when Medicare benefits are used up[†]
Physician or other professional provider services	80% of approved charges after annual Part B deductible	Full coverage of Medicare deductible and coinsurance
Skilled nursing facility— participating with Medicare*	 Full coverage for days 1–20 Coverage for days 21–100 after daily Part A coinsurance 	 Full coverage of Medicare daily coinsurance for days 21–100 \$10 daily for days 101–365
Skilled nursing facility— not participating with Medicare*	No benefits	\$8 daily for 365 days per benefit period
Outpatient Care		
Office visits, emergency services, surgery, radiation therapy, X-ray and lab tests, podiatrists' services, durable medical equipment, and cardiac rehabilitation services	80% of approved charges after annual Part B deductible	Full coverage of Medicare deductible and coinsurance
Blood glucose monitors and materials to test for the presence of blood sugar	80% of approved charges after annual Part B deductible for all diabetics	Full coverage of Medicare deductible and coinsurance
Urine test strips (Claims must be submitted on a Medex Subscriber Claim form)	No benefits	Full coverage based on the allowed charge
Chiropractor services	80% of approved charges after annual Part B deductible, for manual manipulation of the spine to correct a subluxation demonstrated by an X-ray	Full coverage of Medicare deductible and coinsurance for Medicare-approved charges only
Short-term rehabilitation – physical therapy, speech-pathology, and occupational therapy services approved by Medicare	80% of approved charges after annual Part B deductible	Full coverage of Medicare deductible and coinsurance

	Medicare Provides	Medex Provides		
Mental Health and Substance Use Treatment				
Biologically based mental conditions**				
Inpatient admissions in a general or mental hospital	 Coverage for days 1–60 per benefit period after Part A deductible Coverage for days 61–90 after daily Part A coinsurance Coverage for an additional 60 lifetime reserve days after daily Part A coinsurance Coverage for mental hospital admissions is limited to a 190 day lifetime maximum 	 Full coverage of Medicare deductible and coinsurance Full coverage of lifetime reserve day coinsurance Full coverage up to a lifetime maximum of 365 additional hospital days when Medicare benefits are used up[†] 		
Outpatient visits	80% of approved charges after annual Part B deductible	 When covered by Medicare, full coverage of Medicare deductible and coinsurance with no visit maximum When visits are not covered by Medicare, full coverage with no visit maximum 		
Non-biologically based mental conditi	ons			
Inpatient admissions in a general hospital	 Coverage for days 1–60 per benefit period after Part A deductible Coverage for days 61–90 after daily Part A coinsurance Coverage for an additional 60 lifetime reserve days after daily Part A coinsurance 	 Full coverage of Medicare deductible and coinsurance Full coverage of lifetime reserve day coinsurance Full coverage up to a lifetime maximum of 365 additional hospital days when Medicare benefits are used up[†] 		
Inpatient admissions in a mental hospital	Same coverage as a general hospital, but coverage is limited to a 190 day lifetime maximum	 Full coverage of Medicare deductible and coinsurance Full coverage of lifetime reserve day coinsurance When Medicare benefits are used up, full coverage up to 120 days per benefit period (at least 60 days per calendar year), less any days in a mental hospital already covered by Medicare or Medex in that benefit period (or calendar year)[†] 		
Outpatient visits	80% of approved charges after annual Part B deductible	 When covered by Medicare, full coverage of Medicare deductible and coinsurance with no visit maximum When not covered by Medicare, full coverage up to 24 visits per calendar year 		

[†] The additional days are a combination of days in a general or mental hospital.

* A combined maximum of 365 days per benefit period in a Medicare participating and non-participating skilled nursing facility.

** Treatment of rape-related mental or emotional disorders for victims of an assault with intent to rape is covered to the same extent as biologically based conditions.

Preventive Services Approved by Medicare and Medex

Medicare provides coverage for certain preventive services at no cost to members. For the current list of covered preventive services, refer to your Medicare & You handbook or go to **medicare.gov**. Some preventive covered services are highlighted below.

- One routine fecal-occult blood test every year for members age 50 or older (Full coverage for tests)
- One routine flexible sigmoidoscopy every four years for members age 50 or older (Full coverage for tests)
- One routine colonoscopy every two years for a high-risk member (Full coverage for tests)
- Other routine colorectal cancer screening tests or procedures and changes to tests or procedures according to frequency limits set by Medicare (Full coverage for tests)
- Routine prostate cancer screening for members 50 or older including one (PSA) test and one digital rectal exam, per calendar year (Full coverage for exam if doctor accepts assignment, full coverage for PSA test)
- One routine gynecological exam every two years (Full coverage for exam if doctor accepts assignment)
- One routine gynecological exam per calendar year for a member at high risk for cancer (Full coverage for exam if doctor accepts assignment)
- One baseline mammogram during the five year period a member is age 35-39 and one routine mammogram per calendar year for members age 40 and older (Full coverage for screening)
- One routine Pap smear test per calendar year (Full coverage for test)

Important Information

- The Medicare inpatient deductible and coinsurance amounts are subject to change January 1 of each year.
- Benefits are available immediately upon your effective date.
- Blue Cross Blue Shield and Medicare will pay only for services that are medically necessary.

Get the Most from Your Plan: Visit us at bluecrossma.org or call 800-258-2226 to learn about discounts, savings, resources, and special programs available to you, like those listed below.

Fitness Reimbursement: a benefit that rewards participation in qualified fitness programs (see your plan description for details)

\$150 per calendar year

Weight Loss Reimbursement: a benefit that rewards participation in a qualified weight loss program (see your plan description for details)

\$150 per calendar year

Limitations and Exclusions. These pages summarize your health care plan. Your plan description and riders define the full terms and conditions. Should any questions arise concerning benefits, the plan description and riders will govern. For a complete list of limitations and exclusions, refer to your plan description and riders.

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SAVE MONEY ON YOUR MEDICATIONS WITH THE MAIL SERVICE PHARMACY

Maintenance medications, also known as long-term medications, are used to treat chronic or ongoing conditions. Save 33% when you order them in 90-day supplies through the mail service pharmacy.¹



BENEFITS OF USING THE MAIL SERVICE PHARMACY



You'll pay 33% less for 90-day supplies of most maintenance medications (that's one less copay).



There's no additional cost for standard delivery.



Signing up for automatic refills makes it less likely to miss a dose.

EXAMPLE OF HOW YOU'LL SAVE²

TYPE OF PRESCRIPTION	MEDICATION COPAY		
THE STARTSON HOW	Tier 1	Tier 2	Tier 3
30-day supply, retail pharmacy	\$15	\$30	\$50
90-day supply, mail service pharmacy	\$30	\$60	\$150

^{1.} In most cases for eligible maintenance medications. Check plan materials for more details.

^{2.} For illustrative purposes only, using a 3-tier plan.

HOW TO USE THE MAIL SERVICE PHARMACY

Download the MyBlue app or create an account at **bluecrossma.org**. Once signed in, click **Pharmacy Benefit Manager** under **My Medications**, then go to the **Prescriptions** tab. To:

TRANSFER PRESCRIPTIONS

ORDER REFILLS

SET UP AUTOMATIC REFILLS

Click

Start Rx Delivery by Mail

Click
View/Refill All Prescriptions

Click
Manage Automatic Refills

You can also fill prescriptions by calling CVS Customer Care at 1-877-817-0477 (TTY: 711), or by using the included order form.

WHY ISN'T MY MEDICATION AVAILABLE THROUGH THE MAIL SERVICE PHARMACY?

Certain medications that require immediate administration or are used for short periods of time aren't available through the mail service pharmacy. In addition, some specialty medications are only available through specialty pharmacies.

Please Note:

Certain prescribed medications may be subject to other dispensing limitations and to the professional judgment of the pharmacist. If you have any questions about your medication, call CVS Customer Care at 1-877-817-0477 (TTY: 711).

It's the patient's responsibility to report any changes in drug allergies, health conditions, chronic diseases, and drug sensitivities. Prescription information about members and dependents is used to administer your prescription program. That information is reported to Blue Cross Blue Shield of Massachusetts, and is used for reporting and analysis, without identifying individual patients in accordance with applicable laws.

Questions?

If you have any questions, call CVS Customer Care at 1-877-817-0477 (TTY: 711).



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New Prescriptions - Mail your new prescription	•	Number of New prescriptions:	
Refills - Order by Web, phone, or write in Rx no TO RECEIVE YOUR ORDER SOONER reque Go to 90-Day Mail Service under My Medica	est refills or new pres	Number of Refill prescriptions: scriptions online at bluecrossma.org .	
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B Refills. To order mail service refills, enter your prescription number(s) here.			
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CVS Caremark wants to provide you with high quality medicines at the best possible price. In order to do this, we will substitute equivalent generic medicines for brand name medicines whenever possible. If you do not want us to substitute generics, please provide specific instructions, including drug names, in the "Special Instructions" section of this form.

CaremarkPCS Health, LLC ("CVS Caremark") is an independent company that has been contracted to administer pharmacy benefits and provide certain pharmacy services for Blue Cross Blue Shield of Massachusetts. CVS Caremark is part of the CVS Health family of companies. Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association.

We may package all of these prescriptions together unless you tell us not to.

All claims for prescriptions submitted to CVS Caremark Mail Service Pharmacy using this form will be submitted to your prescription benefit plan for payment. If you do not want them submitted to your plan, do not use this form. You may call Customer Care to make alternate arrangements for submission of your order and payment.



First person with a refill or new prescription.	Spanish forms and lab First Name MI Suffix (JR,SR)
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Medical conditions: Arthritis Asthma Dia High blood pressure High cholesterol Other:	Migraine Osteoporosis Prostate issues Thyro
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Medical conditions: Arthritis Asthma Dia High blood pressure High cholesterol Other: Special instructions: How would you like to pay for this order? (If you Electronic check. Pay from your bank accoun Use your card on file. Use your card on file. Use a new card or update your card's expirate Exp. Make check or money order payable to CVS Cart Write your prescription benefit ID number on your payable to CVS Cart Amount: \$	betes Acid reflux Glaucoma Heart problet Migraine Osteoporosis Prostate issues Thyromatical Company is \$0, you do not need to provide payment information and the context of the context o



GET TO KNOW THE MEDICATION LOOKUP TOOL

With a simple search, you can see which medications your plan covers.

Our **Medication Lookup** tool lets you easily learn more about your coverage for prescription medications, including those with additional requirements like Prior Authorization. Search anytime, anywhere at **bluecrossma.org** or using the MyBlue app.



KEY FEATURES

Using the tool, you can:



SEARCH FOR ANY MEDICATION

See if it's covered by your plan



GET DETAILED INFORMATION

Including the medication's strength, tier, and how it's dispensed



VIEW ADDITIONAL COVERAGE REQUIREMENTS

Such as Prior Authorization, Step Therapy, and Quality Care Dosing



SEE COVERED ALTERNATIVES

For non-covered medications

Start Searching

For more information about your prescription coverage, sign in to MyBlue at **bluecrossma.org** or open the MyBlue app, and go to **Medication Lookup Tool** under **My Medications**. If you're not a member, you can get more information by visiting **bluecrossma.org/medication**.

GETTING COVERAGE INFORMATION, SIMPLIFIED

We're making it easier than ever for everyone to learn more about our medication coverage.

PERSONALIZED SEARCH

When you're signed in to your MyBlue account, your plan's formulary and tier structure will be automatically displayed in the tool. That way, you'll know you're getting the most accurate search results for your plan.

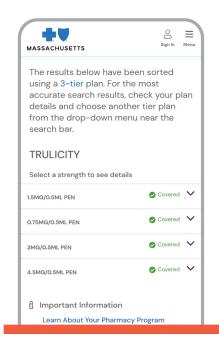
ANYONE CAN USE IT

The Medication Lookup tool is available to everyone, even if you aren't a member yet. You can easily find out if your medication is covered, or see covered alternatives, before you enroll.

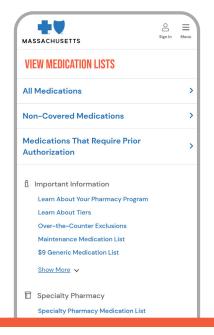
HOW TO USE THE TOOL



Sign in to MyBlue and go to the Medication Lookup Tool under My Medications. If you're not a member, go to bluecrossma.org/medication and choose the formulary you want to search. When not signed in, the tool will default to a 3-tier plan.



Select a medication to see if it's covered and get even more information, including strength and additional coverage requirements. Plus, if it's not covered, you can see covered alternatives.



Access important resources, like medication lists and Specialty Pharmacy Contact Information lists, in the Important Information and Specialty Pharmacy sections. If you're signed in to MyBlue, this list will be customized to match your benefits.

Learn More

To learn more about your pharmacy benefits, including which tier structure your plan uses, sign in to your MyBlue account at bluecrossma.org or check your plan materials for details.

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: 711). ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. L'lame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711). ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: 711).



THE CARE YOU NEED.
WHENEVER AND WHEREVER.

You have more ways than ever to get expert medical opinions and advice. Right when you need them.













Learn More

Visit bluecrossma.org to review your medical care options.

Go to the nearest emergency room, or call 911 when you're facing a life-threatening situation or think you could put your health in danger by delaying care.

KNOWING YOUR OPTIONS FOR CARE COULD SAVE YOUR TIME AND MONEY



When you're uncertain if your symptoms are serious or if an injury needs immediate care, get a nurse's advice 24/7, even on holidays. Call 1–888–247–BLUE (2583).

Cost: Time: Severity:

Best for: advice on when to seek care or questions about your symptoms, or whether they might be serious.



Get convenient medical and mental health care from licensed doctors, therapists, and psychologists using your favorite device. Sign in to the MyBlue app or visit bluecrossma.org, and click Well Connection.

Cost:

Severity:

Best for: colds, minor cuts, cough, wheezing, sore throat, headache or migraine, mild allergies, fever, skin rash, etc.



Visit your doctor for scheduled checkups and urgent health concerns that occur during office hours.

Best for: asthma, minor burns, nausea, urination problems, back pain, minor injuries, suspected flu, sinus infection, behavioral health, conjunctivitis or other eye irritation.





Found in local pharmacies, you can visit a limited service clinic for simple medical concerns.

Best for: cold and flu, bronchitis, sinus and respiratory infections, sore throat, diarrhea, gout, strep throat, urinary tract infections, pinkeye, hypertension, migraines, pneumonia.



Cost:



Go to a nearby urgent care center when you need immediate, in-person help for a non-life-threatening problem and you can't see your doctor.

Best for: joint/muscle pain or injuries, nausea or diarrhea, respiratory issues, bites, cuts, concussion screening, stitches, asthma attack, X-rays, and suspected strep throat or bronchitis.



Find a Provider

To find a doctor, hospital, limited service clinic, or urgent care center near you, sign in to MyBlue at **bluecrossma.org** and go to **Find a Doctor & Estimate Costs**.

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DOCTORS ON CALL, ON YOUR DEVICE.

Get convenient access to telehealth care by using Well Connection. Sign in to MyBlue, or create an account, then click Well Connection Video Visit under My Care.



REAL DOCTORS. REAL EXPERIENCE. REALLY FAST.



GET MEDICAL CARE 24/7

Speak face to face with a doctor, in the privacy of your home.¹



THERAPY THAT COMES TO YOU

Talk to a licensed therapist or psychiatrist—on your terms. It's convenient and confidential.



HIGHLY EXPERIENCED, HIGHLY RATED

Qualified providers. Rated 4.8/5 stars and averaging 15 years of experience.²

Sign In

Download the MyBlue App from the App Store® or Google Play™, or go to **bluecrossma.org**.

^{1.} Medical services are available 24/7. Mental health visits must be made by appointment. If your local doctor in the Blue Cross Blue Shield of Massachusetts network offers covered services using live video visits through a service other than Well Connection, you're still covered. This service is only available in the United States.

^{2.} Source: American Well. Amwell Telehealth Report, February 2018. Patient Satisfaction Survey Data compiled December 2017-February 2018. Data, compiled December 2017-February 2018. Data reverified, August 2020.



IS A VIDEO DOCTOR VISIT RIGHT FOR ME?

You can do a lot over your tablet, laptop, or smartphone. Here's how members are using this service.

"I'm not feeling well."

Get care for:

- Cold and flu symptoms
- Fever
- Runny nose, sinus pain
- Sore throat
- Pink eye
- Skin rash

"I need emotional support."

Talk to a therapist about:

- Depression and anxiety
- Substance use disorder
 - use disorder Em
- Loss of a loved one
- Relationship issues
- Emotional trauma
- Stress

You can also schedule a visit with a psychiatrist for medication management services.

"My loved one is under the weather."

If they're on your plan:

- Get quick, expert family care
- Save time in your busy family schedule



WELL CONNECTION IS HIGHLY RATED: 4.8 out of 5 Doctor and Provider rating from our members³

Licensed doctors and providers in the Well Connection network have an average of 15 years of experience. They can look up your medical history, diagnose and treat your symptoms, and prescribe medication,⁴ if necessary.

- 3. Source: American Well. AmWell TeleHealth Report, February 2018. Patient Satisfaction Survey Data, compiled December 2017-February 2018. Data reverified, August 2020.
- 4. Prescription availability is defined by doctor judgment.

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DENTAL BLUE QUICK-START GUIDE

For Large Employer Groups

Thank you for choosing Dental Blue. This guide will help you get the most from your plan by providing you with a summary of common benefits and services, as well as a general understanding of how your dental coverage works. For specific details about the benefits available to you, refer to your subscriber certificate.

If you have any questions, call Team Blue at the Member Service number on the front of your ID card.



How Dental Plans Work

Basic plans help offset the cost of diagnostic and preventive dental care. More comprehensive plans may also cover a percentage of restorative care. Most plans limit the benefit expenses per calendar year (or per lifetime, in the case of orthodontic benefits).

hfill What You Should Know Before Visiting a Dentist

Which Plan Do You Have?

Our plans include Dental Blue®, Dental Blue® PPO, Dental Blue® Select, Dental Blue® Freedom, and Dental Blue® Value. Refer to your benefit summary, or sign in to MyBlue at bluecrossma.org to view your plan details.

If You Have a Deductible or Co-insurance

You may be responsible for some of the costs for services. Knowing your deductible and co-insurance amounts will help you understand what you have to pay.

If You Qualify for Enhanced Dental Benefits

See page 3 for more information about the program.

Know How to Read Your ID Card

Your Dental Blue ID card contains important information like our Member Service phone number and your ID number. Be sure to always carry your ID card with you, and show it to all of your providers, so they can keep your records up to date.

Get Your Digital ID Card

MyBlue gives you digital access to your ID cards, so you can easily use it from your computer or mobile device. Download the MyBlue app or create an account at bluecrossma.org.



OUR PLANS

Dental Blue

Our traditional dental plan offers flexible dental coverage across a large network of dental providers. When you receive services from in-network dentists, you'll see lower rates, and pay lower out-of-pocket costs.

Dental Blue PPO

You'll get better rates for services when you see one of the dentists in the Dental Blue PPO network. If you go out-of-network, you're still covered, but you'll have to pay higher out-of-pocket costs.

Dental Blue Select

Similar to our PPO plan, you'll get better rates for services when you see one of the dentists in the Dental Blue PPO network. There's a deductible for out-of-network preventive services, and you won't be charged for preventive services after the deductible is met.

Dental Blue Freedom

Dental Blue Freedom offers the largest selection of network dentists. You'll get the best rates for in-network care, especially when you see dentists in the Dental Blue PPO network. If you go out-of-network, you're still covered, but you'll pay the highest out-of-pocket costs for service.

Dental Blue Value

Our standard Table of Allowance plan offers coverage across a large network of dental providers. When you see an in-network dentist, you're responsible for the difference between the Dental Blue Value Table of Allowance amount and our contracted provider's fee schedule.

≙ Our Networks

Dental Blue

Our traditional network offers access to more than 98 percent of dentists in Massachusetts.

Dental Blue PPO

You'll receive the most coverage when you see one of the thousands of dentists in Massachusetts who participate in our PPO network.

OUR MEMBERS HAVE ACCESS TO LOCATIONS NATIONWIDE

Dian Name				
Plan Name	Dental Blue	Dental Blue PPO	Nationwide Network Access	Out-of-Network Providers
Dental Blue	•		•	*
Dental Blue PPO		•	•	•
Dental Blue Select		•	•	•
Dental Blue Freedom	•	•	•	•
Dental Blue Value	•	•	•	•

Filing Your Claims

If Your Dentist Files the Claim

Most participating dentists will send your claims to us. We'll pay them directly if we receive the claim within two years of the completed service.

If Your Dentist Doesn't File the Claim

If your dentist doesn't file the claim, which may occur when you visit a non-participating dentist, download our dental claim form at **bluecrossma.org**, complete it, and mail it to:

Blue Cross Blue Shield of Massachusetts Dental Operations P.O. Box 986030 Boston, MA 02298

S Manage Your Dental Budget: Tips to Help You Plan for Any Out-of-Pocket Costs

Show Your Dental Blue ID Card Every Time You See a Dentist

This will ensure that your claims are filed properly.

Find Out What You Owe for Each Visit

Some plans require you to pay a deductible or co-insurance.

Know Your Benefit Maximum

Once you reach the calendar-year limit and use any additional accumulated maximum rollover benefit, no more services will be covered until the following year.

Monitor the Balance of Your Benefit Maximum

Team Blue can help you keep an eye on your account balances. Call the Member Service number on the front of your ID card.

Visit Dentists in Our Network

You'll receive the most coverage when you visit dentists who participate in our network.

QUESTIONS?

If you have any questions, call Team Blue at the Member Service number on the front of your ID card, Monday through Friday, 8:00 a.m. to 6:00 p.m. ET (TTY: 711)

GET THE MOST FROM YOUR PLAN

Enhanced Dental Benefits

Dental Blue offers the only condition–specific total health solution with a complete program for at–risk members with qualifying medical conditions. Our Enhanced Dental Benefits offer additional, specific support, including full coverage for preventive and periodontal services that have been connected to improved overall health. To learn more about specific conditions included in this benefit, review your subscriber certificate on MyBlue at bluecrossma.org.

Accumulated Maximum Rollover

Some plans allow you to roll over a portion of your unused dental benefits from year to year. This can help offset higher out-of-pocket costs for complex procedures. To find out if you have this benefit, sign in to MyBlue at **bluecrossma.org**.

MyBlue

MyBlue is your online member account that gives you instant digital access to your plan benefits, tools and resources. Track your claims, view your digital member ID card, and get answers to your questions. To get started, download the MyBlue app or create an account at bluecrossma.org.

Find a Doctor or Dentist

Our **Find a Doctor & Estimate Costs** tool makes it easy for you to find what you need.

- Search for doctors, dentists, hospitals, and other health care providers
- · Read and write reviews
- · Compare up to 10 doctors at a time

To start searching, download the MyBlue app or sign in at **bluecrossma.org**, then select **Find a Doctor & Estimate Costs** under **My Care**.

FREQUENTLY ASKED QUESTIONS

Q: I only received two Dental Blue ID cards. How do I get additional cards for my family?

A: You can order replacement and/or additional ID cards online through MyBlue at **bluecrossma.org**. You can also call Member Service at the number on the front of your ID card.

Q: How do I find a dentist or specialty dental provider who is participating with my dental plan?

A: You can use our **Find a Doctor & Estimate Costs** tool at **bluecrossma.com/findadoctor** to search for dentists and other specialty providers that participate in your plan. Sign in to your MyBlue account for the best results, or continue without signing in by choosing your current dental plan.

Q: Do all Dental Blue members have nationwide network access?

A: Yes, all dental members have access to 500,000 credentialed provider locations nationwide. To find a dentist, visit **bluecrossma.com/findadoctor**.

Q: Where do I find my specific dental coverage information?

A: You can look up your coverage information, including services and amounts covered, deductible, co-insurance, and annual benefit maximum, by signing in to MyBlue at **bluecrossma.org** and reviewing your subscriber certificate. You can also call Member Service at the number on the front of your ID card.

Q: My plan has a calendar-year maximum. Is that per person, or do all my family's dental services apply toward one calendar-year maximum? How do I check to see if my maximum has been reached?

A: Your calendar-year maximum applies individually for each person enrolled. To find out how much has been applied toward your plan maximum, call Member Service at the number on the front of your ID card.

Q: If my cleanings are covered at 100 percent, does that count toward my calendar-year maximum?

A: Generally, all services paid by Dental Blue are applied toward your plan-year or calendar-year maximum. However, if you're enrolled in our Enhanced Dental Benefits program, deductibles and co-insurance don't apply to condition-specific services that are provided in addition to dental benefits already covered by your plan, and condition-specific services are excluded from the calendar-year maximum.

Q: My previous plan had orthodontic coverage, and my child is in the middle of a 24-month treatment plan. Will some orthodontic services still be covered under my new Dental Blue plan?

A: Any remaining orthodontic treatment received after your new plan's effective date will be covered based on your plan's orthodontic benefits and up to the applicable lifetime maximum.

Not all plans include orthodontic coverage. Please review your Dental Blue plan specifics for more details.

Q: How do I enroll in the Enhanced Dental Benefits program?

A: Call Member Service at the number on the front of your ID card to request an enrollment form and to find out more information. You may also be automatically enrolled in the Enhanced Dental Benefits program if you have medical coverage through Blue Cross Blue Shield of Massachusetts and have been identified to have a qualifying medical condition.

Q: My children are covered by both my dental plan and my spouse's dental plan. Am I able to coordinate benefits so I can reduce my out-of-pocket expenses?

A: Yes, specific criteria determine which plan should be billed as the primary coverage when a family has duplicate coverage. If either coverage is a medical plan, that plan would be primary. When the family has both Dental Blue and coverage through another dental insurer, the primary coverage is determined based on the parents' birthdates. Review your benefit information by signing in to MyBlue at **bluecrossma.org**, or check your subscriber certificate for more details.

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DENTAL BLUE® ACCUMULATED MAXIMUM ROLLOVER

At Blue Cross Blue Shield of Massachusetts, we know that oral health is a critical part of overall health. That's why we offer a dental benefit that will allow you to roll over a portion of your unused dental benefits from year to year.

HOW MAXIMUM ROLLOVER WORKS

Beginning 60 days after the last day of your benefit period, your rollover amount will be added to your maximum benefit amount, increasing it for you to use that year and beyond (see below for amounts and maximums).

There is no cost to you. You don't need to do anything. To figure out the amount of benefit dollars that are eligible to roll over, just use the chart below. Start by searching for your benefit period maximum in the first column. If Blue Cross

doesn't pay out more claims dollars on your behalf than the amount in the second column, your benefit maximum for the next year will increase by the amount in the third column.

And, your rollover amount keeps growing and is available for you to use as long as your employer offers this rollover benefit.* The last column will show you the total amount of additional benefit dollars you can earn. It's one more way we're working to improve health care for all our members.

You can accumulate benefit dollars to help offset higher out-of-pocket costs for complex procedures. This benefit applies to you automatically if:

- You receive at least one service during the benefit period
- You remain a member of the plan throughout the benefit period
- You don't exceed the claim payment threshold in the benefit period

If your dental plan's annual maximum benefit amount is:	And if your total claims don't exceed this amount for the benefit period:*	We'll roll over this amount for you to use next year and beyond:*	However, rollover totals will be capped at this amount:*
\$500-\$749	\$200	\$150	\$500
\$750-\$999	\$300	\$200	\$500
\$1,000-\$1,249	\$500	\$350	\$1,000
\$1,250-\$1,499	\$600	\$450	\$1,250
\$1,500-\$1,999	\$700	\$500	\$1,250
\$2,000-\$2,499	\$800	\$600	\$1,500
\$2,500-\$2,999	\$900	\$700	\$1,500
\$3,000 or more	\$1,000	\$750	\$1,500

^{*}This is not a flexible spending account (FSA). The amount reflects your benefit maximum for a given year.

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DENTAL BLUE® ENHANCED DENTAL BENEFITS

Additional Support for Members with Qualifying Conditions

The connection is clear: good oral health leads to better overall health. That's why your Dental Blue plan includes Enhanced Dental Benefits, a complete program that focuses on at-risk members with qualifying medical conditions. We offer additional, specific support, including full coverage for preventive and periodontal services that have been connected to improved overall health.

Condition	One cleaning or periodontal maintenance, 4 per calendar year¹	Periodontal scaling, once per quadrant every 24 months¹	Oral cancer screening, twice per calendar year	Fluoride treatment, 4 per calendar year
DIABETES	✓	<u> </u>		
CORONARY ARTERY DISEASE	~	~		
STROKE	~			
PREGNANCY	~	✓		
ORAL CANCER	~		✓	✓
SJÖGREN'S SYNDROME	~		~	~

^{1.} Periodontal maintenance and scaling are available on plans that offer periodontal benefits. There must be at least three months between a periodontal maintenance cleaning and any other cleanings covered under your dental plan, including these Enhanced Dental Benefits.

Please Note: Service frequencies displayed in the chart are effective on renewal starting April 1, 2021. For renewals prior to this date, these services are covered at the following frequencies: cleaning or periodontal maintenance every three months; periodontal scaling, once per quadrant every 24 months; oral cancer screening every six months; and fluoride treatment every three months. Condition-specific eligibility requirements must be met to receive coverage. Certain dental plans cover preventive dental services and Enhanced Dental Benefits at different frequency intervals. Please check your plan benefits to confirm your coverage before scheduling dental services.

NO ADDITIONAL COST TO RECEIVE THESE EXTRA SERVICES*

Enhanced Dental Benefits are included with your dental coverage, at no additional cost. These services aren't subject to a deductible, co-insurance, or annual maximum when provided by a dentist in our network. If you have a PPO plan and choose to receive services from a dentist not in our network, you may be subject to co-insurance.

*Qualifying members only.

Questions?

If you have any questions, please call Member Service at the number on the front of your ID card.

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).

ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: 711).

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ENHANCED DENTAL BENEFITS ENROLLMENT FORM

Dear Physician:

This is an application for your patient to receive Enhanced Dental Benefits from Blue Cross Blue Shield of Massachusetts. These Enhanced Dental Benefits will provide coverage for additional preventive services to this Dental Blue® member if diagnosed with one or more of the qualifying medical conditions listed below. Please complete this form so that your patient may receive Enhanced Dental Benefits. Thank you.

(Note: Your patient's dental coverage policy must include Enhanced Dental Benefits in order to be eligible for coverage.)

Please check qualifying medical conditions:						
☐ Diabetes ☐ Coronary Artery Disease ☐ Pregnancy (Expected date of birth/)	lrome					
Subsc	criber/Mem	ber Information				
Subscriber Name	Member	Name		Date of Birth//		
Member Address		City	State	ZIP Code		
Member Telephone # (Home) Member Telephone # (Other)						
Blue Cross Blue Shield of Massachusetts Dental ID	#					
	Physician Ir	nformation				
I hereby confirm that my patient has been diagnosed with the conditions listed above. Date //						
Physician Name (please print, circle MD or DO) MD/DO	License #	•		State		
Physician Address		Physician Telephone	#			

Please complete this form, keep a copy for your records, and return the original to:

Enhanced Dental Benefits Program
Blue Cross Blue Shield of Massachusetts
Dental Operations
P.O. Box 986040
Boston, MA 02298



Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).

ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: 711).

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Blue MedicareRx[™] (PDP)



2022 SUMMARY OF BENEFITS

Blue MedicareRx (PDP)

EMPLOYER GROUP MEDICARE PRESCRIPTION DRUG PLAN WITH SUPPLEMENTAL COVERAGE: \$10 / \$25 / \$40

Option 34

Blue MedicareRx (PDP)

(a Medicare Prescription Drug Plan (PDP) offered by ANTHEM INSURANCE CO. & BCBSMA & BCBSRI & BCBSVT with a Medicare contract)

SUMMARY OF BENEFITS

January 1, 2022 - December 31, 2022

Thank you for your interest in Blue MedicareRx. Blue MedicareRx includes standard Medicare Part D benefits supplemented with coverage provided by your former employer/union health plan. Blue MedicareRx is referred to throughout this Summary of Benefits as "plan" or "this plan."

This Summary of Benefits tells you some features of our plan. It doesn't list every drug we cover, every limitation, or exclusion. To get a complete list of our benefits, please call us and ask for the "Evidence of Coverage."

For More Information

Hours of Operation

You can call us 24 hours a day, 7 days a week.

Blue MedicareRx Phone Numbers and Website

Please call Blue MedicareRx for more information about our plan.

Current members should call toll-free 1-888-543-4917 (TTY/TDD 711).

Prospective Members, please contact your benefits administrator.

Visit us at groups.rxmedicareplans.com.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

This document is available in other formats such as Braille and large print. For additional information, call us at **1-888-543-4917**, 24 hours a day, 7 days a week. TTY/TDD users should call **711**.

Who can join?

You can join this plan if you are entitled to Medicare Part A and/or enrolled in Medicare Part B, are a US citizen or are lawfully present in the United States and live in the service area which includes the United States and its territories (excluding the Virgin Islands).

If you are enrolled in a MA coordinated care (HMO or PPO) plan or a MA private fee-for-service (MA PFFS) plan that includes Medicare prescription drugs, you may not enroll in a prescription drug plan (PDP) unless you disenroll from the HMO, PPO or MA PFFS plan.

Enrollees in a private fee-for-service (PFFS) plan that does not provide Medicare prescription drug coverage or a MA Medical Savings Account (MSA) plan may enroll in a PDP. Enrollees in an 1876 Cost plan may enroll in a PDP. Please contact your local benefits administrator for more information.

Which drugs are covered?

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our Document portal at: mydocumentsource.memberdoc.com.

Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each medication into one of 3 "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier, your out-ofpocket prescription costs to date and what stage of the benefit you have reached. Later in this document we discuss the benefit stages in your Medicare prescription drug coverage that occur: Initial Coverage, Coverage Gap, and Catastrophic Coverage. For more information about formulary tiers and stages of the benefit, please see the plan's formulary and the Evidence of Coverage on our Document portal at: mydocumentsource.memberdoc.com, or contact Customer Care at the number listed above.

Which pharmacies can I use?

We have a network of pharmacies and you must generally use these pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's pharmacy directory on our Document portal at: **mydocumentsource. memberdoc.com**. Or, call us and we will send you a copy of the pharmacy directory.

SUMMARY OF BENEFITS

January 1, 2022 - December 31, 2022

Prescription Drug Benefits

The benefits described below are offered by Blue MedicareRx, a standard Medicare Part D plan supplemented with benefits provided by your former employer.

Initial Coverage		You pay the following until your total yearly drug costs reach \$4,4301:			
Standard Ret	ail Cost Sharing	One-month supply	Three-month supply ²		
Tier 1	Generic	\$10	\$30		
Tier 2	Preferred Brand	\$25	\$75		
Tier 3	Non-Preferred Drug	\$40	\$120		
		Specialty drugs are limited to a one-month supply per fill.			
Mail Order Co	ost Sharing	One-month supply	Three-month supply		
Tier 1	Generic	\$10	\$10		
Tier 2	Preferred Brand	\$25	\$25		
Tier 3	Non-Preferred Drug	\$40 \$40			
		Specialty drugs are limited to a one-month supply per fill.			

Coverage Gap	After your total yearly drug costs reach \$4,430, your former employer provides supplemental coverage that will keep your copayments and/or coinsurance as outlined above. Your copayments and/or coinsurance will not change until you qualify for Catastrophic Coverage.
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Lanasimonii Ciloverane	After your yearly out-of-pocket drug costs reach \$7,050, you pay:
Generic (including brand drugs treated as generic)	\$3.95
All other Drugs	\$9.85

¹ All covered drugs are on the Blue MedicareRx group formulary/drug list.

² Available at retail pharmacies that have agreed to allow members to fill 90-day supplies of their prescriptions.



GENERAL INFORMATION

In some cases, the plan requires you to first try one drug to treat your medical condition before they will cover another drug for that condition.

Certain prescription drugs will have maximum quantity limits.

Your provider must get prior authorization from Blue MedicareRx for certain prescription drugs.

Covered Part D drugs are available at out-of-network pharmacies in special circumstances as long as the pharmacy is located within the United States and its territories (excluding the Virgin Islands). For examples of what would qualify as special circumstances, refer to the Evidence of Coverage (EOC). Your copayment and/or coinsurance at out-of-network pharmacies is the same as at network pharmacies and depends on whether you purchase a Generic, Preferred Brand, Specialty or Non-Preferred drug.

Medicare considers drugs which cost more than \$670 for a one month supply to be specialty drugs.

Medicare Coverage Gap Discount Program

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs to Part D enrollees who have reached year-to-date "total drug costs" of \$4,430 and are not already receiving "Extra Help."

If you have reached year-to-date "total drug costs" of \$4,430, your former employer provides supplemental coverage that will keep your copayments and/or coinsurance in the Coverage Gap the same as what you pay in the Initial Coverage Level. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs and move you through the Coverage Gap. The amount discounted by the manufacturer will count toward your out-of-pocket costs as if you had paid this amount. Your Explanation of Benefits (EOB) will show any discounted amount provided.

Once your out-of-pocket costs reach \$7,050, you will move to the Catastrophic Coverage phase and the Medicare Coverage Gap Discount Program will no longer be applicable.

If you have any questions about the availability of discounts for the drugs you are taking or about the Medicare Coverage Gap Discount Program in general, please contact Customer Care.

Blue MedicareRxSM (PDP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue MedicareRx does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue MedicareRx:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - » Qualified sign language interpreters
 - » Written information in other formats (Braille, large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - » Qualified interpreters
 - » Information written in other languages

If you need these services, call the number on the back of your Member ID Card. TTY/TDD users should call 711.

If you believe that Blue MedicareRx has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Blue MedicareRx (PDP) Grievance Department Coordinator P.O. Box 30016 Pittsburgh, PA 15222-0330

Phone: **1-866-884-9478** Fax: **1-866-217-3353**

You can file a grievance in person, by mail, or fax. If you need help filing a grievance, Blue MedicareRx Grievance Department is available to help you.

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 ocrportal.hhs.gov/ocr/portal/lobby.isf, or by mail or phone at:

U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD)

THIS INFORMATION IS NOT A COMPLETE DESCRIPTION OF BENEFITS. PLEASE REFER TO THE CONTACT LIST BELOW FOR MORE INFORMATION.

Please call Blue MedicareRx for more information about our plan. Current members should call toll-free 1-888-543-4917 (TTY/TDD 711). Prospective Members, please contact your benefits administrator.

Visit us at groups.rxmedicareplans.com.

Customer Care Hours:

24 hours a day, 7 days a week

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, visit medicare.gov on the web.

If you have special needs, this document may be available in other formats.



Blue Cross and Blue Shield of Massachusetts, Inc., is an Independent Licensee of the Blue Cross and Blue Shield Association.

Anthem Insurance Companies, Inc., Blue Cross and Blue Shield of Massachusetts, Inc., Blue Cross & Blue Shield of Rhode Island, and Blue Cross and Blue Shield of Vermont are the legal entities which have contracted as a joint enterprise with the Centers for Medicare & Medicaid Services (CMS) and are the risk-bearing entities for Blue MedicareRx (PDP) plans. The joint enterprise is a Medicare-approved Part D Sponsor.

Enrollment in Blue MedicareRx (PDP) depends on contract renewal.

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Blue MedicareRxSM (PDP) 3 Tier Select 2022 Formulary

(List of Covered Drugs)

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

This formulary was updated on 09/13/2021. For more recent information or other questions, please contact Blue MedicareRx, at 1-888-543-4917 or, for TTY/TDD users, 711, 24 hours a day, 7 days a week, or visit Groups.RxMedicarePlans.com.

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 Blue MedicareRxSM (PDP). When it refers to "plan" or "our plan," it means Blue MedicareRx.

This document includes a list of the drugs (formulary) for our plan which is current as of January 1, 2022. For an updated formulary, please contact us. 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, 2023, and from time to time during the year.

What is the Blue MedicareRx Formulary?

A formulary is a list of covered drugs selected by Blue MedicareRx in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Blue MedicareRx will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Blue MedicareRx network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your *Evidence of Coverage*.

Can the Formulary (drug list) change?

Most changes in drug coverage happen on January 1, but Blue MedicareRx 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 the 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.

o 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 you may take to request an exception, and you can also find information in the section below titled "How do I request an exception to the Blue MedicareRx 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, 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. The enclosed formulary is current as of January 1, 2022.

o 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 the information in the section below entitled "How do I request an exception to the Blue MedicareRx Formulary?

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Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2022 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2022 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.

If we have other types of mid-year non-maintenance formulary changes unrelated to the reasons stated above (e.g. remove drugs from our formulary, add prior authorization requirements, quantity limits and/or step therapy restrictions on a drug, or move a drug to a higher cost sharing tier), we will notify you by mail. You may also access our formulary on our website at Groups.RxMedicarePlans.com to get information showing changes to, additions, and/or deletions of medications contained in our formulary. To get updated information about the drugs covered by Blue MedicareRx, please contact us. Our contact information appears on the front and back cover pages.

How do I use the Formulary?

There are two ways to find your drug within the formulary:

Medical Condition

The formulary begins on page 1. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, "Cardiovascular". If you know what your drug is used for, look for the category name in the list that begins on page 1. Then look under the category name for your drug.

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins at the back of this document. The Index provides an alphabetical list of all of the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your 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 your drug in the first column of the list.

What are generic drugs?

Blue MedicareRx 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.

Are there any restrictions on my coverage?

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

Prior Authorization: Blue MedicareRx requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from our plan before you fill your prescriptions. If you don't get approval, we may not cover the drug.

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Quantity Limits: For certain drugs, Blue MedicareRx limits the amount of the drug that we will cover. For example, our plan provides 2 units per prescription for FLOVENT HFA. This may be in addition to a standard one-month or three-month supply.

Step Therapy: In some cases, Blue MedicareRx requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, our plan may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 1. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We have posted online documents that explain our prior authorization and step therapy restrictions. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask Blue MedicareRx to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, "How do I request an exception to the Blue MedicareRx formulary?" on page III 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 formulary (list of covered drugs), you should first contact Customer Care and ask if your drug is covered.

If you learn that Blue MedicareRx does not cover your drug, you have two options:

You can ask Customer Care for a list of similar drugs that are covered by Blue MedicareRx. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by our plan.

You can ask Blue MedicareRx to make an exception and cover your drug. See below for information about how to request an exception.

Compounds may or may not be covered by your plan benefit.

How do I request an exception to the Blue MedicareRx Formulary?

You can ask us to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

You can ask us to cover a drug even if it is not on our 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.

You can ask us to cover a formulary drug at a lower cost sharing level if this drug is not on the specialty tier. If approved this would lower the amount you must pay for your drug.

You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, Blue MedicareRx limits the amount of the drug that we will cover. If

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your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

Generally, Blue MedicareRx will only approve your request for an exception if the alternative drug is included on the plan's formulary, the lower cost sharing drug or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary, tiering or utilization restriction exception. When you request a formulary, tiering or utilization restriction exception you should submit a statement from your prescriber or physician supporting your request. Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 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 get a supporting statement from your doctor or other prescriber.

What do I do before I can talk to my doctor about changing my drugs or requesting an exception?

As a new or continuing member in our plan you may be taking drugs that are not on our formulary. Or, you may be taking a drug that is on our formulary but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 30-day supply (unless you have a prescription written for fewer days) when you go to a network pharmacy. After your first 30-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility, and you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug while you pursue a formulary exception.

If you change your level of care, such as a move from a hospital to a home setting, and you need a drug that is not on our formulary or if your ability to get your drugs is limited but you are past the first 90 days of membership in our plan, we will cover up to a temporary 30-day supply when you go to a network pharmacy. After your first 30-day supply, you are required to use the plan's exception process.

Our transition supply will not cover drugs that Medicare does not allow Part D plans to cover or drugs that are covered under Medicare Part B.

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For more information

For more detailed information about your Blue MedicareRx prescription drug coverage, please review your *Evidence of Coverage* and other plan materials.

If you have questions about Blue MedicareRx, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

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/7 days a week. TTY/TDD users should call 1-877-486-2048. Or, visit www.medicare.gov.

Blue MedicareRx Formulary

The formulary that begins on page 1 provides coverage information about the drugs covered by Blue MedicareRx. If you have trouble finding your drug on the list, turn to the Index that begins at the back of this document.

The first column of the chart lists the drug name. Brand name drugs are capitalized (e.g., ADVAIR DISKUS) and generic drugs are listed in lower-case italics (e.g., *atorvastatin*).

The information in the Requirements/Limits column tells you if Blue MedicareRx has any special requirements for coverage of your drug. The abbreviations you may see in the drug listing include:

- o B/D stands for drugs covered under Medicare Part B or D.
- o QL stands for Quantity Limits.
- o PA stands for Prior Authorization.
- o ST stands for Step Therapy.
- o LA stands for Limited Access. This prescription may be available only at certain pharmacies. For more information consult your Pharmacy Directory or call Customer Care at 1-888-543-4917, 24 hours a day, 7 days a week. TTY/TDD users should call 711.
- o NM stands for No Mail Order. This prescription drug is not available through mail order service.

In the drug listing, the Tier column identifies which tier each drug is on. The amount you will pay at the pharmacy, also known as copayment or coinsurance, is determined by the drug tier.

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
ANALGESICS GOUT			ibuprofen TABS 400mg, 600mg, 800mg	Tier '	1
allopurinol (generic of ZYLOPRIM) TABS 100mg	Tier ′	1	meloxicam (generic of MOBIC) TABS 7.5mg, 15mg	Tier ′	1
colchicine (generic of COLCRYS) TABS .6mg	Tier 3	3 QL	nabumetone TABS 500mg 750mg		
QL (120 tabs / 30 days)			naproxen TABS 250mg, 375mg	Tier '	
colchicine w/ probenecid ta 0.5-500 mg	bTier 2	2	naproxen (generic of NAPROSYN) TABS 500mg	Tier '	1
MITIGARE CAPS .6mg QL (60 caps / 30 days	•	· 	naproxen (generic of EC- NAPROSYN) TBEC 375mo	Tier '	1 QL
probenecid TABS 500mg	Tier 2	<u> </u>	QL (120 tabs / 30 days)		
NSAIDS celecoxib (generic of CELEBREX) CAPS 50mg QL (240 caps / 30	Tier 2	2 QL	naproxen (generic of EC- NAPROSYN) TBEC 500mg QL (90 tabs / 30 days)	_	3 QL
days)	T: (sulindac TABS 150mg, 200mg	Tier '	1
celecoxib (generic of CELEBREX) CAPS 100mg	Tier 2	2 QL	OPIOID ANALGESICS, I	ONG	-ACTING
QL (120 caps / 30	9		fentanyl PT72 12mcg/hr,	Tier 3	3 QL PA
days)			25mcg/hr, 50mcg/hr,		
celecoxib (generic of CELEBREX) CAPS 200mg	-	2 QL	75mcg/hr, 100mcg/hr QL (10 patches / 30		
QL (60 caps / 30 days			days) hydrocodone bitartrate	Tier 2	2 QL PA
celecoxib (generic of CELEBREX) CAPS 400mg QL (30 caps / 30 days	•	2 QL	(generic of HYSINGLA ER) T24A 20mg, 30mg, 40mg,	11012	Z QLIA
diclofenac potassium TAB 50mg		2 QL	60mg, 80mg, 100mg, 120mg		
QL (120 tabs / 30			QL (30 tabs / 30 days)		0
days)			HYSINGLA ER T24A	Tier 2	2 QL PA
diclofenac sodium TB24	Tier 2	2	20mg, 30mg, 40mg, 60mg, 80mg, 100mg, 120mg		
100mg diclofenac sodium TBEC	Tier 1		QL (30 tabs / 30 days))	
25mg, 50mg, 75mg	ı i C i	I	methadone hcl SOLN	Tier 2	2 QL PA
ec-naproxen (generic of EC	C-Tier	l QL	5mg/5ml, 10mg/5ml		
NAPROSYN) TBEC 375m			QL (450 mL / 30 days		
QL (120 tabs / 30 days)			methadone hcl TABS 5mg		2 QL PA
ec-naproxen (generic of EC		3 QL	QL (90 tabs / 30 days) methadone hydrochloride i		2 QL PA
NAPROSYN) TBEC 500m	_		(generic of METHADOSE)	i iei z	2 QLPA
QL (90 tabs / 30 days flurbiprofen TABS 100mg) Tier 2)	CONC 10mg/ml		
	Tier 2		QL (90 mL / 30 days)		
ibu TABS 600mg, 800mg ibuprofen SUSP 100mg/5r					
ibuprofer 303F 100ffg/3f	111111111111111111111111111111111111111	<u> </u>			

Drug Name	Drug F Tier	Requirements/ Limits	Drug Name	Drug F Tier	Requirements/ Limits
morphine sulfate (generic of MS CONTIN) TBCR 15mg, 30mg, 60mg, 100mg, 200mg QL (90 tabs / 30 days)		QL PA	hydrocodone- acetaminophen soln 7.5-325 mg/15ml QL (2700 mL / 30 days)	Tier 3	QL
OPIOID ANALGESICS, S		-ACTING	hydrocodone-	Tier 2	QL
acetaminophen w/ codeine soln 120-12 mg/5ml QL (2700 mL / 30 days)		QL	acetaminophen tab 5-325 mg QL (240 tabs / 30 days)		
acetaminophen w/ codeine tab 300-15 mg QL (400 tabs / 30 days)		QL	hydrocodone- acetaminophen tab 7.5-325 mg QL (180 tabs / 30	Tier 2	QL
acetaminophen w/ codeine tab 300-30 mg QL (360 tabs / 30 days) acetaminophen w/ codeine		QL QL	days) hydrocodone- acetaminophen tab 10-325 mg QL (180 tabs / 30	Tier 2	QL
tab 300-60 mg QL (180 tabs / 30 days)			days) hydrocodone-ibuprofen tab 7.5-200 mg QL (150 tabs / 30	Tier 2	QL
endocet tab 2.5-325mg (generic of PERCOCET) QL (360 tabs / 30 days)	Tier 2	QL	days) hydromorphone hcl (generic of DILAUDID) LIQD 1 mg/m	l	QL
endocet tab 5-325mg (generic of PERCOCET) QL (360 tabs / 30 days)	Tier 2	QL	QL (600 mL / 30 days) hydromorphone hcl (generic of DILAUDID) TABS 2mg, 4mg, 8mg		QL
endocet tab 7.5-325mg (generic of PERCOCET) QL (240 tabs / 30	Tier 2	QL	QL (180 tabs / 30 days) morphine sulfate SOLN	Tier 3	B/D
days)			1mg/ml		_,_
endocet tab 10-325mg (generic of PERCOCET) QL (180 tabs / 30	Tier 2	QL	MORPHINE SULFATE SOLN 2mg/ml, 4mg/ml, 5mg/ml, 8mg/ml, 10mg/ml	Tier 3	B/D
days) fentanyl citrate (generic of ACTIQ) LPOP 200mcg QL (120 lozenges / 30	Tier 3	QL PA	morphine sulfate (generic of MORPHINE SULFATE) SOLN 4mg/ml, 8mg/ml, 10mg/ml		B/D
days) fentanyl citrate (generic of ACTIQ) LPOP 400mcg,	Tier 1	QL PA	morphine sulfate SOLN 10mg/5ml, 20mg/5ml QL (900 mL / 30 days)	Tier 2	QL
600mcg, 800mcg, 1200mcg 1600mcg QL (120 lozenges / 30 days)			morphine sulfate SOLN 100mg/5ml QL (180 mL / 30 days)	Tier 2	QL

Drug Name	Drug Tier	Requirements/ Limits
morphine sulfate TABS	Tier 2	QL
15mg, 30mg		
QL (180 tabs / 30		
days)		
nalbuphine hcl SOLN	Tier 3	
10mg/ml, 20mg/ml		
oxycodone hcl SOLN	Tier 3	QL
5mg/5ml		
QL (900 mL / 30 days)		
oxycodone hcl (generic of	Tier 2	QL
ROXICODONE) TABS		
5mg, 15mg, 30mg		
QL (180 tabs / 30		
days)		
oxycodone hcl TABS 10mg	Tier 2	QL
20mg		
QL (180 tabs / 30		
days)		
oxycodone w/	Tier 2	QL
acetaminophen tab 2.5-325		
mg (generic of PERCOCET))	
QL (360 tabs / 30		
days)		
oxycodone w/	Tier 2	QL
acetaminophen tab 5-325		
mg (generic of PERCOCET))	
QL (360 tabs / 30		
days)		
oxycodone w/	Tier 2	QL
acetaminophen tab 7.5-325		
mg (generic of PERCOCET))	
QL (240 tabs / 30		
days)		
oxycodone w/	Tier 2	QL
acetaminophen tab 10-325		
mg (generic of PERCOCET))	
QL (180 tabs / 30		
days)		_
tramadol hcl (generic of	Tier 1	QL
ULTRAM) TABS 50mg		
QL (240 tabs / 30		
days)		
ANESTHETICS		
LOCAL ANESTHETICS		
lidocaine hcl (local anesth.)	Tier 2	B/D
(generic of XYLOCAINE-		
MPF) SOLN .5%, 1%, 1.5%		

Drug Name	Drug Tier	Requirements/ Limits
lidocaine hcl (local anesth.)	Tier 2	B/D
(generic of XYLOCAINE)		
SOLN .5%, 1%, 2%		
ANTI-INFECTIVES		
ANTI-INFECTIVES - MISC	CELL	ANEOUS
albendazole (generic of	Tier 1	
ALBENZA) TABS 200mg		
amikacin sulfate SOLN	Tier 3	
1gm/4ml, 500mg/2ml		
atovaquone (generic of	Tier 3	
MEPRON) SUSP		
750mg/5ml		
aztreonam (generic of	Tier 3	
AZACTAM) SOLR 1gm,	1101 0	
2gm		
CAYSTON SOLR 75mg	Tier 2	NM LA PA
clindamycin hcl (generic of	Tier 1	
CLEOCIN) CAPS 75mg,	1101 1	
150mg, 300mg		
clindamycin phosphate	Tier 2	
(generic of CLEOCIN		
PHOSPHATE) SOLN		
300mg/2ml, 600mg/4ml,		
900mg/6ml, 9000mg/60ml		
colistimethate sodium	Tier 3	
(generic of COLY-MYCIN		
M) SOLR 150mg		
dapsone TABS 25mg,	Tier 2	
100mg		
DAPTOMYCIN SOLR	Tier 2	_
350mg		
daptomycin (generic of	Tier 1	_
DAPTOMYCIN) SOLR		
350mg		
daptomycin (generic of	Tier 1	
CUBICIN) SOLR 500mg		
EMVERM CHEW 100mg	Tier 1	QL
QL (12 tabs / year)		
ertapenem sodium (generic	Tier 3	
of INVANZ) SOLR 1gm		
gentamicin in saline inj 0.8	Tier 2	
mg/ml		
gentamicin in saline inj 2	Tier 2	
mg/ml		
gentamicin sulfate SOLN	Tier 2	
10mg/ml, 40mg/ml		
imipenem-cilastatin	Tier 3	
intravenous for soln 250 mg		

imipenem-cilastatin Tier 3 intravenous for soln 500 mg (generic of PRIMAXIN IV) ivermectin (generic of Tier 2 STROMECTOL) TABS 3mg Ilinezolid (generic of ZYVOX) Tier 3 SOLN 600mg/300ml Ilinezolid (generic of ZYVOX) Tier 1 QL (SUSR 100mg/5ml QL (1800 mL / 30 days) Iniezolid (generic of ZYVOX) Tier 3 Ilinezolid (generic of ZYVOX) Tier 3 QL (Stabs / 30 days) Iniezolid (generic of ZYVOX) Tier 3 QL (60 tabs / 30 days) Iniezolid (generic of ZYVOX) Tier 3 Iniezolid (generic of ZYVOX) Tier 3 Ilinezolid (generic of ZYVOX) Tier 3 QL (60 tabs / 30 days) Iniezolid in sodium chloride Iniezolid (generic of ZYVOX) Tier 3 Iniezolid (generic of ZYVOX) Tier 3 Iniezolid (generic of ZYVOX) Tier 3 QL (60 tabs / 30 days) Iniezolid in sodium chloride Irier 3 Iniezolid (generic of Tier 4 Iniezolid (generic of Tier 4 Iniezolid (generic of Tier 5 Iniezolid (generic of Tier 1 Iniezolid (generic of Ti	Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
Igm SULFADIAZINE TABS Tier 3 SULFADIAZINE TABS Tier 2 SULFADIAZINE TABS Tier 2 SULFADIAZINE TABS Tier 2 SULFADIAZINE TABS Tier 3 SULFADIAZINE TABS Tier 3 SULFADIAZINE TABS Tier 4 SULFADIAZINE TABS Tier 5 SULFADIAZINE TABS Tier 6 SULFADIAZINE TABS Tier 7 SULFADIAZINE TABS Tier 1 SULFADIAZINE TABS Tier 2 SULFADIAZINE TABS Tier 3 SULFADIAZINE TABS Tier 2 SULFADIAZINE TABS Tier 3 SULFADIAZINE TABS Tier 4 SULFADIAZINE TABS Tier 5 SULFADIAZINE TABS Tier 1 SULFADIAZINE TABS Tier 1 SULFADIAZINE TABS Tier 2 SULFADIAZINE TABS Tier 3 SULFADIAZINE TABS Tier 3 SULFADIAZINE TABS Tier 4 SULFADIAZINE TABS Tier 5 SULFADIAZINE TABS Tier 5 SULFADIAZINE TABS Tier 5 SULFADIA	-		3		Tier 3	3
STROMECTOL) TABS 3mg linezolid (generic of ZYVOX) Tier 3 SOLN 600mg/300ml silvezolid (generic of ZYVOX) Tier 1 QL SUSR 100mg/5ml QL (1800 mL/ 30 days) linezolid (generic of ZYVOX) Tier 3 QL (60 tabs / 30 days) linezolid (generic of ZYVOX) Tier 3 QL (60 tabs / 30 days) linezolid in sodium chloride linezolid (generic of ZYVOX) Tier 3 linezolid (generic of ZYVOX) Tier 3 QL (60 tabs / 30 days) linezolid in sodium chloride linezolid in sodium chloride linezolid (generic of Lier 3 linethozazole linethoxazole linethoxa		Tier	2	. ,	Tier 3	3
SOLN 600mg/300ml linezoild (generic of ZYVOX) Tier 1 QL SUSR 100mg/5ml QL (1800 mL / 30 days) linezoild (generic of ZYVOX) Tier 3 QL TABS 600mg QL (60 tabs / 30 days) linezoild in sodium chloride in sodium chloride in sodiom chloride in sulfamethoxazole in trimethoprim tab 400-80 mg/5ml sulfamethoxazole in trimethoprim susp 200-40 mg/5ml sulfamethoxazole in trimethoprim tab 400-80 mg/5ml sulfamethoxazole in trimethoprim tab 800-160 mg/5ml sulfamethoxazole in trimethoprim tab 800-160 mg/5ml sulfamethoxazole in trimethoprim tab 80-160 mg/5ml sulfamethoxazole in trimethoprim tab 80-160 mg/5ml sulfamethoxazole in trimethoprim tab 80-160 mg/5ml sulfamethoxazole in trimethoprim t	STROMECTOL) TABS 3m		3	SULFADIAZINE TABS	Tier 3	3
SUSR 100mg/5ml	SOLN 600mg/300ml	•		sulfamethoxazole-	Tier 3	3
days) linezolid (generic of ZYVOX)Tier 3 QL TABS 600mg QL (60 tabs / 30 days) linezolid in sodium chloride Tier 3 iv soln 600 mg/300ml-0.9% meropenem SOLR 1gm, Tier 3 500mg methenamine hippurate Tier 3 (generic of HIPREX) TABS 1gm metronidazole TABS 1gm metronidazole TABS 1gm metronidazole (generic of Tier 1 ELAGYL) TABS 500mg metronidazole (generic of Tier 1 FLAGYL) TABS 500mg metronidazole in nacl 0.79% Tier 2 iv soln 500 mg/100ml neomycin sulfate TABS nitazoxanide (generic of Tier 1 ALINIA) TABS 500mg QL (6 tabs / 30 days) nitrofurantoin macrocrystal (generic of BACTRIM) SYNERCID INJ 500MG Tier 2 tobramycin (generic of Tier 1 NM PA KITABIS PAK) NEBU 300mg/5ml tobramycin sulfate SOLN Tier 2 1.2gm/30ml, 10mg/ml, 40mg/ml, 80mg/2ml trimethoprim TABS 100mg Tier 1 vancomycin hcl (generic of Tier 3 QL VANCOCIN HCL) CAPS 125mg QL (80 caps / 180 days) nitrofurantoin monohyd Tier 2 macro (generic of MACRODANTIN) CAPS 50mg, 100mg nitrofurantoin monohyd Tier 2 macro (generic of MACROBID) CAPS 100mg paromomycin sulfate (generic of HUMATIN) CAPS 250mg pentamidine isethionate inh Tier 3 (generic of NEBUPENT) SOLR 300mg pentamidine isethionate inf Tier 3 dAMBISOME SUSR 50mg Tier 2 B/D amphotericin b SOLR 50mg Tier 3 B/D	SUSR 100mg/5ml	y rici	ı QL	mg/5ml	Tier 2)
TABS 600mg QL (60 tabs / 30 days) Inrecolla in sodium chloride Tier 3 iv soln 600 mg/300ml-0.9% meropenem SOLR 1gm, Tier 3 500mg methenamine hippurate 1generic of HIPREX) TABS 1gm metronidazole TABS 1gm metronidazole TABS Tier 1 250mg metronidazole (generic of Tier 1 FLAGYL) TABS 500mg metronidazole in nacl 0.79%Tier 2 iv soln 500 mg/100ml neomycin sulfate TABS Tier 1 250mg mitrofurantoin macrocrystal Tier 2 QL (B (abs / 30 days) nitrofurantoin macrocrystal Tier 2 (generic of HUMATIN) CAPS 250mg macro (generic of MACROBID) CAPS 100mg paromomycin sulfate QL (B Cabs / 30 days) pentamidine isethionate inh Tier 3 QL (BR 300mg pentamidine isethionate inj Tier 3 sulfamethoxazole- trimethoprim tab 800-80 mg (generic of BACTRIM sulfamethoxazole- trimethoprim tab 800-160 mg (generic of BACTRIM DS) SYNERCID INJ 500MG Tier 1 Virinethoprim tab 800-160 mg (generic of BACTRIM sulfamethoxazole- trimethoprim tab 800-160 mg (generic of BACTRIM DS) SyNERCID INJ 500MG Tier 2 tobramycin (generic of Tier 1 NM PA HITABIS PAK) NEBU 300mg/sml tobramycin (generic of Tier 1 Vancomycin sulfate SOLN Tier 2 1.2gm/30ml, 10mg/ml, 40mg/ml, 80mg/2ml trimethoprim tab 800-160 mg (generic of Tier 1 Vancomycin (generic of Tier 2 1.2gm/30ml, 10mg/ml, 40mg/ml, 80mg/2ml trimethoprim tab 800-160 mg (generic of BACTRIM DS) SyNERCID INJ 500MG Tier 2 trimethoprim tab 800-160 mg (generic of BACTRIM DS) SyNERCID INJ 500MG Tier 2 trimethoprim tab 800-160 mg (generic of BACTRIM DS) SyNERCID INJ 500MG Tier 2 trimethoprim tab 800-160 mg (generic of BACTRIM DS) SyNERCID INJ 500MG Tier 2 tobramycin (generic of Tier 1 Vancomycin (generic of Tier 2 trimethoprim tab 800-160 mg (generic of Actronic place of Tier 2 trimethoprim tab 800-160 mg (generic of BACTRIM DS) SyNERCID INJ 500MG Tier 1 NM PA UTACCOCIN (CL) CAPS 1.2gm/30ml, 10mg/ml, 40mg/ml, 40mg/ml, 80mg/2ml tobram	days)	1 Tier '	3 01	trimethoprim susp 200-40	1101 2	-
Inezolid in sodium chloride Tier 3 iv soln 600 mg/300ml-0.9% Tier 3 500mg Tier 1 700mg Tier 2 700mg Tier 1 700mg Tier 2 700mg Tier 2 700mg Tier 3 700mg 70	TABS 600mg	•	J QL	sulfamethoxazole-		
meropenem SOLR 1gm, Tier 3 500mgtrimethoprim tab 800-160 mg (generic of BACTRIM DS)methenamine hippurate (generic of HIPREX) TABSTier 3 SYNERCID INJ 500MGTier 21gmtobramycin (generic of KITABIS PAK) NEBU 300mg/5mlTier 1NM PAmetronidazole (generic of FLAGYL) TABS 500mg metronidazole in nacl 0.79%Tier 2 iv soln 500 mg/100mlTier 1tobramycin sulfate SOLN Lognysom, 10mg/ml, 40mg/ml, 80mg/2mlTier 2nitazoxanide (generic of 	linezolid in sodium chloride	Tier	3	(generic of BACTRIM)		
SYNERCID INJ 500MG Tier 2 tobramycin (generic of Tier 1 NM PA NEBU 300mg/5ml Tobramycin sulfate SOLN Tier 2 1.2gm/30ml, 10mg/ml, 40mg/ml, 80mg/2ml trimethoprim TABS 100mg Tier 1 100mg 10	meropenem SOLR 1gm, 500mg	Tier		trimethoprim tab 800-160 mg (generic of BACTRIM	Her	
metronidazole TABSTier 1KITABIS PAK) NEBU 300mg/5ml250mgmetronidazole (generic of FLAGYL) TABS 500mg metronidazole in nacl 0.79%Tier 2 iv soln 500 mg/100mltobramycin sulfate SOLN 1.2gm/30ml, 10mg/ml, 40mg/ml, 80mg/2mlneomycin sulfate TABSTier 1 40mg/ml, 80mg/2mltrimethoprim TABS 100mg 1trimethoprim TABS 100mg Tier 1neomycin sulfate TABSTier 1 40mg/ml, 80mg/2mlvancomycin hcl (generic of Tier 3 VANCOCIN HCL) CAPS 125mg QL (80 caps / 180 days)nitrofurantoin macrocrystal (generic of MACRODANTIN) CAPS 50mg, 100mgTier 2 vancomycin hcl (generic of Tier 3 VANCOCIN) CAPS 250mg QL (160 caps / 180 days)nitrofurantoin monohyd macro (generic of MACROBID) CAPS 100mgTier 2 vancomycin hcl SOLR 1gm, Tier 3 5gm, 10gm, 500mg, 750mgparomomycin sulfate (generic of HUMATIN) CAPS 250mg pentamidine isethionate inh pentamidine isethionate inh pentamidine isethionate inj pentamidine isethionate injTier 3 Tier 3ANTIFUNGALS amphotericin b SOLR 50mg Tier 2 amphotericin b SOLR 50mg Tier 3 amphotericin b SOLR 50mg Tier 3 amphotericin b SOLR 50mg Tier 3			3		Tier 2	2
metronidazole (generic of FLAGYL) TABS 500mgTier 1tobramycin sulfate SOLN Tier 2metronidazole in nacl 0.79%Tier 21.2gm/30ml, 10mg/ml, 40mg/ml, 80mg/2mliv soln 500 mg/100ml40mg/ml, 80mg/2mlneomycin sulfate TABS Tier 1vancomycin hcl (generic of Tier 3 QL500mgVANCOCIN HCL) CAPSnitazoxanide (generic of Tier 1 QL125mgALINIA) TABS 500mgQL (80 caps / 180QL (6 tabs / 30 days)QL (80 caps / 180nitrofurantoin macrocrystal Tier 2 (generic of MACRODANTIN) CAPSVancomycin hcl (generic of Tier 3 QL50mg, 100mgQL (160 caps / 180nitrofurantoin monohydTier 2macro (generic of MACROBID) CAPS 100mgVancomycin hcl SOLR 1gm, Tier 3paromomycin sulfate (generic of HUMATIN)Tier 3CAPS 250mgVANCOMYCIN INJ 1 GM Tier 3pentamidine isethionate inh Tier 3 (generic of NEBUPENT)B/DSOLR 300mgAMBISOME SUSR 50mg Tier 2 B/Dpentamidine isethionate inj Tier 3B/D	metronidazole TABS	Tier	1	KITABIS PAK) NEBU	Tier 1	NM PA
iv soln 500 mg/100ml neomycin sulfate TABS Tier 1 500mg nitazoxanide (generic of Tier 1 QL ALINIA) TABS 500mg QL (6 tabs / 30 days) nitrofurantoin macrocrystal (generic of MACRODANTIN) CAPS 50mg, 100mg nitrofurantoin monohyd Tier 2 macro (generic of MACROBID) CAPS 100mg paromomycin sulfate (generic of HUMATIN) CAPS 250mg pentamidine isethionate inh Tier 3 (generic of NEBUPENT) SOLR 300mg pentamidine isethionate inj Tier 3 rier 1 vancomycin hcl (generic of Tier 3 QL VANCOCIN) CAPS 250mg QL (160 caps / 180 days) vancomycin hcl (generic of Tier 3 QL VANCOCIN) CAPS 250mg QL (160 caps / 180 days) vancomycin hcl SOLR 1gm, Tier 3 5gm, 10gm, 500mg, 750mg VANCOMYCIN INJ 1 GM Tier 3 VANCOMYCIN INJ 500MG Tier 3 VANCOMYCIN INJ 750MG Tier 3 ANTIFUNGALS ABELCET SUSP 5mg/ml Tier 3 B/D AMBISOME SUSR 50mg Tier 2 B/D amphotericin b SOLR 50mgTier 3 B/D amphotericin b SOLR 50mgTier 3 B/D	metronidazole (generic of FLAGYL) TABS 500mg			tobramycin sulfate SOLN 1.2gm/30ml, 10mg/ml,	Tier 2	2
Source S	iv soln 500 mg/100ml				Tier 1	
ALINIA) TABS 500mg QL (6 tabs / 30 days) nitrofurantoin macrocrystal Tier 2 (generic of MACRODANTIN) CAPS 50mg, 100mg nitrofurantoin monohyd Tier 2 macro (generic of MACROBID) CAPS 100mg paromomycin sulfate Tier 3 (generic of HUMATIN) CAPS 250mg pentamidine isethionate inh Tier 3 (generic of NEBUPENT) SOLR 300mg pentamidine isethionate inj Tier 3 QL (160 caps / 180 VANCOCIN) CAPS 250mg QL (160 caps / 180 VANCOMYCIN SOLR 1gm, Tier 3 5gm, 10gm, 500mg, 750mg VANCOMYCIN INJ 1 GM Tier 3 VANCOMYCIN INJ 500MG Tier 3 VANCOMYCIN INJ 500MG Tier 3 VANCOMYCIN INJ 750MG Tier 3 ANTIFUNGALS ABELCET SUSP 5mg/ml Tier 3 B/D AMBISOME SUSR 50mg Tier 2 B/D amphoteric b SOLR 50mg Tier 2 B/D amphoteric b SOLR 50mg Tier 3 B/D	500mg				Tier 3	3 QL
(generic of MACRODANTIN) CAPS 50mg, 100mg nitrofurantoin monohyd MACROBID) CAPS 100mg paromomycin sulfate (generic of HUMATIN) CAPS 250mg pentamidine isethionate inh Tier 3 (generic of NEBUPENT) SOLR 300mg pentamidine isethionate inj Tier 3 VANCOCIN) CAPS 250mg QL (160 caps / 180 days) vancomycin hcl SOLR 1gm, Tier 3 5gm, 10gm, 500mg, 750mg VANCOMYCIN INJ 1 GM Tier 3 VANCOMYCIN INJ 500MG Tier 3 VANCOMYCIN INJ 750MG Tier 3 ANTIFUNGALS ABELCET SUSP 5mg/ml Tier 3 B/D AMBISOME SUSR 50mg Tier 2 B/D amphotericin b SOLR 50mgTier 3 B/D	ALINIA) TABS 500mg QL (6 tabs / 30 days)			QL (80 caps / 180		
macro (generic of MACROBID) CAPS 100mg paromomycin sulfate Tier 3 (generic of HUMATIN) CAPS 250mg pentamidine isethionate inh Tier 3 (generic of NEBUPENT) SOLR 300mg pentamidine isethionate inj Tier 3 Sign, 10gm, 500mg, 750mg VANCOMYCIN INJ 1 GM Tier 3 VANCOMYCIN INJ 500MG Tier 3 VANCOMYCIN INJ 750MG Tier 3 ANTIFUNGALS ABELCET SUSP 5mg/ml Tier 3 B/D AMBISOME SUSR 50mg Tier 2 B/D amphotericin b SOLR 50mgTier 3 B/D	(generic of MACRODANTIN) CAPS			VANCOCIN) CAPS 250mg QL (160 caps / 180	Tier 3	3 QL
paromomycin sulfate Tier 3 (generic of HUMATIN) CAPS 250mg pentamidine isethionate inh Tier 3 (generic of NEBUPENT) SOLR 300mg pentamidine isethionate inj Tier 3 Pentamidine isethionate inj Tier 3 VANCOMYCIN INJ 500MG Tier 3 VANCOMYCIN INJ 750MG Tier 3 ANTIFUNGALS ABELCET SUSP 5mg/ml Tier 3 B/D AMBISOME SUSR 50mg Tier 2 B/D amphotericin b SOLR 50mgTier 3 B/D	macro (generic of		2	5gm, 10gm, 500mg, 750mg	Tier 3	3
(generic of HUMATIN) CAPS 250mg pentamidine isethionate inh Tier 3 (generic of NEBUPENT) SOLR 300mg pentamidine isethionate inj Tier 3 ANTIFUNGALS ABELCET SUSP 5mg/ml Tier 3 AMBISOME SUSR 50mg Tier 2 amphotericin b SOLR 50mgTier 3 B/D amphotericin b SOLR 50mgTier 3 B/D						
pentamidine isethionate inh Tier 3 (generic of NEBUPENT) SOLR 300mg pentamidine isethionate inj Tier 3 ANTIFUNGALS ABELCET SUSP 5mg/ml Tier 3 B/D AMBISOME SUSR 50mg Tier 2 B/D amphotericin b SOLR 50mgTier 3 B/D	(generic of HUMATIN)			VANCOMYCIN INJ 750MG		
pentamidine isethionate inj Tier 3 amphotericin b SOLR 50mgTier 3 B/D	pentamidine isethionate inf (generic of NEBUPENT)	Tier	3 B/D	ABELCET SUSP 5mg/ml		
pertamente localionato injulici o		Tier '	3			
(generic of PENTAM 300) SOLR 300mg (generic of CANCIDAS) SOLR 50mg, 70mg	(generic of PENTAM 300)	1101		caspofungin acetate (generic of CANCIDAS)	Tier 3	

Drug Name	Drug Tier	Requirements/ Limits
fluconazole (generic of DIFLUCAN) SUSR	Tier 2	
10mg/ml, 40mg/ml; TABS 50mg, 100mg, 200mg		
fluconazole (generic of DIFLUCAN) TABS 150mg	Tier 1	
fluconazole in nacl 0.9% inj 200 mg/100ml	Tier 2	
fluconazole in nacl 0.9% inj 400 mg/200ml	Tier 2	
flucytosine (generic of ANCOBON) CAPS 250mg, 500mg	Tier 1	PA
griseofulvin microsize SUSP 125mg/5ml; TABS 500mg	Tier 3	
griseofulvin ultramicrosize TABS 125mg, 250mg	Tier 3	
itraconazole (generic of SPORANOX) CAPS 100mg	Tier 3	PA PA
ketoconazole TABS 200mg		
micafungin sodium (generic of MYCAMINE) SOLR 50mg, 100mg	Tier 1	
NOXAFIL SUSP 40mg/ml QL (630 mL / 30 days)	Tier 2	QL PA
nystatin TABS 500000unit	Tier 2	
posaconazole (generic of NOXAFIL) TBEC 100mg QL (93 tabs / 30 days)	Tier 1	QL PA
terbinafine hcl (generic of LAMISIL) TABS 250mg QL (90 tabs / year)	Tier 1	QL
voriconazole (generic of VFEND IV) SOLR 200mg	Tier 1	PA
voriconazole (generic of VFEND) SUSR 40mg/ml	Tier 1	PA
voriconazole (generic of VFEND) TABS 50mg QL (480 tabs / 30 days)	Tier 3	QL PA
voriconazole (generic of VFEND) TABS 200mg QL (120 tabs / 30 days)	Tier 3	QL PA

	Limits
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Tier 3	
T: 0	
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T: 0	
Her 2	
Tior 2	
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Tior 3	PA
11613	IA
NTS	
	NM
11010	I VIVI
Tier 2	NM
Tier 2	NM
Tier 2	NM
Tier 2	NM
Tier 3	NM
Tier 1	
Tier 1	NM
Tier 2	NM
Tier 3	
Tier 2	NM
	Tier 3 Tier 1 Tier 1

Drug Name	Tier	Requirements/ Limits
INVIRASE TABS 500mg	Tier 2	. NM
ISENTRESS CHEW 25mg; PACK 100mg	Tier 2	. NM
ISENTRESS CHEW 100mg; TABS 400mg	Tier 2	. NM
ISENTRESS HD TABS 600mg	Tier 2	. NM
lamivudine (generic of EPIVIR) SOLN 10mg/ml; TABS 150mg, 300mg	Tier 2	. NM
LEXIVA SUSP 50mg/ml	Tier 3	S NM
nevirapine (generic of VIRAMUNE) SUSP 50mg/5ml	Tier 3	s NM
nevirapine TABS 200mg	Tier 1	NM
nevirapine TB24 100mg	Tier 3	s NM
nevirapine (generic of VIRAMUNE XR) TB24 400mg	Tier 3	s NM
NORVIR PACK 100mg; SOLN 80mg/ml	Tier 3	8 NM
PIFELTRO TABS 100mg	Tier 2	. NM
PREZISTA SUSP 100mg/ml QL (400 mL / 30 days)	Tier 2	QL NM
PREZISTA TABS 75mg QL (480 tabs / 30 days)	Tier 3	B QL NM
PREZISTA TABS 150mg QL (240 tabs / 30 days)	Tier 2	2 QL NM
PREZISTA TABS 600mg QL (60 tabs / 30 days)	Tier 2	
PREZISTA TABS 800mg QL (30 tabs / 30 days)	Tier 2	? QL NM
REYATAZ PACK 50mg	Tier 2	. NM
ritonavir (generic of NORVIR) TABS 100mg	Tier 2	. NM
RUKOBIA TB12 600mg	Tier 2	. NM
SELZENTRY SOLN 20mg/ml; TABS 75mg, 150mg, 300mg	Tier 2	. NM
SELZENTRY TABS 25mg	Tier 2	. NM
tenofovir disoproxil fumarate (generic of VIREAD) TABS 300mg	eTier 2	2 NM
TIVICAY TABS 10mg	Tier 2	. NM

Drug Name	Drug Tier	Requirements/ Limits
TIVICAY TABS 25mg, 50mg	Tier 2	NM
TIVICAY PD TBSO 5mg	Tier 2	NM
TYBOST TABS 150mg	Tier 2	NM
VIRACEPT TABS 250mg, 625mg	Tier 2	NM
VIREAD POWD 40mg/gm; TABS 150mg, 200mg, 250mg	Tier 2	NM
zidovudine (generic of RETROVIR) CAPS 100mg; SYRP 50mg/5ml	Tier 3	NM
zidovudine TABS 300mg	Tier 2	NM
ANTIRETROVIRAL COM		
AGENTS	-	
abacavir sulfate-lamivudine tab 600-300 mg (generic of EPZICOM)	Tier 2	NM
abacavir sulfate-lamivudine zidovudine tab 300-150-300 mg (generic of TRIZIVIR)	_	NM
BIKTARVY TAB	Tier 2	NM
CIMDUO TAB 300-300	Tier 2	NM
COMPLERA TAB	Tier 2	NM
DELSTRIGO TAB	Tier 2	NM
DESCOVY TAB 200/25MG	Tier 2	NM
DOVATO TAB 50-300MG	Tier 2	NM
efavirenz-emtricitabine- tenofovir df tab 600-200-300 mg (generic of ATRIPLA)	Tier 1	NM
efavirenz-lamivudine- tenofovir df tab 400-300-300 mg (generic of SYMFI LO)	Tier 1	NM
efavirenz-lamivudine- tenofovir df tab 600-300-300 mg (generic of SYMFI)		NM
emtricitabine-tenofovir disoproxil fumarate tab 100- 150 mg (generic of TRUVADA) QL (30 tabs / 30 days)	Tier 1	QL NM
emtricitabine-tenofovir disoproxil fumarate tab 133- 200 mg (generic of TRUVADA) QL (30 tabs / 30 days)	Tier 1	QL NM

Drug Name	Tier	equirements/ Limits
emtricitabine-tenofovir	Tier 1	QL NM
disoproxil fumarate tab 167	-	
250 mg (generic of		
TRUVADA)		
QL (30 tabs / 30 days)	<u> </u>	
emtricitabine-tenofovir	Tier 1	QL NM
disoproxil fumarate tab 200	-	
300 mg (generic of		
TRUVADA)		
QL (30 tabs / 30 days) EVOTAZ TAB 300-150	Tier 2	NM
GENVOYA TAB	Tier 2	NM
JULUCA TAB 50-25MG	Tier 2	NM
KALETRA TAB 100-25MG KALETRA TAB 200-50MG	Tier 3	NM NM
lamivudine-zidovudine tab	Tier 3 Tier 3	NM
150-300 mg (generic of	Hel 3	INIVI
COMBIVIR)		
lopinavir-ritonavir soln 400-	Tior 2	NM
100 mg/5ml (80-20 mg/ml)	11613	INIVI
(generic of KALETRA)		
lopinavir-ritonavir tab 100-25	Tier 3	NM
mg (generic of KALETRA)		
lopinavir-ritonavir tab 200-50	CTier 3	NM
mg (generic of KALETRA)		
ODEFSEY TAB	Tier 2	NM
PREZCOBIX TAB 800-150	Tier 2	NM
STRIBILD TAB	Tier 2	NM
SYMTUZA TAB	Tier 2	NM
TEMIXYS TAB 300-300	Tier 2	NM
TRIUMEQ TAB	Tier 2	NM
ANTITUBERCULAR AGE	ENTS	
cycloserine CAPS 250mg	Tier 1	
ethambutol hcl TABS	Tier 2	
_100mg		
ethambutol hcl (generic of	Tier 2	
MYAMBUTOL) TABS		
400mg		
isoniazid TABS 100mg,	Tier 1	
300mg	 : 0	
PASER PACK 4gm	Tier 3	
PRIFTIN TABS 150mg	Tier 3	
pyrazinamide TABS 500mg		
rifabutin (generic of	Tier 3	
MYCOBUTIN) CAPS		
150mg		

Drug Name	Drug Tier	Requirements/ Limits
rifampin CAPS 150mg, 300mg	Tier 2	!
rifampin (generic of RIFADIN) SOLR 600mg	Tier 3	,
SIRTURO TABS 20mg, 100mg	Tier 2	LA PA
TRECATOR TABS 250mg	Tier 3	<u> </u>
ANTIVIRALS	<u> </u>	
acyclovir CAPS 200mg; TABS 400mg, 800mg	Tier 1	
acyclovir sodium SOLN 50mg/ml	Tier 3	B/D
adefovir dipivoxil (generic of HEPSERA) TABS 10mg	Tier 3	s NM
BARACLUDE SOLN .05mg/ml	Tier 2	. NM
entecavir (generic of BARACLUDE) TABS .5mg, 1mg	Tier 3	s NM
EPCLUSA TAB 200-50MG	Tier 2	NM PA
EPCLUSA TAB 400-100	Tier 2	NM PA
EPIVIR HBV SOLN 5mg/ml	Tier 3	NM
famciclovir TABS 125mg, 250mg, 500mg	Tier 2	
ganciclovir sodium SOLR 500mg	Tier 3	B/D
HARVONI PAK 33.75- 150MG	Tier 2	NM PA
HARVONI PAK 45-200MG	Tier 2	NM PA
HARVONI TAB 45-200MG	Tier 2	
HARVONI TAB 90-400MG	Tier 2	
lamivudine (hbv) (generic of EPIVIR HBV) TABS 100mg	Tier 3	
MAVYRET TAB 100-40MG	Tier 2	NM PA
oseltamivir phosphate (generic of TAMIFLU) CAPS 30mg QL (168 caps / year)	Tier 2	. QL
oseltamivir phosphate (generic of TAMIFLU) CAPS 45mg, 75mg QL (84 caps / year)	Tier 2	. QL
oseltamivir phosphate (generic of TAMIFLU) SUSR 6mg/ml QL (1080 mL / year)	Tier 2	. QL
PEGASYS SOLN 180mcg/0.5ml, 180mcg/ml	Tier 2	NM PA

Drug Name	Tier	Requirements/ Limits
PREVYMIS TABS 240mg,	Tier 2	QL PA
480mg QL (28 tabs / 28 days)		
RELENZA DISKHALER	Tier 2	QL
AEPB 5mg/blister	1101 2	α_
QL (6 inhalers / year)		
ribavirin (hepatitis c) CAPS	Tier 2	NM
200mg ribavirin (hepatitis c) TABS	Tior 2	NM
200mg	11613	INIVI
rimantadine hydrochloride	Tier 3	
TABS 100mg		
valacyclovir hcl (generic of	Tier 2	
VALTREX) TABS 1gm,		
500mg	T:0 # 4	
valganciclovir hcl (generic of VALCYTE) SOLR 50mg/ml	Herm	
valganciclovir hcl (generic of	Tier 2	
VALCYTE) TABS 450mg		
VOSEVI TAB	Tier 2	NM PA
CEPHALOSPORINS		
cefaclor CAPS 250mg,	Tier 2	
500mg		
cefadroxil CAPS 500mg	Tier 1	
cefadroxil SUSR	Tier 2	
250mg/5ml, 500mg/5ml CEFAZOLIN INJ 1GM/50ML	Tior 3	
cefazolin sodium SOLR	Tier 2	
1gm, 10gm, 500mg	1101 2	
CEFAZOLIN SOLN	Tier 3	
2GM/100ML-4%		
cefdinir CAPS 300mg	Tier 1	
cefdinir SUSR 125mg/5ml,	Tier 2	
250mg/5ml	T: 0	
cefepime hcl SOLR 1gm,	Tier 3	
2gm cefoxitin sodium SOLR	Tier 3	
1gm, 2gm, 10gm	1101 0	
cefpodoxime proxetil TABS	Tier 2	
_100mg, 200mg		
cefprozil TABS 250mg,	Tier 2	
500mg	T : 0	
ceftazidime (generic of	Tier 3	
FORTAZ) SOLR 1gm ceftazidime SOLR 2gm,	Tier 3	
6gm	1 101 0	
J - ·		

Drug Name	Tier	Requirements/ Limits
ceftriaxone sodium SOLR	Tier 3	3
1gm, 2gm, 10gm, 250mg,		
500mg		
cefuroxime axetil TABS	Tier 2	<u> </u>
_250mg, 500mg		
cefuroxime sodium SOLR	Tier 2	2
1.5gm, 7.5gm, 750mg		
cephalexin CAPS 250mg,	Tier 1	
500mg		
cephalexin SUSR	Tier 2) -
125mg/5ml, 250mg/5ml		
tazicef (generic of FORTAZ)	Tier 3	3
SOLR 1gm		
tazicef SOLR 1gm, 2gm,	Tier 3	3
6gm		
TEFLARO SOLR 400mg,	Tier 2	2
600mg		_
ERYTHROMYCINS/MAC		
azithromycin PACK 1gm	Tier 2	2
azithromycin (generic of	Tier 2	<u> </u>
ZITHROMAX) SOLR		
500mg; SUSR 100mg/5ml,		
200mg/5ml		
azithromycin (generic of	Tier 1	
ZITHROMAX) TABS		
250mg, 500mg		
azithromycin TABS 600mg	Tier 1	
clarithromycin SUSR	Tier 3	3
125mg/5ml, 250mg/5ml		
clarithromycin TABS	Tier 2	<u>-</u>
250mg, 500mg		
ery-tab TBEC 250mg,	Tier 3	3
333mg, 500mg		
ERYTHROCIN	Tier 2	<u>-</u>
LACTOBIONATE SOLR		
500mg		
erythromycin base CPEP	Tier 3	3
250mg; TABS 250mg,		
500mg; TBEC 250mg,		
333mg, 500mg		
FLUOROQUINOLONES	- -	
ciprofloxacin 200 mg/100ml	lier 2	<u>}</u>
in d5w	—	
ciprofloxacin 400 mg/200ml	Lier 2	2
in d5w	T: 0	
ciprofloxacin hcl TABS	Tier 3	5
_100mg		

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
ciprofloxacin hcl (generic of CIPRO) TABS 250mg,	Tier '		ampicillin & sulbactam sodium for inj 3 (2-1) gm	Tier 3	3
500mg ciprofloxacin hcl TABS	Tier '		(generic of UNASYN) ampicillin & sulbactam	Tier 3	3
750mg levofloxacin SOLN 25mg/m	nlTier 3	3	sodium for iv soln 1.5 (1-0.5) gm)	
levofloxacin (generic of LEVAQUIN) TABS 250mg,	Tier 1		ampicillin & sulbactam sodium for iv soln 3 (2-1) gm	Tier 3	3
500mg, 750mg levofloxacin in d5w iv soln	Tier 2)	ampicillin & sulbactam sodium for iv soln 15 (10-5)	Tier 3	3
250 mg/50ml levofloxacin in d5w iv soln	Tier 2		gm (generic of UNASYN ÉBULK PACK)		
500 mg/100ml			ampicillin sodium SOLR 1gm, 2gm, 10gm, 125mg,	Tier 3	3
levofloxacin in d5w iv soln 750 mg/150ml	Tier 2		250mg, 500mg		
PENICILLINS			BICILLIN L-A SUSP 600000unit/ml,	Tier 3	3
amoxicillin CAPS 250mg, 500mg; CHEW 125mg, 250mg; SUSR 125mg/5ml,	Tier '		1200000unit/2ml, 2400000unit/4ml		
200mg/5ml, 250mg/5ml, 400mg/5ml; TABS 500mg,			dicloxacillin sodium CAPS 250mg, 500mg	Tier 2	2
875mg amoxicillin & k clavulanate	Tier 3	2	nafcillin sodium SOLR 1gm, 2gm	Tier 3	3
chew tab 200-28.5 mg amoxicillin & k clavulanate	Tier 3		nafcillin sodium SOLR 10gm	Tier 1	
chew tab 400-57 mg			PEN GK/DEXTR INJ 40000/ML	Tier 3	3
amoxicillin & k clavulanate for susp 200-28.5 mg/5ml	Tier 2		PEN GK/DEXTR INJ 60000/ML	Tier 3	3
amoxicillin & k clavulanate for susp 250-62.5 mg/5ml (generic of AUGMENTIN)	Tier 3	3	penicillin g potassium SOLR 5000000unit,	Tier 3	3
amoxicillin & k clavulanate	Tier 2	2	20000000unit PENICILLIN G PROCAINE	Tier 3	<u> </u>
for susp 400-57 mg/5ml amoxicillin & k clavulanate	Tier 2	2	SUSP 600000unit/ml		
for susp 600-42.9 mg/5ml (generic of AUGMENTIN			penicillin g sodium SOLR 5000000unit	Tier 3	
ES-600) amoxicillin & k clavulanate	Tier 2)	<i>penicillin v potassium</i> SOLR 125mg/5ml,	Tier 1	
tab 250-125 mg			250mg/5ml; TABS 250mg, 500mg		
amoxicillin & k clavulanate tab 500-125 mg (generic of AUGMENTIN)	Tier '		pfizerpen SOLR 5000000unit, 2000000unit	Tier 3	3
amoxicillin & k clavulanate tab 875-125 mg	Tier '		piperacillin sod-tazobactam na for inj 3.375 gm (3-0.375		3
ampicillin CAPS 500mg	Tier 2		gm) piperacillin sod-tazobactam	Tier 3	<u> </u>
ampicillin & sulbactam sodium for inj 1.5 (1-0.5) gr (generic of UNASYN)	Tier 3 n	3	sod for inj 2.25 gm (2-0.25 gm)		,
(generic of ONASTN)					

Drug Name	Drug I Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
piperacillin sod-tazobactan	Tier 3		methotrexate sodium S	OLNTier 2	B/D
sod for inj 4.5 gm (4-0.5 gm	ı)		1gm/40ml, 50mg/2ml,		
piperacillin sod-tazobactan	Tier 3		250mg/10ml; SOLR 1gr		
sod for inj 13.5 gm (12-1.5			ONUREG TABS 200m	g, Tier 2	NM LA PA
_gm)			300mg		
piperacillin sod-tazobactam	Tier 3		PURIXAN SUSP	Tier 2	NM
sod for inj 40.5 gm (36-4.5			2000mg/100ml		
gm)			TABLOID TABS 40mg	Tier 3	
TETRACYCLINES	T: 0		HORMONAL ANTINE		
doxy 100 SOLR 100mg	Tier 3		abiraterone acetate (ge		NM PA
doxycycline (monohydrate)	Tier 1		of ZYTIGA) TABS 250r	ng,	
CAPS 50mg, 100mg					
doxycycline (monohydrate)	Tier 2		anastrozole (generic of	Tier 1	
TABS 50mg, 75mg, 100mg	T: 0		ARIMIDEX) TABS 1mg	T' 4	
doxycycline hyclate CAPS	Lier 2		bicalutamide (generic o		
50mg; TABS 20mg, 100mg	T: 0		CASODEX) TABS 50m		
doxycycline hyclate (generi	c Her 2		EMCYT CAPS 140mg	Tier 2	
of VIBRAMYCIN) CAPS			ERLEADA TABS 60mg		
100mg doxycycline hyclate SOLR	Tior 2	_	exemestane (generic of		
100mg	i iei 3		AROMASIN) TABS 25r		
minocycline hcl CAPS	Tier 2		flutamide CAPS 125mg		
50mg, 75mg			letrozole (generic of FEMARA) TABS 2.5mg	Tier 1	
minocycline hcl (generic of	Tier 2		leuprolide acetate KIT	Tier 3	NM PA
MINOCIN) CAPS 100mg	T' 4		1mg/0.2ml		
mondoxyne nl CAPS	Tier 1		LUPRON DEPOT (1-	Tier 2	NM PA
100mg	Tier 3	PA	MONTH) KIT 3.75mg		
tetracycline hcl CAPS 250mg, 500mg	Her 3	PA	LUPRON DEPOT (3-	Tier 2	NM PA
TIGECYCLINE SOLR	Tier 2		MONTH) KIT 11.25mg		
50mg	i iei z		LYSODREN TABS 500		-
tigecycline (generic of	Tier 3		megestrol acetate TAB	S Tier 2	
TYGACIL) SOLR 50mg	11613		20mg, 40mg		
ANTINEOPLASTIC AGE	NTS	_	nilutamide (generic of	Tier 1	
ALKYLATING AGENTS			NILANDRON) TABS		
cyclophosphamide CAPS	Tier 2	B/D	150mg	T: 0	NIM I A DA
25mg, 50mg	1101 2	טוט	NUBEQA TABS 300mg		
CYCLOPHOSPHAMIDE	Tier 3	B/D	ORGOVYX TABS 120r		
TABS 25mg, 50mg	1101 0	2,2	SOLTAMOX SOLN 10mg/5ml	Tier 2	
LEUKERAN TABS 2mg	Tier 3		tamoxifen citrate TABS	Tier 1	
ANTIMETABOLITES	1101 0	_	10mg, 20mg	i iei i	
INQOVI TAB 35-100MG	Tier 2	NM LA PA	toremifene citrate (gene	ric Tier 1	
LONSURF TAB 15-6.14	Tier 2	NM PA	of FARESTON) TABS		
LONSURF TAB 20-8.19	Tier 2	NM PA	60mg		
mercaptopurine TABS	Tier 2	I NIVI I //	TRELSTAR MIXJECT	Tier 2	NM PA
50mg	1101 2		SUSR 3.75mg, 11.25mg		
			XTANDI CAPS 40mg;	Tier 2	NM LA PA
			TABS 40mg, 80mg		

Drug Name	Drug Requirements/ Tier Limits	Drug Name	Drug Requirements/ Tier Limits
<i>IMMUNOMODULATORS</i>	S	ALUNBRIG TABS 30mg,	Tier 2 NM LA PA
POMALYST CAPS 1mg,	Tier 2QL NM LA PA	90mg, 180mg	
2mg		ALUNBRIG PAK	Tier 2 NM LA PA
QL (21 caps / 21 days		AYVAKIT TABS 25mg,	Tier 2QL NM LA PA
POMALYST CAPS 3mg,	Tier 2QL NM LA PA	50mg, 100mg, 200mg,	
4mg		300mg	Α.
QL (21 caps / 28 days	s) Tier 2QL NM LA PA	QL (30 tabs / 30 days	,
REVLIMID CAPS 2.5mg, 5mg, 10mg, 15mg	Her ZQL NIVI LA PA	BALVERSA TABS 3mg, 4mg, 5mg	Tier 2 NM LA PA
QL (28 caps / 28 days	e)	BOSULIF TABS 100mg,	Tier 2 NM PA
REVLIMID CAPS 20mg,	Tier 2QL NM LA PA	400mg, 500mg	HEIZ MINIFA
25mg	TICI Z QL IVIVI L/X I /X	BRAFTOVI CAPS 75mg	Tier 2 NM LA PA
QL (21 caps / 28 days	s)	BRUKINSA CAPS 80mg	Tier 2 NM LA PA
THALOMID CAPS 50mg,		CABOMETYX TABS 20mg	
100mg		40mg, 60mg	5,,
QL (28 caps / 28 days		QL (30 tabs / 30 days	3)
THALOMID CAPS 150mg	, Tier 2 QL NM PA	CALQUENCE CAPS	Tier 2QL NM LA PA
200mg		100mg	
QL (56 caps / 28 days	s)	QL (60 caps / 30 days	s)
MISCELLANEOUS	T' 4 NIM DA	CAPRELSA TABS 100mg	, Tier 2 NM LA PA
bexarotene (generic of	Tier 1 NM PA	300mg) T:
TARGRETIN) CAPS 75mg		COMETRIQ (60MG DOSE) Her 2 NM LA PA
hydroxyurea (generic of	Tier 1	KIT 20mg COMETRIQ KIT 100MG	Tier 2 NM LA PA
HYDREA) CAPS 500mg KISQALI 200 PAK FEMAR	Δ Tier 2 OL NIM PΔ	COMETRIQ KIT 140MG	Tier 2 NM LA PA
QL (49 tabs / 28 days		COPIKTRA CAPS 15mg,	Tier 2 NM LA PA
KISQALI 400 PAK FEMAR		25mg	TICI Z TAWI ETTIT
QL (70 tabs / 28 days		COTELLIC TABS 20mg	Tier 2 NM LA PA
KISQALI 600 PAK FEMAR		DAURISMO TABS 25mg,	Tier 2 NM LA PA
QL (91 tabs / 28 days	s)	100mg	
MATULANE CAPS 50mg	Tier 2 NM LA	ERIVEDGE CAPS 150mg	Tier 2 NM LA PA
SYNRIBO SOLR 3.5mg	Tier 2 NM PA	erlotinib hcl (generic of	Tier 1 QL NM PA
tretinoin (chemotherapy)	Tier 1	TARCEVA) TABS 25mg	
CAPS 10mg		QL (90 tabs / 30 days	
MOLECULAR TARGET		erlotinib hcl (generic of	Tier 1 QL NM PA
AFINITOR TABS 10mg	Tier 2 QL NM PA	TARCEVA) TABS 100mg,	
QL (30 tabs / 30 days		150mg QL (30 tabs / 30 days	.)
AFINITOR DISPERZ TBS	O Her 2 QL NIM PA	everolimus (generic of	Tier 1 QL NM PA
2mg QL (150 tabs / 30		AFINITOR) TABS 2.5mg,	TICLL QLIMITA
days)		5mg, 7.5mg	
AFINITOR DISPERZ TBS	O Tier 2 OL NM PA	QL (30 tabs / 30 days	3)
3mg	2 Q= (M) / /	FARYDAK CAPS 10mg,	Tier 2 NM LA PA
QL (90 tabs / 30 days	s)	_15mg, 20mg	
AFINITOR DISPERZ TBS		FOTIVDA CAPS .89mg,	Tier 2QL NM LA PA
5mg		1.34mg	. \
QL (60 tabs / 30 days		QL (21 caps / 28 days	
ALECENSA CAPS 150mg	Tier 2 NM LA PA	GAVRETO CAPS 100mg	Tier 2 NM LA PA

Drug Name	Drug Requirements/ Tier Limits	Drug Name	Drug Requirements/ Tier Limits
GILOTRIF TABS 20mg,	Tier 2 NM LA PA	KISQALI 600 DOSE TBPK	Tier 2 QL NM PA
30mg, 40mg		200mg	
IBRANCE CAPS 75mg,	Tier 2QL NM LA PA	QL (63 tabs / 28 days)	
100mg, 125mg		lapatinib ditosylate (generic	Tier 1 NM PA
QL (21 caps / 28 days	s)	of TYKERB) TABS 250mg	
IBRANCE TABS 75mg,	Tier 2QL NM LA PA	LENVIMA 4 MG DAILY	Tier 2QL NM LA PA
100mg, 125mg		DOSE CPPK 4mg	
QL (21 tabs / 28 days		QL (30 caps / 30 days	
ICLUSIG TABS 10mg	Tier 2QL NM LA PA	LENVIMA 8 MG DAILY	Tier 2QL NM LA PA
QL (60 tabs / 30 days		DOSE CPPK 4mg	.
ICLUSIG TABS 15mg,	Tier 2QL NM LA PA	QL (60 caps / 30 days	
30mg, 45mg		LENVIMA 10 MG DAILY	Tier 2QL NM LA PA
QL (30 tabs / 30 days	•	DOSE CPPK 10mg	
IDHIFA TABS 50mg,	Tier 2QL NM LA PA	QL (30 caps / 30 days	
100mg		LENVIMA 12MG DAILY	Tier 2QL NM LA PA
QL (30 tabs / 30 days		DOSE CPPK 4mg	,
imatinib mesylate (generic		QL (90 caps / 30 days	
of GLEEVEC) TABS 100m	_	LENVIMA 20 MG DAILY	Tier 2QL NM LA PA
QL (90 tabs / 30 days		DOSE CPPK 10mg	\
imatinib mesylate (generic		QL (60 caps / 30 days	
of GLEEVEC) TABS 400m	•	LENVIMA CAP 14 MG	Tier 2QL NM LA PA
QL (60 tabs / 30 days		QL (60 caps / 30 days	
IMBRUVICA CAPS 70mg		LENVIMA CAP 18 MG	Tier 2QL NM LA PA
QL (30 caps / 30 days		QL (90 caps / 30 days LENVIMA CAP 24 MG	Tier 2QL NM LA PA
QL (120 caps / 30	J Hel ZQL NIVI LA PA		
days)		QL (90 caps / 30 days LORBRENA TABS 25mg,	
IMBRUVICA TABS 140mg	Tior 201 NM LA DA	100mg	HEIZ INWILAFA
280mg, 420mg, 560mg	J, HEIZQLINN LAFA	LUMAKRAS TABS 120mg	Tior 2 NIMI A DA
QL (30 tabs / 30 days	:)	LYNPARZA TABS 100mg,	
INLYTA TABS 1mg	Tier 2 QL NM LA PA	150mg	HEI ZQL NIVI LA FA
QL (180 tabs / 30	TICLE QETWILL TO	QL (120 tabs / 30	
days)		days)	
INLYTA TABS 5mg	Tier 2QL NM LA PA	MEKINIST TABS.5mg,	Tier 2 NM LA PA
QL (120 tabs / 30	TIOT Z QZ TWW Z/YT /Y	2mg	TIOI Z THIN EXTIN
days)		MEKTOVI TABS 15mg	Tier 2 NM LA PA
INREBIC CAPS 100mg	Tier 2 NM LA PA	NERLYNX TABS 40mg	Tier 2 NM LA PA
IRESSA TABS 250mg	Tier 2 NM LA PA	NEXAVAR TABS 200mg	Tier 2QL NM LA PA
JAKAFI TABS 5mg, 10mg		QL (120 tabs / 30	TIOI Z QL I IIII L/ I / I
15mg, 20mg, 25mg	,	days)	
QL (60 tabs / 30 days	s)	NINLARO CAPS 2.3mg,	Tier 2 QL NM PA
KISQALI 200 DOSE TBPK	Tier 2 QL NM PA	3mg, 4mg	
200mg		QL (3 caps / 28 days)	
QL (21 tabs / 28 days	s)	ODOMZO CAPS 200mg	Tier 2 NM LA PA
KISQALI 400 DOSE TBPK		PEMAZYRE TABS 4.5mg,	Tier 2 NM LA PA
200mg		9mg, 13.5mg	
QL (42 tabs / 28 days	3)	PIQRAY 200MG DAILY	Tier 2 NM PA
		DOSE TBPK 200mg	

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
PIQRAY 250MG TAB DOSE	Tier 2	NM PA	VENCLEXTA TABS 10mg	Tier 3	BQL NM LA PA
PIQRAY 300MG DAILY	Tier 2	NM PA	QL (112 tabs / 28		
DOSE TBPK 150mg			days)		
QINLOCK TABS 50mg	Tier 2	NM LA PA	VENCLEXTA TABS 50mg	Tier 2	QL NM LA PA
RETEVMO CAPS 40mg,	Tier 2	NM LA PA	QL (112 tabs / 28		
80mg			days)		
ROZLYTREK CAPS 100mg, 200mg	Tier 2	NM LA PA	VENCLEXTA TABS 100mg QL (180 tabs / 30	Tier 2	QL NM LA PA
RUBRACA TABS 200mg,	Tier 2	QL NM LA PA	days)		
250mg, 300mg			VENCLEXTA TAB START	Tier 2	QL NM LA PA
QL (120 tabs / 30			PK		
days)			QL (42 tabs / 28 days)		01 11141 4 54
RYDAPT CAPS 25mg	Tier 2		VERZENIO TABS 50mg,	l ier 2	QL NM LA PA
SPRYCEL TABS 20mg, 50mg, 70mg, 80mg, 100mg,	Tier 2	NM PA	100mg, 150mg, 200mg QL (56 tabs / 28 days)		
_140mg			VITRAKVI CAPS 25mg,	Tier 2	NM LA PA
STIVARGA TABS 40mg	Tier 2		100mg; SOLN 20mg/ml		
SUTENT CAPS 12.5mg,	Tier 2	QL NM PA	VIZIMPRO TABS 15mg,	Tier 2	NM LA PA
25mg, 37.5mg, 50mg			30mg, 45mg	- : -	NINAL A DA
QL (30 caps / 30 days)			VOTRIENT TABS 200mg	Tier 2	
TABRECTA TABS 150mg,	Tier 2	NM PA	XALKORI CAPS 200mg, 250mg	Tier 2	NM LA PA
Z00mg	T: 0	NIM L A DA	XOSPATA TABS 40mg	Tier 2	NM LA PA
TAFINLAR CAPS 50mg, 75mg	Tier 2	NM LA PA	XPOVIO 40 MG ONCE	Tier 2	
TAGRISSO TABS 40mg,	Tior 2	QL NM LA PA	WEEKLY TBPK 20mg,	1161 2	. INIVILATA
80mg	11012	QLIVIVI LATA	40mg		
QL (30 tabs / 30 days)			XPOVIO 40 MG TWICE	Tier 2	NM LA PA
TALZENNA CAPS 1mg		QL NM LA PA	WEEKLY TBPK 20mg,		
QL (30 caps / 30 days)		Q22//	40mg		
TALZENNA CAPS .25mg		QL NM LA PA	XPOVIO 60 MG ONCE	Tier 2	NM LA PA
QL (90 caps / 30 days))		WEEKLY TBPK 20mg,		
TASIGNA CAPS 50mg,	Tier 2	NM PA	60mg		
150mg, 200mg			XPOVIO 60 MG TWICE	Tier 2	NM LA PA
TAZVERIK TABS 200mg	Tier 2	NM LA PA	WEEKLY TBPK 20mg		
TEPMETKO TABS 225mg	Tier 2	NM LA PA	XPOVIO 80 MG ONCE	Tier 2	NM LA PA
TIBSOVO TABS 250mg	Tier 2	NM LA PA	WEEKLY TBPK 20mg,		
TRUSELTIQ 50 MG DAILY	Tier 2	NM LA PA	40mg	T: C	NIMAL A DA
DOSE CPPK 25mg			XPOVIO 80 MG TWICE	i ier 2	NM LA PA
TRUSELTIQ 75 MG DAILY	Tier 2	NM LA PA	WEEKLY TBPK 20mg	Tior	NM LA PA
DOSE CPPK 25mg			XPOVIO 100 MG ONCE WEEKLY TBPK 20mg,	Hel 2	NIVILAPA
TRUSELTIQ 100 MG DAILY DOSE CPPK 100mg	Tier 2	NM LA PA	50mg		
TRUSELTIQ 125 MG DAIL	/Tior 2	NIM I A DA	ZEJULA CAPS 100mg	Tier 2	QL NM LA PA
DOSE	1161 2		QL (90 caps / 30 days		·
TUKYSA TABS 50mg,	Tier 2	NM LA PA	ZELBORAF TABS 240mg	Tier 2	NM LA PA
150mg			ZOLINZA CAPS 100mg	Tier 2	NM PA
TURALIO CAPS 200mg	Tier 2	NM LA PA	ZYDELIG TABS 100mg,	Tier 2	NM LA PA
UKONIQ TABS 200mg	Tier 2		150mg		

PROTECTIVE AGENTS leucovorin calcium TABS Tier 2 12.5 5mg, 10mg leucovorin calcium TABS Tier 3 15mg, 25mg 25 mm MESNEX TABS 400mg Tier 2 VASE fosin Mesnex TABS 400mg Tier 2 Tosin Mydro Mesnex TABS 400mg Tier 2 Tosin Mydrochlorothiazide tab 20- 25 mg (generic of LOTREL) QL (30 caps / 30 days) 21.5 mg (generic of LOTREL) QL (30 caps / 30 days) 22.5 mg (generic of LOTREL) QL (30 caps / 30 days) 22.5 mg (generic of LOTREL) QL (30 caps / 30 days) 22.5 mg (generic of LOTREL) QL (30 caps / 30 days) 22.5 mg (generic of LOTREL) QL (30 caps / 30 days) 22.5 mg (generic of LOTREL) QL (30 caps / 30 days) 22.5 mg (generic of LOTREL) QL (30 caps / 30 days) 22.5 mg (generic of LOTREL) QL (30 caps / 30 days) 22.5 mg (generic of LOTREL) 25.5 mg (ge	Drug Name	Drug Requirements/ Tier Limits	Drug I
leucovorin calcium TABS Tier 2 5mg, 10mg leucovorin calcium TABS Tier 3 15mg, 25mg MESNEX TABS 400mg Tier 2 VASE CARDIOVASCULAR ACE INHIBITOR COMBINATIONS amlodipine besylate- Tier 1 QL benazepril hcl cap 2.5-10 mg (12.5 mg) (12.5	ZYKADIA TABS 150mg	Tier 2 NM LA PA	enala
International Processing International Proce	PROTECTIVE AGENTS	_	hydro
Ieucovorin calcium TABS Tier 3 15mg, 25mg MESNEX TABS 400mg Tier 2 Tier 2 Tosim Tabs Tier 3 Tier 3 Tier 4 Tier 5 Tier 6 Tier 6 Tier 6 Tier 6 Tier 7 Tier 7 Tier 7 Tier 8 Tier 9 Tier 9 Tier 9 Tier 1 Tier 1 Tier 9 Tier 1 Tier 1 Tier 9 Tier 1 Tier 9 Tier 1 Tier 9 Tier 1 Tier 9 Tier 9 Tier 1 Tier 9	leucovorin calcium TABS	Tier 2	12.5 r
MESNEX TABS 400mg Tier 2 Tosim	5mg, 10mg		enala
MESNEX TABS 400mg Tier 2 CARDIOVASCULAR ACE INHIBITOR COMBINATIONS amlodipine besylate- Tier 1 QL fosin hydromag QL (30 caps / 30 days) amlodipine besylate- Tier 1 QL benazepril hcl cap 5-10 mg (generic of LOTREL) QL (30 caps / 30 days) amlodipine besylate- Tier 1 QL benazepril hcl cap 5-20 mg (generic of LOTREL) QL (30 caps / 30 days) amlodipine besylate- Tier 1 QL benazepril hcl cap 5-20 mg (generic of LOTREL) QL (30 caps / 30 days) amlodipine besylate- Tier 1 QL benazepril hcl cap 5-40 mg QL (30 caps / 30 days) amlodipine besylate- Tier 1 QL benazepril hcl cap 5-40 mg QL (30 caps / 30 days) amlodipine besylate- Tier 1 QL guine hydro (generic of LOTREL) QL (30 caps / 30 days) amlodipine besylate- Tier 1 QL guine hydro (generic of LOTREL) QL (30 caps / 30 days) amlodipine besylate- Tier 1 QL guine hydro (generic of LOTREL) QL (30 caps / 30 days) benazepril & Tier 2 hydrochlorothiazide tab 5-6.25 mg benazepril & Tier 2 hydrochlorothiazide tab 10-12.5 mg (generic of LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 20-12.5 mg (generic of LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 20-12.5 mg (generic of LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 20-12.5 mg (generic of LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 20-12.5 mg (generic of LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 5-5mg, fosin	leucovorin calcium TABS	Tier 3	hydro
MESNEX TABS 400mg Tier 2 VASSE CARDIOVASCULAR ACE INHIBITOR COMBINATIONS fosin amlodipine besylate- benazepril hcl cap 2.5-10 mg QL (30 caps / 30 days) Tier 1 	15mg, 25mg		25 mg
ACE INHIBITOR COMBINATIONS amlodipine besylate- Tier 1 QL fosin hydromageril hcl cap 2.5-10 mg QL (30 caps / 30 days) amlodipine besylate- Tier 1 QL benazepril hcl cap 5-10 mg (generic of LOTREL) QL (30 caps / 30 days) amlodipine besylate- Tier 1 QL benazepril hcl cap 5-20 mg (generic of LOTREL) QL (30 caps / 30 days) amlodipine besylate- Tier 1 QL benazepril hcl cap 5-20 mg (generic of LOTREL) QL (30 caps / 30 days) amlodipine besylate- Tier 1 QL benazepril hcl cap 5-40 mg QL (30 caps / 30 days) amlodipine besylate- Tier 1 QL benazepril hcl cap 10-20 mg (generic of LOTREL) QL (30 caps / 30 days) amlodipine besylate- Tier 1 QL guina hydromageril hcl cap 10-20 mg (generic of LOTREL) QL (30 caps / 30 days) amlodipine besylate- Tier 1 QL guina hydromageril hcl cap 10-40 mg (generic of LOTREL) QL (30 caps / 30 days) benazepril & Tier 2 quina hydrochlorothiazide tab 5-6.25 mg benazepril & Tier 2 hydrochlorothiazide tab 10-12.5 mg (generic of LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 20-12.5 mg (generic of LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 20-12.5 mg (generic of LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 20-12.5 mg (generic of LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 5-5mg, generic of LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 5-5mg, generic of LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 5-5mg, generic of LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 5-5mg, generic of LOTENSIN HCT)		Tier 2	
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benazepril hol cap 5-10 mg (generic of LOTREL)			
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QL (30 caps / 30 days) amlodipine besylate- Tier 1 QL hydro days (generic of LOTREL) QL (30 caps / 30 days) amlodipine besylate- Tier 1 QL benazepril hcl cap 5-40 mg QL (30 caps / 30 days) amlodipine besylate- Tier 1 QL hydro days (generic of LOTREL) QL (30 caps / 30 days) amlodipine besylate- Tier 1 QL quine hydro days (generic of LOTREL) QL (30 caps / 30 days) amlodipine besylate- Tier 1 QL quine hydro (generic of LOTREL) QL (30 caps / 30 days) benazepril hcl cap 10-40 mg (generic of LOTREL) QL (30 caps / 30 days) benazepril & Tier 2 quine hydro days (generic of LOTREL) C25 mg benazepril & Tier 2 quine hydro days (generic of LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 10-12.5 mg (generic of LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 20-12.5 mg (generic of LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 20-12.5 mg (generic of LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 20-12.5 mg (generic of LOTENSIN HCT) benazepril & Tier 2 for 2 for 20 mg (generic of LOTENSIN HCT) benazepril & Tier 2 for 2 for 20 mg (generic of LOTENSIN HCT) benazepril & Tier 2 for 2 for 20 mg (generic of LOTENSIN HCT) benazepril & Tier 2 for 2 for 20 mg (generic of LOTENSIN HCT)		•	
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QL (30 caps / 30 days) amlodipine besylate- Tier 1 QL benazepril hcl cap 10-20 mg (generic of LOTREL) QL (30 caps / 30 days) amlodipine besylate- Tier 1 QL benazepril hcl cap 10-40 mg (generic of LOTREL) QL (30 caps / 30 days) benazepril hcl cap 10-40 mg (generic of LOTREL) QL (30 caps / 30 days) benazepril & Tier 2 hydrochlorothiazide tab 5-6.25 mg benazepril & Tier 2 hydrochlorothiazide tab 10-12.5 mg (generic of LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 20-12.5 mg (generic of LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 20-25 mg (generic of LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 20-25 mg (generic of Smg, generic of Generic of Smg, generic of Generi	amlodipine besylate-	Tier 1 QL	
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amlodipine besylate- Tier 1 QL quina hydro (generic of LOTREL) 12.5 QL (30 caps / 30 days) ACCI amlodipine besylate- Tier 1 QL benazepril hol cap 10-40 mg (generic of LOTREL) 12.5 QL (30 caps / 30 days) ACCI quina hydro (generic of LOTREL) 12.5 QL (30 caps / 30 days) ACCI quina hydrochlorothiazide tab 5-6.25 mg benazepril & Tier 2 hydrochlorothiazide tab 10-12.5 mg (generic of LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 20-12.5 mg (generic of LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 20-12.5 mg (generic of LOTENSIN HCT) enala hydrochlorothiazide tab 20-12.5 mg (generic of LOTENSIN HCT) Enala hydrochlorothiazide tab 20-12.5 mg (generic of LOTENSIN HCT) Enala hydrochlorothiazide tab 20-12.5 mg (generic of fosion fosion fosion hydrochlorothiazide tab 20-12.5 mg (generic of fosion hydrochlorot			
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amlodipine besylate- benazepril hcl cap 10-40 mg (generic of LOTREL) QL (30 caps / 30 days) benazepril & Tier 2 hydrochlorothiazide tab 5- 6.25 mg benazepril & Tier 2 hydrochlorothiazide tab 10- 12.5 mg (generic of LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 20- 12.5 mg (generic of LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 20- 12.5 mg (generic of LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 20- 25 mg (generic of LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 20- 25 mg (generic of LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 20- 5 mg (generic of	, -	,	12.5 r
benazepril hcl cap 10-40 mg (generic of LOTREL) QL (30 caps / 30 days) benazepril & Tier 2 hydrochlorothiazide tab 5- 6.25 mg benazepril & Tier 2 hydrochlorothiazide tab 10- 12.5 mg (generic of LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 20- 12.5 mg (generic of LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 20- 20 mg LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 20- 25 mg (generic of LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 20- 25 mg (generic of LOTENSIN HCT) fosing			ACCL
(generic of LOTREL) QL (30 caps / 30 days) benazepril & Tier 2 hydrochlorothiazide tab 5- 6.25 mg benazepril & Tier 2 hydrochlorothiazide tab 10- 12.5 mg (generic of LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 20- 12.5 mg (generic of LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 20- 12.5 mg (generic of LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 20- 20 mg LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 20- 25 mg (generic of LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 20- 5 mg, fosing			quina
QL (30 caps / 30 days) benazepril & Tier 2 hydrochlorothiazide tab 5- 6.25 mg benazepril & Tier 2 hydrochlorothiazide tab 10- 12.5 mg (generic of LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 20- 12.5 mg (generic of LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 20- 12.5 mg (generic of LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 20- 25 mg (generic of fosing		ng	hydro
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12.5 mg (generic of LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 20- 12.5 mg (generic of LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 20- 25 mg (generic of 25 mg (generic of 25 mg (generic of 25 mg (generic of	•		
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benazepril & Tier 2 hydrochlorothiazide tab 20- 12.5 mg (generic of LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 20- 25 mg (generic of	2 (2		benaz
hydrochlorothiazide tab 20- 12.5 mg (generic of LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 20- 25 mg (generic of		Tier 2	benaz
12.5 mg (generic of LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 20- 25 mg (generic of fosing)		-	LOTE
LOTENSIN HCT) benazepril & Tier 2 hydrochlorothiazide tab 20- 25 mg (generic of fosing)	•		20mg
hydrochlorothiazide tab 20- 25 mg (generic of 5mg, fosin			enala
25 mg (generic of fosing	benazepril &	Tier 2	
20 mg (generic of	hydrochlorothiazide tab 20	-	<u>5mg, </u>
LOTENSIN HCT) 10mg	25 mg (generic of		
	LOTENSIN HCT)		10mg

Drug Name	Drug Requirements/ Tier Limits
enalapril maleate & hydrochlorothiazide tab 5- 12.5 mg	Tier 1
enalapril maleate & hydrochlorothiazide tab 10- 25 mg (generic of VASERETIC)	Tier 1
fosinopril sodium & hydrochlorothiazide tab 10-12.5 mg	Tier 2
fosinopril sodium & hydrochlorothiazide tab 20-12.5 mg	Tier 2
lisinopril & hydrochlorothiazide tab 10- 12.5 mg (generic of ZESTORETIC)	Tier 1
lisinopril & hydrochlorothiazide tab 20- 12.5 mg (generic of ZESTORETIC)	Tier 1
lisinopril & hydrochlorothiazide tab 20- 25 mg (generic of ZESTORETIC)	Tier 1
quinapril- hydrochlorothiazide tab 10- 12.5 mg (generic of ACCURETIC)	Tier 1
quinapril- hydrochlorothiazide tab 20- 12.5 mg (generic of ACCURETIC)	Tier 1
quinapril- hydrochlorothiazide tab 20- 25 mg (generic of ACCURETIC) ACE INHIBITORS	Tier 1
benazepril hcl TABS 5mg	Tier 1
benazepril hcl (generic of LOTENSIN) TABS 10mg, 20mg, 40mg	Tier 1
enalapril maleate (generic o VASOTEC) TABS 2.5mg, 5mg, 10mg, 20mg	
fosinopril sodium TABS 10mg, 20mg, 40mg	Tier 1

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
lisinopril (generic of ZESTRIL) TABS 2.5mg, 5mg, 10mg, 30mg, 40mg	Tier	1	amlodipine besylate- valsartan tab 10-160 mg (generic of EXFORGE)	Tier 2	2 QL
lisinopril (generic of	Tier	1	QL (30 tabs / 30 days		- 01
PRINIVIL) TABS 20mg moexipril hcl TABS 7.5mg, 15mg			amlodipine besylate- valsartan tab 10-320 mg (generic of EXFORGE)	Tier 2	2 QL
perindopril erbumine TABS 2mg, 4mg, 8mg	i Her	2	QL (30 tabs / 30 days ENTRESTO TAB 24-26MG		2
quinapril hcl (generic of ACCUPRIL) TABS 5mg,	Tier	1	ENTRESTO TAB 49-51MG ENTRESTO TAB 97-103M	Tier 2	2
10mg, 20mg, 40mg ramipril (generic of ALTACE) CAPS 1.25mg, 2.5mg, 5mg, 10mg	Tier	1	irbesartan- hydrochlorothiazide tab 150 12.5 mg (generic of AVALIDE)	Tier '	
trandolapril TABS 1mg,	Tier	1	QL (30 tabs / 30 days		
2mg trandolapril (generic of MAVIK) TABS 4mg	Tier	1	irbesartan- hydrochlorothiazide tab 30 12.5 mg (generic of	Tier ′)-	I QL
ALDOSTERONE RECEPTION ANTAGONISTS	PTOR		AVALIDE) QL (30 tabs / 30 days)	
eplerenone (generic of INSPRA) TABS 25mg, 50mg	Tier	2	losartan potassium & hydrochlorothiazide tab 50-12.5 mg (generic of	Tier 2	2
spironolactone (generic of ALDACTONE) TABS 25mg	Tier	1	HYZAAR) losartan potassium &	Tier 2)
spironolactone (generic of ALDACTONE) TABS 50mg	Tier	1	hydrochlorothiazide tab 10 12.5 mg (generic of HYZAAR)		-
ALPHA BLOCKERS			losartan potassium &	Tier 2	2
doxazosin mesylate (gener of CARDURA) TABS 1 mg,	cTier	1	hydrochlorothiazide tab 10 25 mg (generic of HYZAAR	(1)	01
2mg, 4mg, 8mg prazosin hcl (generic of MINIPRESS) CAPS 1mg, 2mg, 5mg	Tier :		olmesartan medoxomil- hydrochlorothiazide tab 20- 12.5 mg (generic of BENICAR HCT) QL (30 tabs / 30 days		2 QL
terazosin hcl CAPS 1mg, 2mg, 5mg, 10mg	Tier	1	olmesartan medoxomil-	Tier 2	2 QL
ANGIOTENSIN II RECEI ANTAGONIST COMBINA		vs .	hydrochlorothiazide tab 40- 12.5 mg (generic of BENICAR HCT)	-	
amlodipine besylate- valsartan tab 5-160 mg (generic of EXFORGE)	Tier :	2 QL	QL (30 tabs / 30 days olmesartan medoxomil-hydrochlorothiazide tab 40	Tier 2	2 QL
QL (30 tabs / 30 days amlodipine besylate- valsartan tab 5-320 mg (generic of EXFORGE)	Tier	2 QL	25 mg (generic of BENICAI HCT) QL (30 tabs / 30 days	₹	
QL (30 tabs / 30 days)				

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
valsartan-	Tier 2	2 QL	valsartan (generic of	Tier 2	2 QL
hydrochlorothiazide tab 80	•		DIOVAN) TABS 40mg,		
12.5 mg (generic of			80mg, 160mg		
DIOVAN HCT)			QL (60 tabs / 30 days)	T: (2 01
QL (30 tabs / 30 days valsartan-	Tier 2	QL	<i>valsartan</i> (generic of DIOVAN) TABS 320mg	Tier 2	2 QL
hydrochlorothiazide tab 160		2 QL	QL (30 tabs / 30 days)		
12.5 mg (generic of	,-		ANTIARRHYTHMICS		
DIOVAN HCT)			amiodarone hcl SOLN	Tier 3	2
QL (30 tabs / 30 days)		50mg/ml, 900mg/18ml;	1101	,
valsartan-	Tier 2	2 QL	TABS 100mg, 400mg		
hydrochlorothiazide tab 160)-		amiodarone hcl TABS	Tier 1	1
25 mg (generic of DIOVAN			200mg		
HCT)			disopyramide phosphate	Tier 3	3
QL (30 tabs / 30 days		<u> </u>	(generic of NORPACE)		
valsartan-	Tier 2	QL QL	CAPS 100mg, 150mg		
hydrochlorothiazide tab 320 12.5 mg (generic of)-		dofetilide (generic of	Tier 3	3 NM
DIOVAN HCT)			TIKOSYN) CAPS 125mcg,		
QL (30 tabs / 30 days			250mcg, 500mcg	Tion	
valsartan-	Tier 2	2 QL	flecainide acetate TABS	Tier 2	2
hydrochlorothiazide tab 320)-		50mg, 100mg, 150mg MULTAQ TABS 400mg	Tier 3	2
25 mg (generic of DIOVAN			pacerone TABS 100mg,	Tier 3	
HCT)			400mg	HEIS)
QL (30 tabs / 30 days			pacerone TABS 200mg	Tier 1	1
ANGIOTENSIN II RECEI	PTOR		propafenone hcl (generic of		
ANTAGONISTS			RYTHMOL SR) CP12		
irbesartan (generic of	Tier 2	2 QL	225mg, 325mg, 425mg		
AVAPRO) TABS 75mg,			propafenone hcl TABS	Tier 2	2
150mg, 300mg QL (30 tabs / 30 days			150mg, 225mg, 300mg		
losartan potassium (generic			quinidine sulfate TABS	Tier 1	1
of COZAAR) TABS 25mg,	7 1 101		200mg, 300mg		
50mg, 100mg			sorine (generic of	Tier 1	I
olmesartan medoxomil	Tier '	l QL	BETAPACE) TABS 80mg,		
(generic of BENICAR)			120mg, 160mg sorine TABS 240mg	Tier 1	
TABS 5mg				Tier 1	
QL (60 tabs / 30 days)			sotalol hcl (generic of BETAPACE) TABS 80mg,	riei	
olmesartan medoxomil	Tier 1	l QL	120mg, 160mg		
(generic of BENICAR)			sotalol hcl TABS 240mg	Tier 1	1
TABS 20mg, 40mg			sotalol hcl (afib/afl) (generic		
QL (30 tabs / 30 days telmisartan (generic of	Tier 2	2 QL	of BETAPACE AF) TABS	1 101 2	-
MICARDIS) TABS 20mg,	1161 2	2 QL	80mg, 120mg, 160mg		
40mg, 80mg			ANTILIPEMICS, FIBRAT	ES	
QL (30 tabs / 30 days)		fenofibrate (generic of	Tier 2	2
. ,			TRICOR) TABS 48mg,	_	
			145mg		

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
fenofibrate TABS 54mg, 160mg	Tier 2		colestipol hcl (generic of COLESTID) GRAN 5gm;	Tier 3	3
fenofibrate micronized CAPS 67mg, 134mg,	Tier 2	2	colestipol hcl (generic of	Tier 2	2
200mg gemfibrozil (generic of LOPID) TABS 600mg	Tier '	1	COLESTID) TABS 1gm ezetimibe (generic of ZETIA) TABS 10mg	Tier 2	2
ANTILIPEMICS, HMG-C	oA RE	DUCTASE	niacin (antihyperlipidemic) (generic of NIASPAN)	Tier 2	2 QL
atorvastatin calcium (generic of LIPITOR) TABS 10mg, 20mg, 40mg, 80mg	Tier '	1 QL	TBCR 500mg, 750mg, 1000mg QL (60 tabs / 30 days))	
QL (30 tabs / 30 days lovastatin TABS 10mg,	Tier ²	1 QL	PRALUENT SOAJ 75mg/ml, 150mg/ml	Tier 2	2 NM PA
20mg, 40mg QL (60 tabs / 30 days			prevalite PACK 4gm prevalite (generic of	Tier 2	
pravastatin sodium TABS 10mg, 20mg, 80mg	Tier '	1 QL	QUESTRAN LIGHT) POWD 4gm/dose VASCEPA CAPS .5gm,	Tier 3	
QL (30 tabs / 30 days pravastatin sodium (generion of PRAVACHOL) TABS		1 QL	1gm BETA-BLOCKER/DIURE		
40mg QL (30 tabs / 30 days)		COMBINATIONS atenolol & chlorthalidone ta	bTier ′	
rosuvastatin calcium (generic of CRESTOR) TABS 5mg, 10mg, 20mg,	Tier 2	2 QL	50-25 mg (generic of TENORETIC 50) atenolol & chlorthalidone ta	bTier ′	
40mg QL (30 tabs / 30 days			<i>100-25 mg</i> (generic of TENORETIC 100)		
simvastatin TABS 5mg QL (30 tabs / 30 days			bisoprolol & hydrochlorothiazide tab 2.5	Tier ′ -	I
simvastatin (generic of ZOCOR) TABS 10mg, 20mg, 40mg, 80mg	Tier '	1 QL	6.25 mg (generic of ZIAC) bisoprolol & hydrochlorothiazide tab 5-	Tier ′	<u> </u>
QL (30 tabs / 30 days	LANE		6.25 mg (generic of ZIAC) bisoprolol &	Tier '	
cholestyramine (generic of QUESTRAN) PACK 4gm; POWD 4gm/dose	Tier 2	2	hydrochlorothiazide tab 10- 6.25 mg (generic of ZIAC)	Tier 2	
cholestyramine light PACK 4gm	Tier 2	2	metoprolol & hydrochlorothiazide tab 50- 25 mg		2
cholestyramine light (generic of QUESTRAN LIGHT) POWD 4gm/dose	Tier 2		metoprolol & hydrochlorothiazide tab 100 25 mg		
colesevelam hcl (generic of WELCHOL) PACK 3.75gm TABS 625mg			metoprolol & hydrochlorothiazide tab 100 50 mg	Tier 2)-	<u> </u>

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
BETA-BLOCKERS		•	dilt-xr CP24 120mg,	Tier 2)
acebutolol hcl CAPS	Tier 2	<u> </u>	180mg, 240mg		
200mg, 400mg			diltiazem hcl CP12 60mg,	Tier 3	3
atenolol (generic of	Tier 1		90mg, 120mg		
TENORMIN) TABS 25mg,		•	diltiazem hcl SOLN	Tier 2	<u>)</u>
50mg, 100mg			25mg/5ml, 50mg/10ml,		
bisoprolol fumarate TABS	Tier 1		125mg/25ml		
5mg, 10mg			diltiazem hcl (generic of	Tier 1	
BYSTOLIC TABS 2.5mg,	Tier 3	3 QL	CARDIZEM) TABS 30mg,		
5mg, 10mg			60mg, 120mg		_
QL (30 tabs / 30 days)			diltiazem hcl TABS 90mg	Tier 1	
BYSTOLIC TABS 20mg	Tier 3	3 QL	diltiazem hcl coated beads	Tier 1	
QL (60 tabs / 30 days)			(generic of CARDIZEM CD)		
carvedilol (generic of	Tier 1		CP24 120mg, 180mg,		
COREG) TABS 3.125mg,			240mg, 300mg		
6.25mg, 12.5mg, 25mg			diltiazem hcl coated beads	Tier 3	3
labetalol hcl TABS 100mg,	Tier 2	<u>)</u>	(generic of CARDIZEM CD)		
200mg, 300mg			CP24 360mg		
metoprolol succinate	Tier 1		diltiazem hcl extended	Tier 1	
(generic of TOPROL XL)			release beads (generic of		
TB24 25mg, 50mg, 100mg,			TIAZAC) CP24 120mg,		
200mg			180mg, 240mg, 300mg,		
metoprolol tartrate SOLN	Tier 3	3	360mg, 420mg	- : 4	
5mg/5ml	-		felodipine TB24 2.5mg,	Tier 1	
metoprolol tartrate TABS	Tier 1		5mg, 10mg	T : 6	
25mg	T: 4		nifedipine TB24 30mg,	Tier 2	<u>'</u>
metoprolol tartrate (generic	i ier 1	•	60mg, 90mg	T: C	<u></u>
of LOPRESSOR) TABS			nifedipine (generic of	Tier 2	<u>′</u>
50mg, 100mg	T:	<u></u>	PROCARDIA XL) TB24		
pindolol TABS 5mg, 10mg	Tier 2		30mg, 60mg, 90mg	Tion C	
propranolol hcl (generic of	Tier 2	<u>?</u> .	nimodipine CAPS 30mg	Tier 3	
INDERAL LA) CP24 60mg,			NYMALIZE SOLN 6mg/ml	Tier 2	
80mg, 120mg, 160mg	T:	<u> </u>	taztia xt (generic of TIAZAC)) Lier 1	
propranolol hcl SOLN	Tier 2	<u>′</u>	CP24 120mg, 180mg,		
20mg/5ml, 40mg/5ml	Tier 1	 .	240mg, 300mg, 360mg	T: 4	
propranolol hcl TABS	rier		tiadylt er (generic of	Tier 1	
10mg, 20mg, 40mg, 60mg,			TIAZAC) CP24 120mg,		
80mg timolol maleate TABS 5mg	Tior 3	2	180mg, 240mg, 300mg,		
10mg, 20mg	, 1161		360mg, 420mg	Tior 2)
CALCIUM CHANNEL BL	OCK	FRS	verapamil hcl (generic of VERELAN PM) CP24	Tier 3	•
	Tier 1		100mg, 200mg		
amlodipine besylate (generic of NORVASC)	i iei		verapamil hcl (generic of	Tier 2	
TABS 2.5mg, 5mg, 10mg			VERELAN) CP24 120mg,	1 101 2	-
cartia xt (generic of	Tier 1	<u> </u>	180mg, 240mg		
CARDIZEM CD) CP24	i iCi		verapamil hcl CP24 300mg	Tier 3	<u> </u>
120mg, 180mg, 240mg,			360mg; SOLN 2.5mg/ml	, , , , , ,	•
300mg		-	Cooning, County 2.0mg/mil		
Cooning					

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
verapamil hcl TABS 40mg,	Tier '		triamterene &	Tier 1	
80mg, 120mg; TBCR			hydrochlorothiazide tab		
180mg			37.5-25 mg (generic of		
verapamil hcl (generic of	Tier '		MAXZIDE-25)		
CALAN SR) TBCR 120mg,			triamterene &	Tier 1	
240mg			hydrochlorothiazide tab 75-		
DIURETICS			<i>50 mg</i> (generic of		
acetazolamide CP12	Tier 3	3	MAXZIDE)		
500mg			MISCELLANEOUS		
acetazolamide TABS	Tier 2	<u>)</u>	ADRENALIN SOLN 1mg/ml	Tier 3	3
125mg, 250mg			aliskiren fumarate (generic	Tier 3	3
amiloride &	Tier 1		of TEKTURNA) TABS		
hydrochlorothiazide tab 5-50)		150mg, 300mg [°]		
mg			clonidine (generic of	Tier 3	3
amiloride hcl TABS 5mg	Tier 1		CATAPRÈS-TTS-1) PTWK		
bumetanide SOLN	Tier 2		.1mg/24hr		
.25mg/ml; TABS 1mg, 2mg		-	clonidine (generic of	Tier 3	<u> </u>
bumetanide (generic of	Tier 2)	CATAPRES-TTS-2) PTWK		
BUMEX) TABS .5mg	1101 2	-	.2mg/24hr		
chlorthalidone TABS 25mg.	Tier 1		clonidine (generic of	Tier 3	3
50mg			CATAPRES-TTS-3) PTWK		
furosemide SOLN 8mg/ml,	Tier 1		.3mg/24hr		
10mg/ml	1101		clonidine hcl TABS .1mg,	Tier 1	_
furosemide (generic of	Tier 1		.2mg, .3mg		
LASIX) TABS 20mg, 40mg,	1101		CORLANOR SOLN	Tier 3	3
80mg			5mg/5ml; TABS 5mg, 7.5mg		
furosemide inj SOLN	Tier 2)	digitek (generic of	Tier 1	QL
10mg/ml	1101 2	=	LANOXIN) TABS .125mg,		
hydrochlorothiazide CAPS	Tier 1		.25mg		
12.5mg; TABS 12.5mg,	1101		QL (30 tabs / 30 days)		
25mg, 50mg			digox (generic of LANOXIN)	Tier 1	QL
indapamide TABS 1.25mg,	Tier ′		TABS 125mcg, 250mcg		
2.5mg	1101		QL (30 tabs / 30 days)		
methazolamide TABS	Tier 3	3	digoxin SOLN .05mg/ml	Tier 3	3
25mg, 50mg		•	digoxin (generic of	Tier 3	
metolazone TABS 2.5mg,	Tier 2)	LANOXIN) SOLN .25mg/ml		•
5mg, 10mg	1101 2	=	digoxin (generic of	Tier 1	QL
spironolactone &	Tier 2)	LANOXIN) TABS 125mcg,		~ =
hydrochlorothiazide tab 25-	2	-	250mcg		
25 mg (generic of			QL (30 tabs / 30 days)		
ALDACTAZIDE)			droxidopa (generic of	Tier 1	QL NM PA
torsemide TABS 5mg,	Tier 1		NORTHERA) CAPS 100mg		···
10mg, 20mg, 100mg	1 101	ı	QL (90 caps / 30 days)		
triamterene &	Tier 1		droxidopa (generic of	Tier 1	QL NM PA
hydrochlorothiazide cap	. 101	•	NORTHERA) CAPS		5 -1001/1
37.5-25 mg			200mg, 300mg		
37.0 20 mg			QL (180 caps / 30		
			days)		

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
guanfacine hcl TABS 1mg, 2mg PA if 70 years and older			bosentan (generic of TRACLEER) TABS 62.5mg QL (120 tabs / 30		I QL NM LA PA
hydralazine hcl SOLN 20mg/ml	Tier 3	3	days) bosentan (generic of	Tier 1	I QL NM LA PA
hydralazine hcl TABS 10mg, 25mg, 50mg, 100mg	Tier 1		TRACLEER) TABS 125mg QL (60 tabs / 30 days)		
methyldopa TABS 250mg, 500mg	Tier 1	PA	OPSUMIT TABS 10mg QL (30 tabs / 30 days)		2QL NM LA PA
PA if 70 years and older metyrosine (generic of DEMSER) CAPS 250mg	Tier 1	PA	sildenafil citrate (pulmonary hypertension) (generic of REVATIO) TABS 20mg	Tier 2	2 QL NM PA
midodrine hcl TABS 2.5mg	•		QL (90 tabs / 30 days) VENTAVIS SOLN	Tier 2	2 NM PA
midodrine hcl TABS 10mg minoxidil TABS 2.5mg, 10mg	Tier 3		10mcg/ml, 20mcg/ml CENTRAL NERVOUS SY ANTIANXIETY	STE	M
ranolazine (generic of RANEXA) TB12 500mg, 1000mg	Tier 3	3	alprazolam (generic of XANAX) TABS .25mg, .5mg, 1mg, 2mg	Tier 1	l QL
NITRATES			QL (150 tabs / 30		
isosorbide dinitrate (generic of ISORDIL TITRADOSE) TABS 5mg	Tier 2	<u>)</u>	days) buspirone hcl TABS 5mg, 10mg, 15mg	Tier 1	l
isosorbide dinitrate TABS 10mg, 20mg, 30mg	Tier 2	2	buspirone hcl TABS 7.5mg.	Tier 2	2
isosorbide mononitrate TABS 10mg, 20mg; TB24	Tier 1		fluvoxamine maleate TABS 25mg, 50mg, 100mg	Tier 2	2
30mg, 60mg, 120mg minitran (generic of NITRO	- Tier 2)	lorazepam CONC 2mg/ml QL (150 mL / 30 days)	Tier 2	2 QL
DUR) PT24 .1mg/hr, .2mg/hr, .4mg/hr, .6mg/hr			Iorazepam (generic of ATIVAN) SOLN 2mg/ml,	Tier 1	I
NITRO-BID OINT 2% nitroglycerin PT24 .1mg/hr .2mg/hr, .4mg/hr, .6mg/hr	Tier 2 Tier 2		4mg/ml lorazepam (generic of ATIVAN) TABS .5mg, 1mg,	Tier 1	I QL
nitroglycerin (generic of NITROSTAT) SUBL .3mg,	Tier 2	2	2mg QL (150 tabs / 30 days)		
.4mg, .6mg PULMONARY ARTERIA	L HYF	PERTENSION	lorazepam intensol CONC	Tier 2	QL
ADEMPAS TABS .5mg, 1mg, 1.5mg, 2mg, 2.5mg		2QL NM LA PA	2mg/ml QL (150 mL / 30 days)		
QL (90 tabs / 30 days))		ANTICONVULSANTS	T ' 6	
ambrisentan (generic of LETAIRIS) TABS 5mg,	Tier 1	QL NM LA PA	APTIOM TABS 200mg, 400mg, 600mg, 800mg QL (60 tabs / 30 days)	Tier 3	3 QL
10mg QL (30 tabs / 30 days))		BRIVIACT SOLN 10mg/ml QL (600 mL / 30 days)		3 QL PA
			BRIVIACT SOLN 50mg/5m		B PA

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
BRIVIACT TABS 10mg, 25mg, 50mg, 75mg, 100mg QL (60 tabs / 30 days		3 QL PA	DIACOMIT PACK 250mg QL (360 packets / 30 days)	Tier	3QL NM LA PA
carbamazepine CHEW 100mg	Tier 2		DIACOMIT PACK 500mg QL (180 packets / 30	Tier	3QL NM LA PA
carbamazepine (generic of CARBATROL) CP12 100mg, 200mg, 300mg			days) diazepam CONC 5mg/ml QL (240 mL / 30 days)	Tier 2	2 QL PA
carbamazepine (generic of TEGRETOL) SUSP 100mg/5ml	Tier 3	3	PA if 65 years and older diazepam SOLN 5mg/5ml QL (1200 mL / 30	Tier	2 QL PA
carbamazepine (generic of TEGRETOL) TABS 200mg			days) PA if 65 years and older		
carbamazepine (generic of TEGRETOL-XR) TB12 100mg, 200mg, 400mg			diazepam (generic of VALIUM) TABS 2mg, 5mg, 10mg	Tier	1 QL PA
clobazam (generic of ONFI SUSP 2.5mg/ml	Tier 3 Tier 3		QL (120 tabs / 30 days) PA if 65 years and older		
QL (480 mL / 30 days clobazam (generic of ONFI		B QL PA	diazepam (anticonvulsant) GEL 2.5mg, 10mg, 20mg	Tier	
TABS 10mg, 20mg QL (60 tabs / 30 days)		diazepam inj SOLN 5mg/m DILANTIN CAPS 30mg,	Tier	
clonazepam (generic of KLONOPIN) TABS 2mg QL (300 tabs / 30	Tier 1	l QL	100mg DILANTIN INFATABS CHEW 50mg	Tier	3
days) clonazepam (generic of	Tier 1	l QL	DILANTIN-125 SUSP 125mg/5ml	Tier	3
KLONOPIN) TABS .5mg, 1mg QL (90 tabs / 30 days			divalproex sodium (generic of DEPAKOTE SPRINKLES) CSDR 125me		3
clonazepam TBDP 2mg QL (300 tabs / 30 days)	Tier 2	2 QL	divalproex sodium (generic of DEPAKOTE ER) TB24 250mg, 500mg		2
clonazepam TBDP .125mg .25mg, .5mg, 1mg QL (90 tabs / 30 days		2 QL	divalproex sodium (generic of DEPAKOTE) TBEC 125mg, 250mg, 500mg	Tier	2
clorazepate dipotassium TABS 3.75mg, 7.5mg, 15m QL (180 tabs / 30	Tier 3 g	3 QL PA	EPIDIOLEX SOLN 100mg/ml QL (600 mL / 30 days)		3QL NM LA PA
days) PA if 65 years and older			epitol (generic of TEGRETOL) TABS 200mg	Tier	2
DIACOMIT CAPS 250mg QL (360 caps / 30	Tier 3	BQL NM LA PA	ethosuximide (generic of ZARONTIN) CAPS 250mg	Tier	
days) DIACOMIT CAPS 500mg QL (180 caps / 30	Tier 3	BQL NM LA PA	ethosuximide (generic of ZARONTIN) SOLN 250mg/5ml	Tier	2
days)					

Drug Name	Drug Re	equirements/ Limits
felbamate (generic of FELBATOL) SUSP	Tier 1	
600mg/5ml felbamate (generic of	Tier 3	
FELBATOL) TABS 400mg, 600mg		
FINTEPLA SOLN 2.2mg/ml QL (360 mL / 30 days)	Tier 3QI	L NM LA PA
FYCOMPA SUSP .5mg/ml QL (720 mL / 30 days)	Tier 3	QL PA
FYCOMPA TABS 2mg, 4mg, 6mg	Tier 3	QL PA
QL (60 tabs / 30 days)	T: 0	OL DA
FYCOMPA TABS 8mg, 10mg, 12mg QL (30 tabs / 30 days)	Tier 3	QL PA
gabapentin (generic of NEURONTIN) CAPS	Tier 1	QL
100mg QL (1080 caps / 30 days)		
gabapentin (generic of NEURONTIN) CAPS 300mg QL (360 caps / 30	Tier 1	QL
days) gabapentin (generic of NEURONTIN) CAPS 400mg QL (270 caps / 30	Tier 1	QL
days) gabapentin (generic of NEURONTIN) SOLN 250mg/5ml QL (2160 mL / 30	Tier 2	QL
days) gabapentin (generic of NEURONTIN) TABS 600mg QL (180 tabs / 30 days)	Tier 2	QL
gabapentin (generic of NEURONTIN) TABS 800mg QL (120 tabs / 30 days)	Tier 2	QL

Drug Name	Drug Tier	Requirements/ Limits
lamotrigine (generic of LAMICTAL CHEWABLE DISPERS) CHEW 5mg, 25mg	Tier 2	
lamotrigine (generic of LAMICTAL) TABS 25mg, 100mg, 150mg, 200mg	Tier 1	
levetiracetam (generic of KEPPRA) SOLN 100mg/ml; TABS 250mg, 500mg, 750mg, 1000mg	Tier 2	
levetiracetam (generic of KEPPRA) SOLN 500mg/5ml	Tier 3	
levetiracetam in sodium chloride iv soln 500 mg/100ml (generic of LEVETIRACETAM)	Tier 3	
levetiracetam in sodium chloride iv soln 1000 mg/100ml (generic of LEVETIRACETAM)	Tier 3	3
levetiracetam in sodium chloride iv soln 1500 mg/100ml (generic of LEVETIRACETAM)	Tier 3	
NAYZILAM SOLN 5mg/0.1ml	Tier 3	}
oxcarbazepine (generic of TRILEPTAL) SUSP 300mg/5ml	Tier 3	3
oxcarbazepine (generic of TRILEPTAL) TABS 150mg, 300mg, 600mg	Tier 2	
phenobarbital ELIX 20mg/5ml PA if 70 years and older	Tier 3	B PA
phenobarbital TABS 15mg, 16.2mg, 30mg, 32.4mg, 60mg, 64.8mg, 97.2mg, 100mg PA if 70 years and older	Tier 2	PA
phenobarbital sodium SOLN 65mg/ml, 130mg/ml PA if 70 years and older	Tier 3	
PHENYTEK CAPS 200mg, 300mg	Tier 3	

Drug Name	Drug R Tier	equirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
phenytoin (generic of DILANTIN INFATABS) CHEW 50mg	Tier 2		SPRITAM TB3D 250mg QL (360 tabs / 30 days)	Tier 3	3 QL
phenytoin (generic of DILANTIN-125) SUSP 125mg/5ml	Tier 2		SPRITAM TB3D 500mg QL (180 tabs / 30 days)	Tier 3	3 QL
phenytoin sodium SOLN 50mg/ml phenytoin sodium extende	Tier 2		SPRITAM TB3D 750mg QL (120 tabs / 30 days)	Tier 3	3 QL
(generic of DILANTIN) CAPS 100mg	G 1101 Z		SPRITAM TB3D 1000mg QL (90 tabs / 30 days)	Tier 3	3 QL
phenytoin sodium extende (generic of PHENYTEK) CAPS 200mg, 300mg	d Tier 2		subvenite (generic of LAMICTAL) TABS 25mg, 100mg, 150mg, 200mg	Tier 1	1
pregabalin (generic of LYRICA) CAPS 25mg, 50mg, 75mg, 100mg,	Tier 2	QL PA	SYMPAZAN FILM 5mg, 10mg, 20mg QL (60 films / 30 days	Tier 3	3 QL PA
150mg QL (120 caps / 30 days)			tiagabine hcl (generic of GABITRIL) TABS 2mg, 4mg, 12mg, 16mg	Tier 3	3
pregabalin (generic of LYRICA) CAPS 200mg QL (90 caps / 30 days	Tier 2 s)	QL PA	topiramate (generic of TOPAMAX SPRINKLE) CPSP 15mg, 25mg	Tier 2	2
pregabalin (generic of LYRICA) CAPS 225mg, 300mg	Tier 2	QL PA	topiramate (generic of TOPAMAX) TABS 25mg, 50mg, 100mg, 200mg	Tier 1	
QL (60 caps / 30 days pregabalin (generic of	Tier 3	QL PA	valproate sodium SOLN 100mg/ml	Tier 3	3
LYRICA) SOLN 20mg/ml QL (900 mL / 30 days	s)		valproate sodium SOLN 250mg/5ml	Tier 2	2
primidone (generic of MYSOLINE) TABS 50mg,	Tier 1		valproic acid CAPS 250mg		
250mg			VALTOCO LIQD 5mg/0.1ml, 10mg/0.1ml;	Tier 3	3
roweepra (generic of KEPPRA) TABS 500mg	Tier 2		LQPK 7.5mg/0.1ml, 10mg/0.1ml		
rufinamide (generic of BANZEL) SUSP 40mg/ml QL (2300 mL / 28 days)	Tier 3	QL PA	vigabatrin (generic of SABRIL) PACK 500mg QL (180 packets / 30 days)	Tier ′	I QL NM LA PA
rufinamide (generic of BANZEL) TABS 200mg QL (480 tabs / 30 days)	Tier 3	QL PA	vigabatrin (generic of SABRIL) TABS 500mg QL (180 tabs / 30 days)	Tier ′	I QL NM LA PA
rufinamide (generic of BANZEL) TABS 400mg QL (240 tabs / 30 days)	Tier 3	QL PA	vigadrone (generic of SABRIL) PACK 500mg QL (180 packets / 30 days)	Tier ′	I QL NM LA PA

Drug Name	Drug Tier	Requirements/ Limits
VIMPAT SOLN 10mg/ml QL (1200 mL / 30	Tier 3	g QL
days) VIMPAT SOLN 200mg/20ml	Tier 3	}
VIMPAT TABS 50mg QL (120 tabs / 30 days)	Tier 3	G QL
VIMPAT TABS 100mg, 150mg, 200mg QL (60 tabs / 30 days)	Tier 3	QL QL
XCOPRI TABS 50mg QL (90 tabs / 30 days)	Tier 3	QL QL
XCOPRI TABS 100mg, 150mg, 200mg QL (60 tabs / 30 days)	Tier 3	QL QL
XCOPRI PAK 12.5-25 QL (28 tabs / 28 days)	Tier 3	QL
XCOPRI PAK 50-100MG QL (28 tabs / 28 days)		
XCOPRI PAK 50-200MG QL (56 tabs / 28 days)	Tier 3	
XCOPRI PAK 100-150 QL (56 tabs / 28 days)	Tier 3	·
XCOPRI PAK 150-200MG (MAINTENANCE) QL (56 tabs / 28 days)	Tier 3	QL
XCOPRI PAK 150-200MG (TITRATION) QL (28 tabs / 28 days)	Tier 3	G QL
zonisamide (generic of ZONEGRAN) CAPS 25mg, 100mg	Tier 1	
zonisamide CAPS 50mg ANTIDEMENTIA	Tier 1	
donepezil hydrochloride (generic of ARICEPT) TABS 5mg QL (30 tabs / 30 days)	Tier 1	QL
donepezil hydrochloride (generic of ARICEPT) TABS 10mg	Tier 1	
donepezil hydrochloride TBDP 5mg QL (30 tabs / 30 days)	Tier 1	QL
donepezil hydrochloride TBDP 10mg	Tier 1	

Drug Name	Drug Tier	Requirements/ Limits
(generic of RAZADYNE ER) CP24 8mg, 16mg, 24mg QL (30 caps / 30 days)		
galantamine hydrobromide SOLN 4mg/ml	Tier 3	
galantamine hydrobromide TABS 4mg, 8mg, 12mg QL (60 tabs / 30 days)	Tier 2	QL
memantine hcl (generic of NAMENDA XR) CP24 7mg, 14mg, 21mg, 28mg PA if < 30 yrs		PA PA
memantine hcl SOLN 2mg/ml PA if < 30 yrs	Tier 3	PA
memantine hcl TABS 5mg, 10mg PA if < 30 yrs	Tier 2	PA
NAMZARIC CAP 7-10MG	Tier 3	<u> </u>
NAMZARIC CAP 14-10MG	Tier 3	
NAMZARIC CAP 21-10MG	Tier 3	
NAMZARIC CAP 28-10MG	Tier 3	
NAMZARIC CAP PACK	Tier 3	
rivastigmine (generic of EXELON) PT24 4.6mg/24hr, 9.5mg/24hr, 13.3mg/24hr QL (30 patches / 30 days)	Tier 3	QL
rivastigmine tartrate CAPS 1.5mg, 3mg QL (90 caps / 30 days)		QL
rivastigmine tartrate CAPS 4.5mg, 6mg QL (60 caps / 30 days) ANTIDEPRESSANTS	Tier 2	QL QL
	Tier 2	,
amitriptyline hcl TABS 10mg, 25mg, 50mg, 75mg, 100mg, 150mg	i iei z	
amoxapine TABS 25mg, 50mg, 100mg, 150mg	Tier 2	
bupropion hcl TABS 75mg, 100mg	Tier 2	
bupropion hcl (generic of WELLBUTRIN SR) TB12 100mg, 150mg, 200mg	Tier 2	!

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
bupropion hcl (generic of	Tier 2	<u>)</u>	FETZIMA CAP TITRATIO	Tier 3	B PA
WELLBUTRIN XL) TB24			fluoxetine hcl (generic of	Tier 1	1
150mg, 300mg			PROZAC) CAPS 10mg,		
citalopram hydrobromide	Tier 2	2	_20mg		
SOLN 10mg/5ml citalopram hydrobromide	Tier 1		fluoxetine hcl (generic of PROZAC) CAPS 40mg	Tier 1	1
(generic of CELEXA) TABS			fluoxetine hcl SOLN	Tier 2	2
10mg, 20mg, 40mg ²			20mg/5ml		
clomipramine hcl (generic c	fTier 3	B PA	imipramine hcl TABS 10mg	ı.Tier ´	1
ANAFRANIL) CAPS 25mg,			25mg, 50mg	,,	
50mg, 75mg			MARPLAN TABS 10mg	Tier 3	3 QL
desipramine hcl (generic of		3	QL (180 tabs / 30		
NORPRAMIN) TABS 10mg	١,		days)		
25mg			mirtazapine TABS 7.5mg	Tier 2	2
desipramine hcl TABS	Tier 3	3	mirtazapine (generic of	Tier '	1
50mg, 75mg, 100mg,			REMERON) TABS 15mg,		
150mg	- · ,	01.04	30mg		
desvenlafaxine succinate	Tier 3	3 QL PA	mirtazapine TABS 45mg	Tier 1	
(generic of PRISTIQ) TB24	ŀ		mirtazapine (generic of	Tier 2	2
25mg, 50mg, 100mg QL (30 tabs / 30 days)			REMERON SOLTAB)		
doxepin hcl CAPS 10mg,	Tier 2)	TBDP 15mg, 30mg, 45mg		
25mg, 50mg, 75mg, 100mg		<u>-</u>	nefazodone hcl TABS	Tier 3	3
CONC 10mg/ml	,		50mg, 100mg, 150mg,		
doxepin hcl CAPS 150mg	Tier 3	3	200mg, 250mg	Tior	 1
DRIZALMA SPRINKLE	Tier 3		nortriptyline hcl (generic of PAMELOR) CAPS 10mg,	Tier '	I
CSDR 20mg, 30mg, 40mg,	1101	QLI7	25mg, 50mg, 75mg		
60mg			nortriptyline hcl SOLN	Tier 3	2
QL (60 caps / 30 days)		10mg/5ml	Hers)
duloxetine hcl (generic of	Tier 2	QL	paroxetine hcl (generic of	Tier 1	1
CYMBALTA) CPEP 20mg,			PAXIL) TABS 10mg, 20mg		-
30mg, 60mg			30mg, 40mg	,	
QL (60 caps / 30 days)		PAXIL SUSP 10mg/5ml	Tier 3	3 QL PA
EMSAM PT24 6mg/24hr,	Tier 2	2 QL PA	QL (900 mL / 30 days))	
9mg/24hr, 12mg/24hr			phenelzine sulfate (generic	Tier 2	2
QL (30 patches / 30			of NARDIL) TABS 15mg		
days)	I.T		protriptyline hcl TABS 5mg	, Tier 3	3
escitalopram oxalate SOLN	N Her 3	3	10mg		
5mg/5ml	T: 1		sertraline hcl (generic of	Tier 2	2
escitalopram oxalate	Tier 1		ZOLOFT) CONC 20mg/ml		
(generic of LEXAPRO) TABS 5mg, 10mg, 20mg			sertraline hcl (generic of	Tier 1	1
FETZIMA CP24 20mg,	Tier 3	B QL PA	ZOLOFT) TABS 25mg,		
40mg	1161	O QLIA	50mg, 100mg		
QL (60 caps / 30 days)		tranylcypromine sulfate	Tier 3	3
FETZIMA CP24 80mg,	Tier 3	3 QL PA	(generic of PARNATE)		
120mg		<u> </u>	TABS 10mg	Tion	
QL (30 caps / 30 days)		trazodone hcl TABS 50mg,	i ier '	I
, , ,	,		100mg, 150mg		

Drug Name	Drug R Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
trimipramine maleate CAI 25mg	PSTier 3	QL	carbidopa & levodopa orally disintegrating tab 25-250 m		
QL (240 caps / 30 days)	DOT: 0		carbidopa & levodopa tab 10-100 mg (generic of	Tier 1	I
trimipramine maleate CAI 50mg QL (120 caps / 30	25 Her 3	QL	SINEMET) carbidopa & levodopa tab 25-100 mg (generic of	Tier 1	
days) trimipramine maleate CAI 100mg		QL	SINEMET) carbidopa & levodopa tab 25-250 mg	Tier 1	
QL (60 caps / 30 day TRINTELLIX TABS 5mg QL (120 tabs / 30	Tier 3	QL	carbidopa & levodopa tab e 25-100 mg carbidopa & levodopa tab e		
days) TRINTELLIX TABS 10mg QL (60 tabs / 30 day		QL	50-200 mg carbidopa-levodopa- entacapone tabs 12.5-50-	Tier 3	3
TRINTELLIX TABS 20mg QL (30 tabs / 30 day	Tier 3	QL	200 mg (generic of STALEVO 50)		
venlafaxine hcl (generic of EFFEXOR XR) CP24 37.5mg, 75mg, 150mg			carbidopa-levodopa- entacapone tabs 18.75-75- 200 mg (generic of	Tier 3	3
venlafaxine hcl TABS 25mg, 37.5mg, 50mg, 75mg, 100mg VIIBRYD TABS 10mg,	Tier 2	QL	STALEVO 75) carbidopa-levodopa- entacapone tabs 25-100-	Tier 3	3
20mg, 40mg QL (30 tabs / 30 day		QL	200 mg (generic of STALEVO 100) carbidopa-levodopa-	Tier 3	3
VIIBRYD KIT STARTER ANTIPARKINSONIAN	Tier 3 AGENTS		entacapone tabs 31.25-125 200 mg (generic of	-	
amantadine hcl CAPS 100mg QL (120 caps / 30 days) amantadine hcl SYRP	Tier 2	QL 	STALEVO 125) carbidopa-levodopa- entacapone tabs 37.5-150- 200 mg (generic of STALEVO 150)	Tier 3	3
50mg/5ml benztropine mesylate (generic of COGENTIN)	Tier 3		carbidopa-levodopa- entacapone tabs 50-200- 200 mg	Tier 3	3
SOLN 1mg/ml benztropine mesylate TA	BSTier 2	PA	entacapone (generic of COMTAN) TABS 200mg	Tier 3	2 QL NM PA
.5mg, 1mg, 2mg PA if 70 years and older bromocriptine mesylate (generic of PARLODEL)	Tier 3		KYNMOBI FILM 10mg, 15mg, 20mg, 25mg, 30mg QL (150 films / 30 days)	Hel 2	2 QLINIVIPA
CAPS 5mg; TABS 2.5mg carbidopa & levodopa ora disintegrating tab 10-1001	•		NEUPRO PT24 1mg/24hr, 2mg/24hr, 3mg/24hr, 4mg/24hr, 6mg/24hr,	Tier 3	3
carbidopa & levodopa ora disintegrating tab 25-100	<i>lly</i> Tier 3		8mg/24hr pramipexole dihydrochloride TABS .25mg, 1.5mg	eTier 1	

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
pramipexole dihydrochlorid (generic of MIRAPEX)		1	asenapine maleate (generi of SAPHRIS) SUBL 2.5mg		3 QL
TABS .125mg, .5mg, .75mg	g,		5mg, 10mg QL (60 tabs / 30 days)	
rasagiline mesylate (gener of AZILECT) TABS 1mg	ic Tier 3	3 QL	CAPLYTA CAPS 42mg QL (30 caps / 30 days	Tier 3	3 QL PA
QL (30 tabs / 30 days rasagiline mesylate (gener	•	 3 QL	chlorpromazine hcl SOLN 25mg/ml, 50mg/2ml; TABS	Tier 3	3
of AZILECT) TABS .5mg QL (60 tabs / 30 days		<i>y</i>	10mg, 25mg, 50mg, 100mg 200mg	l,	
ropinirole hydrochloride TABS .25mg, .5mg, 1mg, 2mg, 3mg, 4mg, 5mg	Tier ′	1	clozapine (generic of CLOZARIL) TABS 25mg, 50mg	Tier 2	2
selegiline hcl CAPS 5mg; TABS 5mg trihexyphenidyl hcl SOLN	Tier 2		clozapine (generic of CLOZARIL) TABS 100mg QL (270 tabs / 30	Tier 3	3 QL
.4mg/ml; TABS 2mg, 5mg PA if 70 years and older	i iei z	2 PA	days) clozapine (generic of	Tier 3	3 QL
ANTIPSYCHOTICS	/ T' /		CLOZARIL) TABS 200mg QL (135 tabs / 30	1161) QL
ABILIFY MAINTENA PRS' 300mg, 400mg	r Hers	3 QL	days)	Tion (DA
QL (1 syringe / 28 days)			clozapine TBDP 12.5mg, 25mg	Tier 3	
ABILIFY MAINTENA SREI 300mg, 400mg QL (1 injection / 28	R Tier 3	3 QL	clozapine TBDP 100mg QL (270 tabs / 30 days)	Tier 3	3 QL PA
days)	LTior	3 QL	clozapine TBDP 150mg QL (180 tabs / 30	Tier 3	3 QL PA
aripiprazole SOLN 1mg/m QL (900 mL / 30 days	s)		days)	 : -	01.04
aripiprazole (generic of ABILIFY) TABS 2mg, 5mg 10mg, 15mg, 20mg, 30mg	Tier (3 QL	clozapine TBDP 200mg QL (135 tabs / 30 days)	Tier 3	3 QL PA
QL (30 tabs / 30 days			FANAPT TABS 1mg, 2mg,	Tier 3	3 QL PA
aripiprazole TBDP 10mg, 15mg QL (60 tabs / 30 days	Tier 3	3 QL	4mg, 6mg, 8mg, 10mg, 12mg QL (60 tabs / 30 days)	
ARISTADA PRSY	Tier 3	3 QL	FANAPT PAK	Tier 3	B PA
441mg/1.6ml, 662mg/2.4m 882mg/3.2ml			fluphenazine decanoate SOLN 25mg/ml	Tier 3	
QL (1 syringe / 28 days)			fluphenazine hcl CONC 5mg/ml; ELIX 2.5mg/5ml;	Tier 3	3
ARISTADA PRSY 1064mg/3.9ml	Tier	3 QL	SOLN 2.5mg/ml; TABS 1mg, 2.5mg, 5mg, 10mg		
QL (1 syringe / 56 days)			haloperidol TABS .5mg, 1mg, 2mg, 5mg, 10mg,	Tier 2	2
ARISTADA INITIO PRSY 675mg/2.4ml	Tier				

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
haloperidol decanoate (generic of HALDOL DECANOATE 50) SOLN 50mg/ml	Tier 2	2	olanzapine (generic of ZYPREXA ZYDIS) TBDP 5mg, 15mg, 20mg QL (30 tabs / 30 days)	Tier 3	
haloperidol decanoate (generic of HALDOL DECANOATE 100) SOLN 100mg/ml	Tier 2	2	olanzapine (generic of ZYPREXA ZYDIS) TBDP 10mg QL (60 tabs / 30 days)	Tier 3	3 QL
haloperidol lactate CONC 2mg/ml haloperidol lactate (generic of HALDOL) SOLN 5mg/m			paliperidone (generic of INVEGA) TB24 1.5mg, 3mg, 9mg QL (30 tabs / 30 days)	Tier 3	3 QL
INVEGA SUSTENNA SUSY 39mg/0.25ml, 78mg/0.5ml, 117mg/0.75ml 156mg/ml, 234mg/1.5ml	Tier 3	3 QL	paliperidone (generic of INVEGA) TB24 6mg QL (60 tabs / 30 days) perphenazine TABS 2mg,	Tier 3	
QL (1 syringe / 28 days) INVEGA TRINZA SUSY 273mg/0.875ml, 410mg/1.315ml,	Tier	3 QL	4mg, 8mg, 16mg PERSERIS PRSY 90mg, 120mg QL (1 syringe / 30 days)	Tier 3	3 QL
546mg/1.75ml, 819mg/2.625ml QL (1 syringe / 90 days)			pimozide TABS 1mg, 2mg quetiapine fumarate (generic of SEROQUEL) TABS 25mg, 50mg, 100mg,	Tier 3	
LATUDA TABS 20mg, 40mg, 60mg, 120mg QL (30 tabs / 30 days) LATUDA TABS 80mg QL (60 tabs / 30 days)	Tier 3	<u> </u>	200mg, 300mg, 400mg quetiapine fumarate (generic of SEROQUEL XR TB24 50mg, 300mg, 400mg QL (60 tabs / 30 days)	Tier 3	3 QL PA
loxapine succinate CAPS 5mg, 10mg, 25mg, 50mg molindone hcl TABS 5mg, 10mg, 25mg	Tier 2	3	quetiapine fumarate (generic of SEROQUEL XR TB24 150mg, 200mg QL (30 tabs / 30 days)	Tier 3	3 QL PA
NUPLAZID CAPS 34mg QL (30 caps / 30 days)	BQL NM LA PA	REXULTI TABS 3mg, 4mg QL (30 tabs / 30 days)		
NUPLAZID TABS 10mg QL (30 tabs / 30 days) olanzapine (generic of		BQL NM LA PA B QL	REXULTI TABS .25mg, .5mg, 1mg, 2mg QL (60 tabs / 30 days)	Tier 3	3 QL
ZYPRÉXA) SOLR 10mg QL (3 vials / 1 day) olanzapine (generic of ZYPREXA) TABS 2.5mg, 5mg, 10mg	Tier ′	l QL	RISPERDAL CONSTA SRER 12.5mg, 25mg, 37.5mg, 50mg QL (2 injections / 28 days)	Tier 3	3 QL
QL (60 tabs / 30 days) olanzapine (generic of ZYPREXA) TABS 7.5mg, 15mg, 20mg QL (30 tabs / 30 days)	Tier 1	I QL	risperidone (generic of RISPERDAL) SOLN 1mg/ml QL (240 mL / 30 days)	Tier 2	2 QL

Drug Name	Drug I Tier	Requirements/ Limits
risperidone (generic of RISPERDAL) TABS .5mg,	Tier 1	
1mg, 2mg, 3mg, 4mg		
risperidone TABS .25mg	Tier 1	
risperidone TBDP 1mg,	Tier 3	QL
2mg, 3mg, 4mg		
QL (60 tabs / 30 days)		
risperidone TBDP .25mg,	Tier 3	QL
.5mg		
QL (90 tabs / 30 days)		
SECUADO PT24	Tier 3	QL
3.8mg/24hr, 5.7mg/24hr,		
7.6mg/24hr		
QL (30 patches / 30		
days)		
thioridazine hcl TABS	Tier 2	
10mg, 25mg, 50mg, 100mg		
thiothixene CAPS 1mg,	Tier 3	
2mg, 5mg, 10mg		
trifluoperazine hcl TABS	Tier 2	
1mg, 2mg, 5mg, 10mg		
VERSACLOZ SUSP	Tier 3	QL PA
50mg/ml		
QL (600 mL / 30 days)		
VRAYLAR CAPS 1.5mg	Tier 3	QL PA
QL (60 caps / 30 days))	
VRAYLAR CAPS 3mg,	Tier 3	QL PA
4.5mg, 6mg		
QL (30 caps / 30 days))	
VRAYLAR CAP 1.5-3MG	Tier 3	PA
ziprasidone hcl (generic of	Tier 3	QL
GEODON) CAPS 20mg,		
40mg, 60mg, 80mg		
QL (60 caps / 30 days))	
ziprasidone mesylate	Tier 3	QL
(generic of GEODON)		
SOLR 20mg		
QL (6 injections / 3		
days)		
ZYPREXA RELPREVV	Tier 3	QL PA
SUSR 210mg, 300mg		
QL (2 vials / 28 days)		
ZYPREXA RELPREVV	Tier 3	QL PA
SUSR 405mg		
QL (1 vial / 28 days)		

Drug Name	Drug R Tier	Requirements/ Limits
ATTENTION DEFICIT HY DISORDER	PERA(CTIVITY
amphetamine-	Tier 2	QL PA
dextroamphetamine tab 5		
mg (generic of ADDERALL) QL (60 tabs / 30 days)		
amphetamine-	Tier 2	QL PA
dextroamphetamine tab 7.5 mg (generic of ADDERALL)		
QL (60 tabs / 30 days)		
amphetamine-	Tier 2	QL PA
dextroamphetamine tab 10		
mg (generic of ADDERALL)		
QL (60 tabs / 30 days)		
amphetamine-	Tier 2	QL PA
dextroamphetamine tab		
<i>12.5 mg</i> (generic of ADDERALL)		
QL (60 tabs / 30 days)		
amphetamine-	Tier 2	QL PA
dextroamphetamine tab 15		
mg (generic of ADDERALL)		
QL (60 tabs / 30 days)		
amphetamine-	Tier 2	QL PA
dextroamphetamine tab 20 mg (generic of ADDERALL)		
QL (90 tabs / 30 days)		
amphetamine-	Tier 2	QL PA
dextroamphetamine tab 30		
mg (generic of ADDERALL)		
QL (60 tabs / 30 days)	T: 0	
atomoxetine hcl (generic of		QL
STRATTERA) CAPS 10mg, 18mg, 25mg		
QL (120 caps / 30		
days)		
atomoxetine hcl (generic of	Tier 3	QL
STRATTERA) CAPS 40mg		
QL (60 caps / 30 days)		
atomoxetine hcl (generic of		QL
STRATTERA) CAPS 60mg, 80mg, 100mg	1	
QL (30 caps / 30 days)	1	
dexmethylphenidate hcl	Tier 2	QL PA
(generic of FOCALIN)		· · ·
TABS 2.5mg, 5mg		
QL (120 tabs / 30		
days)		

Drug Name	Drug Tier	Requirements/ Limits		rug ier	Requirements/ Limits
dexmethylphenidate hcl (generic of FOCALIN) TABS 10mg QL (60 tabs / 30 days) guanfacine hcl (adhd)	Tier 2		temazepam (generic of T RESTORIL) CAPS 15mg QL (60 caps / 30 days) PA applies if 65 years and older after a 90 day	ier 3	QL PA
(generic of INTUNIV) TB24 1mg, 2mg, 3mg, 4mg	ļ	QLPA	supply in a calendar year temazepam (generic of T	ier 3	QL PA
QL (30 tabs / 30 days) PA if 70 years and older		OL DA	RESTORIL) CAPS 30mg QL (30 caps / 30 days)		
metadate er TBCR 20mg QL (90 tabs / 30 days)			PA if 65 years and older zolpidem tartrate (generic of T	ier 1	QL PA
methylphenidate hcl (generic of METHYLIN) SOLN 5mg/5ml QL (1800 mL / 30 days)	Tier 3	3 QL PA	AMBIEN) TABS 5mg, 10mg QL (30 tabs / 30 days) PA applies if 70 years and older after a 90 day supply in a calendar year		
methylphenidate hcl (generic of METHYLIN) SOLN 10mg/5ml QL (900 mL / 30 days)	Tier 3	B QL PA	MIGRAINE	ier 2	QL NM PA
methylphenidate hcl (generic of RITALIN) TABS 5mg, 10mg	Tier 2	2 QL PA	dihydroergotamine mesylateT (generic of D.H.E. 45) SOLN 1mg/ml	ier 1	
QL (180 tabs / 30 days) methylphenidate hcl (generic of RITALIN) TABS	Tier 2	2 QL PA	dihydroergotamine mesylateT (generic of MIGRANAL) SOLN 4mg/ml	ier 1	QL PA
20mg QL (90 tabs / 30 days)	ı	OL DA	QL (8 mL / 30 days) ergotamine w/ caffeine tab T 1-100 mg (generic of	ier 2	QL PA
methylphenidate hcl TBCR 10mg, 20mg		3 QL PA	CAFERGOT) QL (40 tabs / 28 days)		
QL (90 tabs / 30 days) HYPNOTICS BELSOMRA TABS 5mg,	Tier 3	B QL	rizatriptan benzoate TABS T 5mg; TBDP 5mg QL (18 tabs / 30 days)	ier 2	QL
10mg, 15mg, 20mg QL (30 tabs / 30 days) doxepin hcl (sleep) (generic	ı		rizatriptan benzoate (genericT of MAXALT) TABS 10mg QL (18 tabs / 30 days)	ier 2	QL
of SILENOR) TABS 3mg, 6mg QL (30 tabs / 30 days) HETLIOZ CAPS 20mg	ı	QL NM LA PA	rizatriptan benzoate (genericT of MAXALT-MLT) TBDP 10mg QL (18 tabs / 30 days)	ier 2	QL
QL (30 caps / 30 days temazepam (generic of RESTORIL) CAPS 7.5mg			sumatriptan (generic of TIMITREX) SOLN 5mg/act QL (24 units / 30 days)	ier 3	QL
QL (30 caps / 30 days PA applies if 65 years and older after a 90 day supply in a calendar year	•		sumatriptan (generic of TIMITREX) SOLN 20mg/act QL (12 units / 30 days)	ier 3	QL

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
sumatriptan succinate (generic of IMITREX	Tier 3	QL	lithium carbonate CAPS 150mg, 300mg, 600mg;	Tier 1	I
STATDOSE SYSTEM) SOAJ 4mg/0.5ml QL (18 injections / 30			TABS 300mg; TBCR 450r lithium carbonate (generic LITHOBID) TBCR 300mg	ofTier ′	I
days) sumatriptan succinate	Tier 3	QL	NUEDEXTA CAP 20-10M	G Tier 3	B QL PA
(generic of IMITREX STATDOSE SYSTEM) SOAJ 6mg/0.5ml QL (12 injections / 30	riei 3	QL.	QL (60 caps / 30 day pregabalin (once-daily) (generic of LYRICA CR) TB24 82.5mg, 165mg, 330mg	Tier 3	3 QL PA
days) sumatriptan succinate (generic of IMITREX STATDOSE REFILL)	Tier 3	QL	QL (60 tabs / 30 day pyridostigmine bromide (generic of MESTINON) TABS 60mg	s) Tier 2	2
SOCT 4mg/0.5ml QL (18 injections / 30			riluzole (generic of RILUTEK) TABS 50mg	Tier 3	3
days) sumatriptan succinate (generic of IMITREX	Tier 3	QL	tetrabenazine (generic of XENAZINE) TABS 12.5m QL (90 tabs / 30 day	_	I QL NM PA
STATDOSE REFILL) SOCT 6mg/0.5ml QL (12 injections / 30 days)			tetrabenazine (generic of XENAZINE) TABS 25mg QL (120 tabs / 30 days)	Tier 1	QL NM PA
sumatriptan succinate	Tier 3	QL	MULTIPLE SCLEROSI	S AGEI	VTS
(generic of IMITREX) SOLN 6mg/0.5ml QL (12 injections / 30	N		BETASERON KIT .3mg QL (14 syringes / 28 days)	Tier 2	
days) sumatriptan succinate	Tier 1	QL	dalfampridine (generic of AMPYRA) TB12 10mg	Tier 2	2 NM PA
(generic of IMITREX) TABS 25mg, 50mg, 100mg			GILENYA CAPS .5mg QL (28 caps / 28 day		2 QL NM PA
QL (12 tabs / 30 days) UBRELVY TABS 50mg, 100mg	Tier 3	QL PA	glatiramer acetate (gener of COPAXONE) SOSY 20mg/ml	c Tier 1	I QL NM PA
QL (16 tabs / 30 days) MISCELLANEOUS			QL (30 syringes / 30 days)		
AUSTEDO TABS 6mg QL (60 tabs / 30 days)		QL NM PA	glatiramer acetate (gener	c Tier	QL NM PA
AUSTEDO TABS 9mg, 12mg QL (120 tabs / 30	Tier 2	QL NM PA	40mg/ml QL (12 syringes / 28 days)		
days) INGREZZA CAPS 40mg, 60mg, 80mg QL (30 caps / 30 days INGREZZA CAP 40-80MG)	QL NM LA PA	glatopa (generic of COPAXONE) SOSY 20mg/ml QL (30 syringes / 30 days)	-	QL NM PA
QL (28 caps / 28 days LITHIUM SOLN 8meg/5ml)		uays <i>j</i>		
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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
glatopa (generic of COPAXONE) SOSY	Tier 1	QL NM PA	buprenorphine hcl-naloxone hcl sl film 8-2 mg (base	eTier 3	3 QL
40mg/ml			equiv) (generic of		
QL (12 syringes / 28 days)			SUBOXONE) QL (90 films / 30 days	١	
MUSCULOSKELETAL T	ΉFRΔ	PY AGENTS	buprenorphine hcl-naloxone		3 QL
baclofen TABS 10mg,	Tier 2		hcl sl film 12-3 mg (base		ζ
_20mg			<i>equiv)</i> (generic of		
cyclobenzaprine hcl TABS	Tier 2	PA	SUBOXONE)		
5mg, 10mg			QL (60 films / 30 days buprenorphine hcl-naloxone		l QL
PA if 70 years and older	Tion		hcl sl tab 2-0.5 mg (base	FILEI	ı QL
dantrolene sodium (generion of DANTRIUM) CAPS	: Her a	•	equiv)		
25mg, 50mg			QL (90 tabs / 30 days)		
dantrolene sodium CAPS	Tier 3		buprenorphine hcl-naloxone	Tier 1	l QL
			hcl sl tab 8-2 mg (base		
tizanidine hcl TABS 2mg	Tier 1		<i>equiv)</i> QL (90 tabs / 30 days)		
tizanidine hcl (generic of	Tier 1		bupropion hcl (smoking	Tier 2)
ZANAFLEX) TABS 4mg			deterrent) TB12 150mg	1101 2	-
NARCOLEPSY/CATAPL		OL DA	CHANTIX TABS .5mg, 1mg	Tier 3	3 QL PA
armodafinil (generic of NUVIGIL) TABS 50mg	Tier 2	QL PA	QL (56 tabs / 28 days)	•	
QL (90 tabs / 30 days)		CHANTIX CONTINUING	Tier 3	3 QL PA
armodafinil (generic of	Tier 2	QL PA	MONTH TABS 1mg		
NUVIGIL) TABS 150mg,			QL (56 tabs / 28 days) CHANTIX PAK 0.5& 1MG	Tier 3	3 QL PA
200mg, 250mg			QL (106 tabs / year)	Hers	O QLFA
QL (30 tabs / 30 days		OL NIMAL A DA	disulfiram TABS 250mg,	Tier 2	2
XYREM SOLN 500mg/ml QL (540 mL / 30 days		QL NM LA PA	500mg		_
PSYCHOTHERAPEUTIC		•	naloxone hcl SOCT	Tier 1	
acamprosate calcium TBE			.4mg/ml; SOLN .4mg/ml,		
333mg	0 1101 0	,	4mg/10ml; SOSY 2mg/2ml	T: 6	
buprenorphine hcl SUBL	Tier 2	QL PA	naltrexone hcl TABS 50mg		
2mg, 8mg			NARCAN LIQD 4mg/0.1ml		
QL (90 tabs / 30 days			NICOTROL INHALER INHA 10mg	Tier 3	3
buprenorphine hcl-naloxon	eTier 3	QL	NICOTROL NS SOLN	Tier 3	3
hcl sl film 2-0.5 mg (base equiv) (generic of			10mg/ml	1101	,
SUBOXONE)			VIVITROL SUSR 380mg	Tier 2	2 NM
QL (90 films / 30 days	.)		ENDOCRINE AND META	BOL	<u>IC</u>
buprenorphine hcl-naloxon	•	QL	ANDROGENS		
hcl sl film 4-1 mg (base			ANDRODERM PT24	Tier 3	3 QL PA
equiv) (generic of			2mg/24hr, 4mg/24hr		
SUBOXONE)	1		QL (30 patches / 30		
QL (90 films / 30 days	<u>') </u>		days) oxandrolone TABS 2.5mg	Tier 2	QL PA
			QL (120 tabs / 30	1 101 2	- QLIA
			days)		

Drug Name	Drug Tier	Requirements/ Limits
oxandrolone TABS 10mg QL (60 tabs / 30 days)	Tier 3	QL PA
testosterone GEL 1% QL (300 gm/30 days)	Tier 3	QL PA
testosterone (generic of ANDROGEL) GEL 25mg/2.5gm, 50mg/5gm QL (300 gm / 30 days)	Tier 3	QL PA
testosterone cypionate (generic of DEPO- TESTOSTERONE) SOLN 100mg/ml, 200mg/ml	Tier 2	PA
testosterone enanthate SOLN 200mg/ml ANTIDIABETICS	Tier 2	PA
acarbose (generic of PRECOSE) TABS 25mg, 50mg, 100mg	Tier 2	
2mg/0.85ml QL (4 pens / 28 days)	Tier 2	
BYETTA SOPN 5mcg/0.02ml, 10mcg/0.04m QL (1 pen / 30 days)	Tier 3 I	QL
FARXIGA TABS 5mg, 10mg QL (30 tabs / 30 days)	Tier 2	QL
glimepiride (generic of AMARYL) TABS 1mg, 2mg QL (90 tabs / 30 days)	Tier 1	QL
glimepiride (generic of AMARYL) TABS 4mg QL (60 tabs / 30 days)	Tier 1	QL
glipizide TABS 5mg QL (240 tabs / 30 days)	Tier 1	QL
glipizide TABS 10mg QL (120 tabs / 30 days)	Tier 1	QL
glipizide (generic of GLUCOTROL XL) TB24 2.5mg, 5mg QL (90 tabs / 30 days)	Tier 1	QL
glipizide (generic of GLUCOTROL XL) TB24 10mg QL (60 tabs / 30 days)	Tier 1	QL

Drug Name	Tier	Requirements/ Limits
glipizide xl (generic of GLUCOTROL XL) TB24 2.5mg, 5mg	Tier 1	QL
QL (90 tabs / 30 days)		
glipizide xl (generic of GLUCOTROL XL) TB24 10mg	Tier 1	QL
QL (60 tabs / 30 days)		
glipizide-metformin hcl tab 2.5-250 mg QL (240 tabs / 30	Tier 2	? QL
days)	Tior	. QL
glipizide-metformin hcl tab 2.5-500 mg QL (120 tabs / 30 days)	Hei Z	. QL
glipizide-metformin hcl tab 5-500 mg QL (120 tabs / 30 days)	Tier 2	2 QL
GLYXAMBI TAB 10-5 MG QL (30 tabs / 30 days)	Tier 2	QL
GLYXAMBI TAB 25-5 MG QL (30 tabs / 30 days)	Tier 2	? QL
JANUMET TAB 50-500MG QL (60 tabs / 30 days)	Tier 2	2 QL
JANUMET TAB 50-1000 QL (60 tabs / 30 days)	Tier 2	2 QL
JANUMET XR TAB 50- 500MG QL (60 tabs / 30 days)	Tier 2	2 QL
JANUMET XR TAB 50-1000 QL (60 tabs / 30 days)		QL
JANUMET XR TAB 100- 1000 QL (30 tabs / 30 days)	Tier 2	
JANUVIA TABS 25mg, 50mg, 100mg QL (30 tabs / 30 days)	Tier 2	2 QL
JARDIANCE TABS 10mg QL (60 tabs / 30 days)	Tier 2	. QL
JARDIANCE TABS 25mg QL (30 tabs / 30 days)	Tier 2	? QL
JENTADUETO TAB 2.5-500 QL (60 tabs / 30 days)	Tier 2	2 QL
JENTADUETO TAB 2.5-850 QL (60 tabs / 30 days)	Tier 2	? QL

Drug Name	Drug Tier	Requirements/ Limits
JENTADUETO TAB 2.5-	Tier 2	QL
1000		
QL (60 tabs / 30 days)		
JENTADUETO TAB XR 2.5-	Tier 2	2 QL
1000MG		
QL (60 tabs / 30 days)		
JENTADUETO TAB XR 5-	Tier 2	2 QL
1000MG		
QL (30 tabs / 30 days)	- : ,	
metformin hcl TABS 500mg	l lier 1	QL
QL (150 tabs / 30		
days)	T: 4	
metformin hcl TABS 850mg	i i ier 1	QL
QL (90 tabs / 30 days)	<u> </u>	
metformin hcl TABS	Tier 1	QL
1000mg		
QL (75 tabs / 30 days)	T: 4	01
metformin hcl TB24 500mg	Her 1	QL
QL (120 tabs / 30		
days)		
(generic of		
GLUCOPHAGE XR)	Tior 1	QL
metformin hcl TB24 750mg	i iei i	QL
QL (60 tabs / 30 days) (generic of		
GLUCOPHAGE XR)		
nateglinide TABS 60mg,	Tier 2	2 QL
120mg	1101 2	. QL
QL (90 tabs / 30 days)		
OZEMPIC (0.25 OR	Tier 2	2 QL
0.5MG/DOSE) SOPN	1101 2	. QL
2mg/1.5ml		
QL (1 pen / 28 days)		
OZEMPIC (1MG/DOSE)	Tier 2	· QL
SOPN 2mg/1.5ml		
QL (2 pens / 28 days)		
OZEMPIC (1MG/DOSE)	Tier 2	· QL
SOPN 4mg/3ml		
QL (1 pen / 28 days)		
pioglitazone hcl (generic of	Tier 1	QL
ACTOS) TABS 15mg,		
30mg, 45mg		
QL (30 tabs / 30 days)		
repaglinide TABS 2mg	Tier 2	QL
QL (240 tabs / 30		
days)		

Drug Name	Drug Tier	Requirements/ Limits
repaglinide TABS .5mg,	Tier 2	QL
1mg		
QL (120 tabs / 30		
days)	Tier 2	<u> </u>
RYBELSUS TABS 3mg, 7mg, 14mg	i iei z	QL
QL (30 tabs / 30 days)		
SYNJARDY TAB 5-500MG		QL
QL (120 tabs / 30	1101 2	QL
days)		
SYNJARDY TAB 5-1000MC	GTier 2	QL
QL (60 tabs / 30 days)		
SYNJARDY TAB 12.5-500	Tier 2	QL
QL (60 tabs / 30 days)		
SYNJARDY TAB 12.5-	Tier 2	QL
1000MG		
QL (60 tabs / 30 days)	T: 0	
SYNJARDY XR TAB 5-	Tier 2	QL
1000MG		
QL (60 tabs / 30 days) SYNJARDY XR TAB 10-	Tier 2	QL
1000	11612	QL
QL (60 tabs / 30 days)		
SYNJARDY XR TAB 12.5-	Tier 2	QL
1000MG		~-
QL (60 tabs / 30 days))	
SYNJARDY XR TAB 25-	Tier 2	QL
1000		
QL (30 tabs / 30 days)		
TRADJENTA TABS 5mg	Tier 2	QL
QL (30 tabs / 30 days)		
TRIJARDY XR TAB ER 24HR 5-2.5-1000MG	Tier 2	QL
QL (60 tabs / 30 days) TRIJARDY XR TAB ER	Tier 2	QL
24HR 10-5-1000MG	1101 2	QL
QL (30 tabs / 30 days)		
TRIJARDY XR TAB ER	Tier 2	QL
24HR 12.5-2.5-1000MG		
QL (60 tabs / 30 days))	
TRIJARDY XR TAB ER	Tier 2	QL
24HR 25-5-1000MG		
QL (30 tabs / 30 days)		
TRULICITY SOPN	Tier 2	QL
.75mg/0.5ml, 1.5mg/0.5ml,		
3mg/0.5ml, 4.5mg/0.5ml		
QL (4 pens / 28 days)		

Drug Name	Drug Tier	Requirements/ Limits
VICTOZA SOPN 18mg/3ml QL (3 pens / 30 days)	Tier 2	2 QL
XIGDUO XR TAB 2.5-1000 QL (60 tabs / 30 days)	Tier 2	2 QL
XIGDUO XR TAB 5-500MG QL (60 tabs / 30 days)	Tier 2	? QL
XIGDUO XR TAB 5- 1000MG	Tier 2	. QL
QL (60 tabs / 30 days)		
XIGDUO XR TAB 10- 500MG	Tier 2	2 QL
QL (30 tabs / 30 days)	-	
XIGDUO XR TAB 10-1000	lier 2	2 QL
QL (30 tabs / 30 days)		
ANTIDIABETICS, INSULI		
BASAGLAR KWIKPEN SOPN 100unit/ml	Tier 2	
BD ALCOHOL SWABS	Tier 2	
FIASP FLEX INJ TOUCH	Tier 2	-
FIASP INJ 100/ML	Tier 2)
FIASP PENFIL INJ U-100	Tier 2)
GAUZE PADS 2" X 2"	Tier 2	2
HUMULIN R U-500 (CONCENTR SOLN	Tier 2	B/D
500unit/ml		
HUMULIN R U-500 KWIKPEN SOPN	Tier 2	2
500unit/ml	<u> </u>	
INSULIN SAFETY	Tier 2	<u>}</u>
NEEDLES	T: C	
INSULIN SYRINGES: BD/ULTIMED/ALLISON/TRI VIDIA/MHC	Tier 2	2
LEVEMIR SOLN 100unit/ml	Tier 2)
LEVEMIR FLEXTOUCH	Tier 2	
SOPN 100unit/ml		
NOVOLIN INJ 70/30 (brand RELION not covered)	Tier 2	2
NOVOLIN INJ 70/30 FP (brand RELION not covered)	Tier 2	2
NOVOLIN N SUSP 100unit/ml (brand RELION not covered)	Tier 2	

Drug Name	Drug R Tier	equirements/ Limits
NOVOLIN N FLEXPEN	Tier 2	
SUPN 100unit/ml		
(brand RELION not		
covered)		
NOVOLIN R SOLN	Tier 2	
100unit/ml		
(brand RELION not		
covered)		
NOVOLIN R FLEXPEN	Tier 2	
SOPN 100unit/ml		
(brand RELION not		
covered)		
NOVOLOG SOLN	Tier 2	
100unit/ml		
(brand RELION not		
covered)		
NOVOLOG FLEXPEN	Tier 2	
SOPN 100unit/ml	1161 2	
(brand RELION not		
•		
covered) NOVOLOG MIX INJ 70/30	Tier 2	
	rier z	
(brand RELION not		
covered)	T: 0	
NOVOLOG MIX INJ	Tier 2	
FLEXPEN		
(brand RELION not		
covered)		
NOVOLOG PENFILL	Tier 2	
SOCT 100unit/ml		
(brand RELION not		
covered)		
	Tier 3	QL PA
QL (1 kit / year)		
OMNIPOD MIS 5 PACK	Tier 3	QL PA
QL (10 pods / 30 days	s)	
PEN NEEDLES:	Tier 2	
NOVO/BD/ULTIMED/OWE	N	
/TRIVIDIA		
SOLIQUA INJ 100/33	Tier 2	QL
QL (10 pens / 30 days		
TRESIBA SOLN 100unit/m		
TRESIBA FLEXTOUCH	Tier 2	
SOPN 100unit/ml,	11012	
200unit/ml		
	Tier 3	QL PA
V-GO 20 KIT	i iei 3	QL PA
QL (1 kit / 30 days)	Tio: 0	OL DA
V-GO 30 KIT	Tier 3	QL PA
QL (1 kit / 30 days)		

Drug Name	Drug Tier	Requirements/ Limits
V-GO 40 KIT QL (1 kit / 30 days)	Tier 3	QL PA
XULTOPHY INJ 100/3.6 QL (5 pens / 30 days)	Tier 2	QL
CALCIUM REGULATOR	S	_
alendronate sodium TABS	Tier 1	
_10mg, 35mg		
alendronate sodium (generion of FOSAMAX) TABS 70mg		
calcitonin (salmon) spray (generic of MIACALCIN)	Tier 2	B/D
SOLN 200unit/act FORTEO SOPN	Tier 2	NM PA
620mcg/2.48ml	i iei z	INIVIEA
ibandronate sodium (generion BONIVA) TABS 150mg	cTier 2	B/D
NATPARA CART 25mcg, 50mcg, 75mcg, 100mcg	Tier 2	NM PA
PAMIDRONATE DISODIUN	/Tier 2	B/D
SOLN 6mg/ml	T: 0	D/D
pamidronate disodium SOLN 30mg/10ml, 90mg/10ml; SOLR 30mg, 90mg	Tier 2	B/D
PROLIA SOSY 60mg/ml QL (1 syringe / 180 days)	Tier 3	QL NM
XGEVA SOLN 120mg/1.7ml	Tier 2	NM PA
zoledronic acid CONC 4mg/5ml; SOLN 4mg/100ml	Tier 3	B/D NM
zoledronic acid (generic of RECLAST) SOLN 5mg/100ml	Tier 3	B/D NM
CHELATING AGENTS		
CHEMET CAPS 100mg	Tier 3	
deferasirox (generic of JADENU SPRINKLE) PACK 90mg, 180mg, 360mg	Tier 1	NM PA
deferasirox (generic of JADENU) TABS 90mg, 180mg, 360mg	Tier 1	NM PA
LOKELMA PACK 5gm, 10gm	Tier 2	
penicillamine (generic of DEPEN TITRATABS) TABS 250mg	Tier 1	NM

Drug Name	Tier	Requirements/ Limits
sodium polystyrene	Tier 2	
sulfonate powder	T: 0	
sps SUSP 15gm/60ml	Tier 2	NINADA
trientine hcl (generic of	Tier 1	NM PA
SYPRINE) CAPS 250mg	Tier 3	PA
VELTASSA PACK 8.4gm, 16.8gm, 25.2gm	Her 3	PA
CONTRACEPTIVES		
afirmelle	Tier 2	
altavera	Tier 2	
alyacen 1/35	Tier 2	
alyacen 7/7/7	Tier 2	
apri	Tier 2	
aranelle	Tier 2	
aubra eq	Tier 2	
aurovela 1/20	Tier 2	
aurovela fe 1.5/30	Tier 2	
aurovela fe 1/20	Tier 2	
aviane	Tier 2	
ayuna	Tier 2	
azurette (generic of MIRCETTE)	Tier 2	
balziva	Tier 2	
bekyree (generic of MIRCETTE)	Tier 2	
blisovi fe 1.5/30	Tier 2	
briellyn	Tier 2	
camila TABS .35mg	Tier 2	
caziant	Tier 2	
chateal	Tier 2	
cryselle-28	Tier 2	
cyclafem 1/35	Tier 2	
cyclafem 7/7/7	Tier 2	
cyred eq	Tier 2	
dasetta 1/35	Tier 2	
dasetta 7/7/7	Tier 2	
deblitane TABS .35mg	Tier 2	
desogest-eth estrad & eth estrad tab 0.15-0.02/0.01 mg(21/5) (generic of MIRCETTE)	Tier 2	
desogestrel & ethinyl estradiol tab 0.15 mg-30 mcg	Tier 2	

estradiol tab 3-0.02 mg (generic of YAZ) drospirenone-ethinyl estradiol tab 3-0.03 mg (generic of YASMIN 28) elinest ELLA TABS 30mg Tier 2 emoquette Tier 2 enpresse-28 Tier 2 enskyce Tier 2 errin TABS .35mg Tier 2 ethynodiol diacetate & Tier 2 ethynodiol diacetate & Tier 2 ethinyl estradiol tab 1 mg-35 mcg ethynodiol diacetate & Tier 2 ethinyl estradiol tab 1 mg-50 mcg falmina Tier 2 femynor Tier 2 hailey 1.5/30 Tier 2 incassia TABS .35mg Tier 2 incassia TABS .35mg Tier 2 introvale Tier 2 jinel 1.5/30 Tier 2 jinel 1.5/30 Tier 2 junel 1.5/30 Tier 2 kelnor 1/35 Tier 2 kelnor 1/50 Tier 2 larin 1.5/30 Tier 2	Drug Name	Drug Requirem Tier Limits	
(generic of YAZ) drospirenone-ethiny Tier 2 estradiol tab 3-0.03 mg (generic of YASMIN 28) elinest Tier 2 ELLA TABS 30mg Tier 2 emoquette Tier 2 enpresse-28 Tier 2 enskyce Tier 2 errin TABS .35mg Tier 2 estarylla Tier 2 ethynodiol diacetate & Tier 2 ethynodiol diacetate & Tier 2 ethinyl estradiol tab 1 mg-35 mcg ethynodiol diacetate & Tier 2 ethinyl estradiol tab 1 mg-50 mcg falmina Tier 2 femynor Tier 2 hailey 1.5/30 Tier 2 incassia TABS .35mg Tier 2 incassia TABS .35mg Tier 2 incassia TABS .35mg Tier 2 introvale Tier 2 insibloom Tier 2 juleber Tier 2 juleber Tier 2 juleber Tier 2 junel 1/20 Tier 2 junel 1/20 Tier 2 junel 1/20 Tier 2 kelnor 1/35 Tier 2 kelnor 1/35 Tier 2 larin 1.5/30 Tier 2	drospirenone-ethinyl	Tier 2	
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larin fe 1/20 Tier 2 larissia Tier 2			
larissia Tier 2			
	larin fe 1/20		
Joons Tior 2	larissia		
ieeria Tierz	leena	Tier 2	

Drug Name	Tier	Requirements/ Limits
lessina	Tier 2	2
levonest	Tier 2	
levonorgestrel & ethinyl	Tier 2	
estradiol (91-day) tab 0.15-		
0.03 mg		
levonorgestrel & ethinyl	Tier 2	
estradiol tab 0.1 mg-20 mcg	7 Tier 2	<u> </u>
levonorgestrel & ethinyl estradiol tab 0.15 mg-30	i ier z	
mcg		
levonorgestrel-eth estra tab	Tier 2)
0.05-30/0.075-40/0.125-		•
30mg-mcg		
levora 0.15/30-28	Tier 2	
lillow	Tier 2	
loestrin 1.5/30-21	Tier 2	
loestrin 1/20-21	Tier 2	
loestrin fe 1.5/30	Tier 2	
loestrin fe 1/20	Tier 2	
loryna (generic of YAZ)	Tier 2	
low-ogestrel	Tier 2	
lutera	Tier 2	
lyleq TABS .35mg	Tier 2	
lyza TABS .35mg	Tier 2	
marlissa	Tier 2) -
medroxyprogesterone	Tier 2) -
acetate (contraceptive)		
(generic of DEPO-		
PROVERA		
CONTRACEPTIV) SUSP		
150mg/ml; SUSY 150mg/ml	Tior	1
microgestin 1.5/30	Tier 2	
microgestin 1/20		
microgestin fe 1.5/30	Tier 2	
microgestin fe 1/20	Tier 2	
mili	Tier 2	
mono-linyah	Tier 2	
necon 0.5/35-28	Tier 2	
nikki (generic of YAZ)	Tier 2	
nora-be TABS .35mg	Tier 2	
norethindrone	Tier 2	
(contraceptive) TABS .35mg		
norethindrone ace & ethinyl	Tier 2)
estradiol tab 1 mg-20 mcg	1 101 2	•

Drug Name	Tier	Requirements/ Limits
norethindrone ace & ethinyl		2
estradiol tab 1.5 mg-30 mcg		
norethindrone ace & ethinyl	i ier 2	<u>′</u>
estradiol-fe tab 1 mg-20		
mcg norgestimate & ethinyl	Tier 2	<u> </u>
estradiol tab 0.25 mg-35	11612	<u>-</u>
mcq		
norgestimate-eth estrad tab	Tier 2)
0.18-25/0.215-25/0.25-25	1.0. 2	-
mg-mcg (generic of ORTHO)	
TRI-CYCLEN LO)		
norgestimate-eth estrad tab	Tier 2	<u> </u>
0.18-35/0.215-35/0.25-35		
mg-mcg		_
norlyroc TABS .35mg	Tier 2	
nortrel 0.5/35 (28)	Tier 2	2
nortrel 1/35 (21)	Tier 2	2
nortrel 1/35 (28)	Tier 2	<u> </u>
nortrel 7/7/7	Tier 2	2
nylia 7/7/7	Tier 2	<u>)</u>
путуо	Tier 2	<u> </u>
ocella (generic of YASMIN 28)	Tier 2	2
orsythia	Tier 2	2
philith	Tier 2	<u>)</u>
pimtrea (generic of MIRCETTE)	Tier 2	2
pirmella 1/35	Tier 2	<u>)</u>
portia-28	Tier 2	2
previfem	Tier 2	<u> </u>
reclipsen	Tier 2	<u> </u>
setlakin	Tier 2	
sharobel TABS .35mg	Tier 2	
simliya (generic of	Tier 2	
MIRCETTE)		
sprintec 28	Tier 2	2
sronyx	Tier 2	
syeda (generic of YASMIN 28)	Tier 2	
tarina fe 1/20 eq	Tier 2	2
tilia fe (generic of	Tier 3	
ESTROSTEP FE)	T: 0	
tri-estarylla	Tier 2	
tri-legest fe (generic of ESTROSTEP FE)	Tier 3	

Drug Name	Drug Tier	Requirements/ Limits
tri-linyah	Tier 2	2
tri-lo-estarylla (generic of ORTHO TRI-CYCLEN LO)	Tier 2	2
tri-lo-marzia (generic of ORTHO TRI-CYCLEN LO)	Tier 2)
tri-lo-mili (generic of ORTHC	Tier 2	
TRI-CYCLEN LO)	7 1 101 2	-
tri-lo-sprintec (generic of	Tier 2	2
ORTHO TRI-CYCLEN LO)		
tri-mili	Tier 2	
tri-nymyo	Tier 2	2
tri-previfem	Tier 2	2
tri-sprintec	Tier 2	2
tri-vylibra	Tier 2	2
tri-vylibra lo (generic of ORTHO TRI-CYCLEN LO)	Tier 2	2
trivora-28	Tier 2	2
velivet	Tier 2	2
vestura (generic of YAZ)	Tier 2	2
vienva	Tier 2	2
viorele (generic of MIRCETTE)	Tier 2	2
vyfemla	Tier 2	2
vylibra	Tier 2	2
wera	Tier 2	2
xulane	Tier 3	3
zafemy	Tier 3	3
zarah (generic of YASMIN 28)	Tier 2	2
zovia 1/35	Tier 2	2
zumandimine (generic of YASMIN 28)	Tier 2	2
ENDOMETRIOSIS		
danazol CAPS 50mg,	Tier 3	3
100mg, 200mg		
SYNAREL SOLN 2mg/ml	Tier 2	2
ESTROGENS		
amabelz	Tier 2	
amabelz (generic of ACTIVELLA)	Tier 2	2
dotti (generic of VIVELLE-DOT) PTTW .025mg/24hr, .037mg/24hr, .05mg/24hr, .075mg/24hr	Tier 2	2

Drug Name	Tier	Requirements/ Limits
estradiol (generic of	Tier 2	2
VIVELLE-DOT) PTTW		
.025mg/24hr, .037mg/24hr,		
.05mg/24hr, .075mg/24hr,		
.1mg/24hr estradiol (generic of	Tier 2	<u> </u>
CLIMARA) PTWK	11612	<u>-</u>
.025mg/24hr, .05mg/24hr,		
.06mg/24hr, .075mg/24hr,		
.1mg/24hr, 37.5mcg/24hr		
estradiol (generic of	Tier 1	
ESTRACE) TABS .5mg,		
1mg, 2mg		
estradiol & norethindrone	Tier 2	2
acetate tab 0.5-0.1 mg		
estradiol & norethindrone	Tier 2	2
acetate tab 1-0.5 mg		
(generic of ACTIVELLA)		
estradiol vaginal (generic of		2
ESTRACE) CREA .1mg/gm		_
estradiol vaginal (generic of	Tier 3	3
VAGIFEM) TABS 10mcg	(= : -	
estradiol valerate (generic o	f Lier 3	3
DELESTROGEN) OIL		
20mg/ml, 40mg/ml	Tier 2	<u> </u>
fyavolv tab 0.5mg-2.5mcg (generic of FEMHRT)	i iei z	<u> </u>
fyavolv tab 1mg-5mcg	Tier 2)
jinteli	Tier 2	
	Tier 2	
<i>lyllana</i> (generic of MINIVELLE) PTTW	i iei z	<u> </u>
.025mg/24hr, .037mg/24hr,		
.05mg/24hr, .075mg/24hr,		
.1mg/24hr		
mimvey (generic of	Tier 2	<u> </u>
ACTIVELLA)		-
norethindrone acetate-	Tier 2	2
ethinyl estradiol tab 0.5 mg-	•	
2.5 mcg (generic of		
FEMHRT)		
norethindrone acetate-	Tier 2	2
ethinyl estradiol tab 1 mg-5		
mcg		_
yuvafem (generic of	Tier 3	3
VAGIFEM) TABS 10mcg		

	Drug Name	Drug Tier	Requirements/ Limits
-	GLUCOCORTICOIDS		
	dexamethasone ELIX	Tier 2	2
	.5mg/5ml; SOLN .5mg/5ml;		
	TABS .5mg, .75mg, 1mg,		
-	1.5mg, 2mg, 4mg, 6mg		_
	dexamethasone sodium	Tier 2	2
	phosphate SOLN 4mg/ml,		
	10mg/ml, 20mg/5ml,		
-	100mg/10ml, 120mg/30ml		
	fludrocortisone acetate	Tier 1	
-	TABS .1mg		
	hydrocortisone (generic of	Tier 2	2
	CORTEF) TABS 5mg,		
-	10mg, 20mg	T : 6	D/D
	methylprednisolone (generic	c lier 2	2 B/D
	of MEDROL) TABS 4mg,		
-	8mg, 16mg, 32mg	- T: - = 4	1
	methylprednisolone (generic	c Her 1	
	of MEDROL DOSEPAK)		
-	TBPK 4mg	Tion	D/D
	methylprednisolone acetate	e Herz	2 B/D
	(generic of DEPO- MEDROL) SUSP 40mg/ml,		
	80mg/ml		
-	methylprednisolone sod	Tier 2	2 B/D
	succ (generic of SOLU-	11612	. b/D
	MEDROL) SOLR 40mg,		
	125mg, 1000mg		
-	prednisolone SOLN	Tier 1	B/D
	15mg/5ml	1101	<i>D, D</i>
-	prednisolone sodium	Tier 1	B/D
	phosphate SOLN 15mg/5m	_	<i>5</i> , <i>5</i>
-	prednisone SOLN 5mg/5m		B/D
-	prednisone TABS 1mg,	Tier 1	
	2.5mg, 5mg, 10mg, 20mg,	1101	<i>5</i> , <i>5</i>
	50mg		
-	prednisone TBPK5mg,	Tier 2)
	10mg		-
-	SOLU-CORTEF SOLR	Tier 3	3
	100mg, 250mg, 500mg,		
	1000mg		
•	GLUCOSE ELEVATING	AGEN	ITS
-	diazoxide (generic of	Tier 1	
	PROGLYCEM) SUSP		
	50mg/ml		
-	GVOKE HYPOPEN 2-PACH	CTier 2	2
	SOAJ .5mg/0.1ml,		
-	1mg/0.2ml		
_	·		

Drug Name	Drug Tier	Requirements/ Limits
GVOKE PFS SOSY	Tier 2	
.5mg/0.1ml, 1mg/0.2ml		
MISCELLANEOUS		
cabergoline TABS .5mg	Tier 2	_
CARBAGLU TABS 200mg	Tier 2	NM LA PA
CERDELGA CAPS 84mg	Tier 2	NM PA
cinacalcet hcl (generic of	Tier 3	B/D QL NM
SENSIPAR) TABS 30mg		
QL (120 tabs / 30		
days)		
cinacalcet hcl (generic of	Tier 1	B/D QL NM
SENSIPAR) TABS 60mg		
QL (60 tabs / 30 days)		
cinacalcet hcl (generic of	Lier 1	B/D QL NM
SENSIPAR) TABS 90mg		
QL (120 tabs / 30		
days)	T: 0	NIM I A
CYSTACON CARS FOrms	Tier 2 Tier 3	
CYSTAGON CAPS 50mg,	Her 3	INIVI LA PA
150mg	Tier 1	
desmopressin acetate (generic of DDAVP) SOLN	i iei i	
4mcg/ml		
desmopressin acetate	Tier 2	
(generic of DDAVP) TABS	11012	
.1mg, .2mg		
desmopressin acetate spray	Tier 3	
SOLN .01%	,	
desmopressin acetate spray	Tier 3	
refrigerated SOLN .01%		
GENOTROPIN SOLR 5mg	Tier 2	NM PA
12mg		
GENOTROPIN MINIQUICK	Tier 2	NM PA
SOLR .2mg, .4mg, .6mg,		
.8mg, 1mg, 1.2mg, 1.4mg,		
1.6mg, 1.8mg, 2mg		
INCRELEX SOLN	Tier 2	NM LA PA
40mg/4ml		
KORLYM TABS 300mg	Tier 2	
levocarnitine (metabolic	Tier 3	B/D
modifiers) (generic of		
CARNITOR) SOLN		
1gm/10ml	T: C	D/D
levocarnitine (metabolic	Tier 2	B/D
modifiers) (generic of CARNITOR) TABS 330mg		
CARNITORY TADO SOUTING		

Drug Name	Drug Tier	Requirements/ Limits
miglustat (generic of	Tier 1	QL NM PA
ZAVESCA) CAPS 100mg		
QL (90 caps / 30 days		
<i>nitisinone</i> (generic of	Tier 1	NM PA
ORFADIN) CAPS 2mg,		
5mg, 10mg	T : 0	NIM DA
octreotide acetate (generic	Tier 3	NM PA
of SANDOSTATIN) SOLN		
50mcg/ml, 100mcg/ml octreotide acetate SOLN	Tier 3	NM PA
200mcg/ml	Hers	NIVI PA
octreotide acetate (generic	Tier 1	NM PA
of SANDOSTATIN) SOLN	1101 1	T WIVE T 7 C
500mcg/ml		
octreotide acetate SOLN	Tier 1	NM PA
1000mcg/ml		
raloxifene hcl (generic of	Tier 2	
EVISTA) TABS 60mg		
sapropterin dihydrochloride	Tier 1	NM PA
(generic of KUVAN) PACK		
100mg, 500mg; TABS		
100mg		
SIGNIFOR SOLN .3mg/ml,	Tier 2	NM LA PA
.6mg/ml, .9mg/ml	T: 4	NINA DA
sodium phenylbutyrate	Tier 1	NM PA
(generic of BUPHENYL)		
POWD 3gm/tsp; TABS 500mg		
SOMATULINE DEPOT	Tier 2	NM PA
SOLN 60mg/0.2ml,	11612	. INIVIEA
90mg/0.3ml, 120mg/0.5ml		
SOMAVERT SOLR 10mg,	Tier 2	NM LA PA
15mg, 20mg, 25mg, 30mg		
PHOSPHATE BINDER A	GEN1	<u>s</u>
calcium acetate (phosphate		
binder) (generic of		
PHOSĹŎ) CAPS 667mg		
QL (360 caps / 30		
days)		
calcium acetate (phosphate	Tier 2	QL
binder) TABS 667mg		
QL (360 tabs / 30		
days)	T: ^	01
sevelamer carbonate	Tier 3	QL
(generic of RENVELA)		
PACK 2.4gm QL (180 packets / 30		
days)		
aay <i>3)</i>		

Drug Name		uirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
sevelamer carbonate (generic of RENVELA)	Tier 1	QL	methimazole (generic of TAPAZOLE) TABS 5mg,	Tier 1	
PACK .8gm			_10mg		
QL (540 packets / 30			propylthiouracil TABS 50m	-	
days)	T: 0	<u> </u>	SYNTHROID TABS 25mcg	, Tier 3	}
sevelamer carbonate (generic of RENVELA)	Tier 3	QL	50mcg, 75mcg, 88mcg,		
TABS 800mg			100mcg, 112mcg, 125mcg,		
QL (540 tabs / 30			137mcg, 150mcg, 175mcg,		
days)			200mcg, 300mcg unithroid (generic of	Tier 1	
PROGESTINS			SYNTHROID) TABS	HEII	
medroxyprogesterone	Tier 1		25mcg, 50mcg, 75mcg,		
acetate (generic of			88mcg, 100mcg, 112mcg,		
PROVERA) TABS 2.5mg,			125mcg, 137mcg, 150mcg,		
5mg, 10mg			175mcg, 200mcg, 300mcg		
megestrol acetate SUSP	Tier 2		VITAMIN D ANALOGS		
40mg/ml			calcitriol (generic of	Tier 1	B/D
norethindrone acetate	Tier 2		ROCALTROL) CAPS		
(generic of AYGESTIN)			.25mcg, .5mcg		
TABS 5mg			calcitriol SOLN 1mcg/ml	Tier 3	
THYROID AGENTS	T' 4		calcitriol (generic of	Tier 3	B/D
euthyrox (generic of	Tier 1		ROCALTROL) SOLN		
SYNTHROID) TABS 25mcg, 50mcg, 75mcg,			1mcg/ml	Tier 3	B/D
88mcg, 100mcg, 112mcg,			paricalcitol (generic of ZEMPLAR) CAPS 1mcg,	ner 3) Б / D
125mcg, 137mcg, 150mcg,			2mcg		
175mcg, 200mcg			paricalcitol CAPS 4mcg	Tier 3	B/D
levo-t (generic of	Tier 1		RAYALDEE CPCR 30mcg	Tier 2	
SYNTHROID) TABS			GASTROINTESTINAL		
25mcg, 50mcg, 75mcg,			ANTIEMETICS		
88mcg, 100mcg, 112mcg,			aprepitant CAPS 40mg,	Tier 3	B/D
125mcg, 137mcg, 150mcg,			125mg		_,_
175mcg, 200mcg, 300mcg	Tion 4		aprepitant (generic of	Tier 3	B/D
levothyroxine sodium (generic of SYNTHROID)	Tier 1		EMEND) CAPS 80mg		
TABS 25mcg, 50mcg,			aprepitant capsule therapy	Tier 3	B/D
75mcg, 88mcg, 100mcg,			pack 80 & 125 mg		
112mcg, 125mcg, 137mcg,			compro SUPP 25mg	Tier 3	
150mcg, 175mcg, 200mcg,			dronabinol (generic of	Tier 3	B/D QL
300mcg			MARINOL) CAPS 2.5mg,		
levoxyl (generic of	Tier 1		5mg, 10mg	`	
SYNTHROID) TABS			QL (60 caps / 30 days meclizine hcl TABS) Tier 1	
25mcg, 50mcg, 75mcg,			12.5mg, 25mg	Hell	
88mcg, 100mcg, 112mcg,			metoclopramide hcl SOLN	Tier 2)
125mcg, 137mcg, 150mcg, 175mcg, 200mcg			5mg/5ml, 5mg/ml	1161 2	•
liothyronine sodium (generi	cTier 2		metoclopramide hcl (generi	cTier 1	
of CYTOMEL) TABS 5mcg			of REGLAN) TABS 5mg,	•	
25mcg, 50mcg	,		_10mg		

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
ondansetron TBDP 4mg, 8mg	Tier 2	B/D	nizatidine CAPS 150mg, 300mg	Tier 3	3
ondansetron hcl SOLN	Tier 2		INFLAMMATORY BOWE	EL DIS	SEASE
4mg/2ml, 40mg/20ml			balsalazide disodium	Tier 2	2
ondansetron hcl (generic of ZOFRAN) TABS 4mg			(generic of COLAZAL) CAPS 750mg		
ondansetron hcl TABS 8mg, 24mg	Tier 2		budesonide (generic of ENTOCORT EC) CPEP	Tier 3	B PA
prochlorperazine SUPP	Tier 3		3mg		
25mg	 :		budesonide (generic of	Tier 1	I PA
prochlorperazine edisylate	Tier 3		UCERIS) TB24 9mg	T: 6	
SOLN 10mg/2ml prochlorperazine maleate	Tier 1		hydrocortisone (intrarectal) (generic of CORTENEMA)	l ier 3	3
TABS 5mg, 10mg	1101 1		ENEM 100mg/60ml		
promethazine hcl (generic o	fTier 2	PA	mesalamine (generic of	Tier 3	3 QL
PHENERGAN) SÖLN			APRISO) CP24 .375gm		
25mg/ml, 50mg/ml			QL (120 caps / 30		
PA if 70 years and older			days)		
promethazine hcl SYRP	Tier 2	PA	mesalamine (generic of	Tier 3	3 QL
6.25mg/5ml; TABS 12.5mg,			DELZICOL) CPDR 400mg		
25mg, 50mg PA if 70 years and older			QL (180 caps / 30 days)		
scopolamine (generic of	Tier 3	QL PA	mesalamine ENEM 4gm	Tier 3	3
TRANSDERM SCOP)	1101 0	QLIT	mesalamine (generic of	Tier 3	
PT72 1mg/3days			CANASA) SUPP 1000mg		
QL (10 patches / 30			mesalamine (generic of	Tier 3	3 QL
days)			LIALDA) TBEC 1.2gm		
PA if 70 years and older			QL (120 tabs / 30		
ANTISPASMODICS	T: 0		days)	<u> </u>	
dicyclomine hcl CAPS	Tier 2		mesalamine w/ cleanser	Tier 3	3
10mg; TABS 20mg dicyclomine hcl SOLN	Tier 3		(generic of ROWASA) KIT		
10mg/5ml	1161 3		4gm sulfasalazine (generic of	Tier 1	 I
glycopyrrolate TABS 1mg,	Tier 2		AZULFIDINE) TABS 500m		
2mg			sulfasalazine (generic of	Tier 2	2
H2-RECEPTOR ANTAGO	ONIST	S	AZULFIDINE EN-TABS)		
famotidine SOLN	Tier 2		TBEC 500mg		
20mg/2ml, 40mg/4ml,			LAXATIVES		
			constulose SOLN	Tier 2	2
famotidine (generic of	Tier 1	QL	10gm/15ml	T: 6	
PEPCID) TABS 20mg			enulose SOLN 10gm/15ml		
QL (120 tabs / 30 days)			gavilyte-c	Tier 1	
famotidine (generic of	Tier 1	QL	gavilyte-g (generic of	Tier 1	
PEPCID) TABS 40mg			GOLYTELY) gavilyte-n/flavor pack	Tier 1	
QL (60 tabs / 30 days)			(generic of NULYTELY)	ilei	I
famotidine in nacl 0.9% iv	Tier 2		generlac SOLN 10gm/15m	l Tier 2)
soln 20 mg/50ml			GOLYTELY SOL	Tier 2	
				01 2	

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
lactulose SOLN 10gm/15n			ursodiol (generic of URSO	Tier 3	3
lactulose (encephalopathy)) Tier 2	2	FORTE) TABS 500mg	Tior	2QL NM LA PA
SOLN 10gm/15ml NULYTELY SOL LMN/LIM	E Tior (<u> </u>	XERMELO TABS 250mg QL (90 tabs / 30 days)		ZQL NIVI LA PA
			XIFAXAN TABS 550mg	Tier 2	2 PA
peg 3350-kcl-na bicarb-na na sulfate for soln 236 gm	ci- i iei	I	PANCREATIC ENZYME		
(generic of GOLYTELY)			CREON CAP 3000UNIT	Tier 2	
peg 3350-kcl-sod bicarb-	Tier '	1	CREON CAP 6000UNIT	Tier 2	
nacl for soln 420 gm			CREON CAP 12000UNT	Tier 2	
(generic of NULYTELY)			CREON CAP 24000UNT	Tier 2	
PLENVU SOL	Tier 3	3	CREON CAP 36000UNT	Tier 2	
SUPREP BOWEL SOL	Tier 3	3	ZENPEP CAP 3000UNIT	Tier 3	
PREP KIT			ZENPEP CAP 5000UNIT	Tier 3	
trilyte (generic of	Tier '	1	ZENPEP CAP 10000UNT	Tier 3	
NULYTELY) MISCELLANEOUS			ZENPEP CAP 15000UNT	Tier 3	
	Tier '	1 QL PA	ZENPEP CAP 20000UNT	Tier 3	
alosetron hcl (generic of LOTRONEX) TABS 1mg	Hei	I QLFA	ZENPEP CAP 25000	Tier 3	
QL (60 tabs / 30 days)		ZENPEP CAP 40000	Tier 3	
alosetron hcl (generic of	Tier 3	3 QL PA	PROTON PUMP INHIBIT		
LOTRONEX) TABS .5mg			DEXILANT CPDR 30mg,	Tier 3	3 QL
QL (60 tabs / 30 days			60mg	1101	g QL
cromolyn sodium	Tier 3	3	QL (30 caps / 30 days)	
(mastocytosis) (generic of			lansoprazole CPDR 15mg	Tier 2	2 QL
GASTROCROM) CONC 100mg/5ml			QL (60 caps / 30 days		
diphenoxylate w/ atropine	Tier 2)	lansoprazole (generic of	Tier 2	2 QL
tab 2.5-0.025 mg (generic		_	PREVACID) CPDR 30mg	`	
LOMOTIL)			QL (60 caps / 30 days omeprazole CPDR 10mg,) Tier ′	 1
GATTEX KIT 5mg	Tier 2	2 NM LA PA	20mg, 40mg	1161	ı
LINZESS CAPS 72mcg,	Tier 3	3 QL	pantoprazole sodium	Tier 2	>
145mcg, 290mcg			(generic of PROTONIX)		_
QL (30 caps / 30 days			SOLR 40mg		
loperamide hcl CAPS 2mg			pantoprazole sodium	Tier '	1
misoprostol (generic of	Tier 2	2	(generic of PROTONIX)		
CYTOTEC) TABS 100mcg 200mcg	,		TBEC 20mg, 40mg		
MOVANTIK TABS 12.5mg	Tier 2	2 QL	GENITOURINARY	VDED	DI 4014
QL (60 tabs / 30 days		e QL	BENIGN PROSTATIC H		
MOVANTIK TABS 25mg	Tier 2	2 QL	alfuzosin hcl (generic of UROXATRAL) TB24 10mg	Tier '	1 QL
QL (30 tabs / 30 days)		QL (30 tabs / 30 days)		
RELISTOR SOLN	Tier 2	2 PA	dutasteride (generic of	Tier 2	2 QL
8mg/0.4ml, 12mg/0.6ml			AVODART) CAPS .5mg		_
sucralfate (generic of	Tier 2	2	QL (30 caps / 30 days)	
CARAFATE) TABS 1gm	T: 1		finasteride (generic of	Tier '	1
ursodiol CAPS 300mg	Tier 2		PROSCAR) TABS 5mg		
ursodiol (generic of URSO	Tier 3	3			
250) TABS 250mg					

Iamsulosin hcl (generic of Tier 1 FLOMAX) CAPS. 4mg MISCELLANEOUS acetic acid SOLN. 25% Tier 1 bethanechol chlorider TABS Tier 2 20mg QL (60 tabs / 30 days) CLEOCIN, 25% Tier 1 bethanechol chlorider TABS Tier 2 25mg, 10mg, 25mg, 50mg potassium citrate Tier 3 (alkalinizer) (generic of UROCIT-K 15) TBCR 15mg potassium citrate Tier 3 (alkalinizer) (generic of UROCIT-K 15) TBCR 15mg potassium citrate Tier 3 (alkalinizer) (generic of UROCIT-K 10) TBCR 10ROCIT-K 10) TBCR	Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
acetic acid SOLN.25% Tier 1 bethanechol chloride TABS Tier 2 Sing, 10mg, 25mg, 50mg potassium citrate Tier 3 (alkalinizer) (generic of (Tier 1		•	Tier 2	2 QL
Dethanechol chloride TABS Tier 2 Sing, 10mg, 25mg, 50mg Somg potassium citrate	MISCELLANEOUS			QL (60 tabs / 30 days	5)	
5mg, 10mg, 25mg, 50mg vaginal (generic of classium citrate vaginal (generic of URCCIT-K 15) TBCR 15meq Tier 3 (alkalinizer) (generic of URCCIT-K 15) TBCR terconazole vaginal GEL Tier 2 15meq terconazole vaginal CREA Tier 2 potassium citrate Tier 3 (alkalinizer) (generic of URCCIT-K 5) TBCR 540mg terconazole vaginal CREA Tier 2 potassium citrate Tier 3 (alkalinizer) (generic of URCCIT-K 10) TBCR HEMATOLOGIC 1080mg HEMATOLOGIC MYRBETRIQ TB24 25mg, Tier 3 (1800mg) ELIQUIS TABS 2.5mg Tier 2 QL QL (60 tabs / 30 days) Oxybutynin chloride SYRP Tier 2 5mg/5ml; TABS 5mg QL (30 tabs / 30 days) Oxybutynin chloride (generic Tier 2 of DITROPAN XL) TB24 QL (30 tabs / 30 days) 5mg QL (30 tabs / 30 days) Oxybutynin chloride (generic Tier 2 of DITROPAN XL) TB24 Oxybutynin chloride (generic Tier 2 of DITROPAN XL) TB24 Oxybutynin chloride (generic Tier 2 of DITROPAN XL) TB24 Oxybutynin chloride TB24 Tier 2 of DITROPAN XL) TB24 Tier 3 (generic of VESICARE) Tondaparinux sodium (generic Tier 3 of LOVENOX) SOLN OL (50 tabs / 30 days) Torodaparinux sodium (porcine) Tier 1 (generic of ARIXTRA) SOLN 5mg/0.4ml, SOLN 5	acetic acid SOLN .25%	Tier 1		VAGINAL ANTI-INFECT	<i>TVES</i>	
(alkalinizer) (generic of UROCIT-K15) TBCR 15meq potassium citrate Tier 3 (alkalinizer) (generic of UROCIT-K5) TBCR 540mg potassium citrate (alkalinizer) (generic of UROCIT-K5) TBCR 540mg potassium citrate (alkalinizer) (generic of UROCIT-K10) TBCR 1080mg DATE OF ORDER STANDOR		S Tier 2	2	vaginal (generic of	Tier 2	2
UROCIT-K15 TBCR 15meq	•	Tier 3	3			
Dotassium citrate	UROCIT-K 15) TBCR			75%		
Alkalinizer) (generic of UROCIT-K 5) TBCR 540mg					lierz	2
DROCIT-K 5) TBCR 540mg	•	Tier 3	3		T : 4	
Dotassium citrate (alkalinizer) (generic of UROCIT-K10) TBCR					l ier 2	2
Calkalinizer) (generic of UROCIT-K 10) TBCR						
URINARY ANTISPASMODICS		l ier 3	3	-		_
1080mg				•		2 QL
URINARY ANTISPASMODICS QL (74 tabs / 30 days) MYRBETRIQ TB24 25mg, Tier 3 QL QL (74 tabs / 30 days) QL (74 tabs / 30 days) SOMB QL (30 tabs / 30 days) QL (74 tabs / 30 days) QL (74 tabs / 30 days) Oxybutynin chloride SYRP Tier 2 5mg/5ml; TABS 5mg QL (30 tabs / 30 days) QL (74 tabs / 30 days) Oxybutynin chloride (generic Tier 2 5mg QL (30 tabs / 30 days) QL (30 tabs / 30 days) Oxybutynin chloride (generic Tier 2 of DITROPAN XL) TB24 QL (60 tabs / 30 days) 150mg/ml, 300mg/3ml Oxybutynin chloride TB24 Tier 2 OL 15mg QL (60 tabs / 30 days) (generic of ARIXTRA) Oxybutynin chloride TB24 Tier 2 QL (generic of VESICARE) QL (30 tabs / 30 days) Tier 1 (generic of ARIXTRA) Solifenacin succinate (generic Tier 3 QL (30 tabs / 30 days) Tier 2 QL HEP SOD/NACL INJ Tier 2 (generic Tier 2 (generic Tier 3 of DETROL LA) CP24 2mg, 4mg QL (30 caps / 30 days) Aug Tier 2 DL (and the parin sodium (porcine) Tier 2 (punit/ml in d5w) Tier 2 Dl (and the parin sodium (porcine) Tier 2 (punit/ml in d5w) Tier 2 Dl (and the parin sodium (porcine) Tier 2 (punit/ml and the parin sodium						
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TBPK 5mg						
QL (30 tabs / 30 days) QL (74 tabs / 30 days) oxybutynin chloride SYRP Tier 2 enoxaparin sodium (generic Tier 3 of LOVENOX) SOLN 5mg/5ml; TABS 5mg 30mg/0.3ml, 40mg/0.4ml, of DITROPAN XL) TB24 5mg 100mg/nl, 120mg/0.8ml, 100mg/ml, 120mg/0.8ml, 100mg/ml, 300mg/3ml oxybutynin chloride (generic Tier 2 of DITROPAN XL) TB24 QL (60 tabs / 30 days) 10mg SOLN 2.5mg/0.5ml QL (60 tabs / 30 days) fondaparinux sodium Oxybutynin chloride TB24 Tier 2 QL 15mg (generic of ARIXTRA) QL (60 tabs / 30 days) SOLN 2.5mg/0.5ml fondaparinux sodium Tier 1 (generic of ARIXTRA) SOLN 5mg/0.4ml, 7.5mg/0.6ml, 10mg/0.8ml sollifenacin succinate Tier 2 QL (generic of VESICARE) 1EF SOD/NACL INJ Tier 2 TABS 5mg, 10mg 25000UNT 1Er 2 QL (30 tabs / 30 days) 25000UNT 1Er 2 OLN 1000unit/ml, 1000unit/	9.	Her 3	3 QL		Tier 2	2 QL
oxybutynin chloride SYRP Tier 2 5mg/5ml; TABS 5mg oxybutynin chloride (generic Tier 2 QL of DITROPAN XL) TB24 5mg QL (30 tabs / 30 days) oxybutynin chloride (generic Tier 2 QL of DITROPAN XL) TB24 5mg QL (30 tabs / 30 days) Oxybutynin chloride (generic Tier 2 QL of DITROPAN XL) TB24 10mg QL (60 tabs / 30 days) QL (60 tabs / 30 days) Oxybutynin chloride TB24 Tier 2 QL 15mg QL (60 tabs / 30 days) Solifenacin succinate QL (30 tabs / 30 days) TABS 5mg, 10mg QL (30 tabs / 30 days) TOBETROL LA) CP24 2mg, 4mg QL (30 caps / 30 days) tolterodine tartrate (generic Tier 3 QL ST of DETROL LA) CP24 2mg, 4mg QL (60 tabs / 30 days) TOVIAZ TB24 4mg, 8mg Tier 2 QL To QL TABS 5mg Oxphatin (generic Tier 3 of LOVENOX) SOLN 30mg/0.8ml, 100mg/0.8ml, 150mg/0.6ml, 10mg/0.8ml Tier 1 (generic of ARIXTRA) SOLN 10mg/0.8ml Tier 1 (generic of ARIXTRA) SOLN 5mg/0.6ml, 10mg/0.8ml Tier 2 (generic of VESICARE) Theparin sodium (porcine) Tier 2 SOUN 1000unit/ml, 10000unit/ml, 10000unit/ml, 10000unit/ml, 1000unit/ml, 10000unit/ml, 10000unit/ml, 1000unit/ml of 5w Tier 2 dextrose iv sol 20000unit/500ml-5% Theparin sodium (porcine) Tier 2 dextrose iv sol 25000 Tier 2 dextrose iv sol 25000)		9	3	
5mg/5ml; TABS 5mg of LOVENOX) SOLN 0xybutynin chloride (generic Tier 2 of DITROPAN XL) TB24 30mg/0.3ml, 40mg/0.4ml, 60mg/0.8ml, 100mg/nl, 120mg/0.8ml, 100mg/ml, 120mg/0.8ml, 150mg/ml, 300mg/3ml 0xybutynin chloride (generic Tier 2 of DITROPAN XL) TB24 QL (60 tabs / 30 days) Tier 3 (generic of ARIXTRA) 15mg QL (60 tabs / 30 days) QL (60 tabs / 30 days) Tier 1 (generic of ARIXTRA) 0xybutynin chloride TB24 Tier 2 OL (generic of Vesicane) QL (60 tabs / 30 days) Tier 1 (generic of ARIXTRA) 15mg QL (60 tabs / 30 days) Tomdaparinux sodium (generic of ARIXTRA) Tier 1 (generic of ARIXTRA) 15mg QL (30 tabs / 30 days) Tomg/0.6ml, 10mg/0.8ml 15mg QL (30 tabs / 30 days) Tomg/0.6ml, 10mg/0.8ml 15mg QL (30 tabs / 30 days) Tomg/0.6ml, 10mg/0.8ml 15mg QL (30 tabs / 30 days) Tomg/0.6ml, 10mg/0.8ml 15mg QL (30 tabs / 30 days) Tomg/0.6ml, 10mg/0.8ml 15mg QL (30 tabs / 30 days) Tomg/0.6ml, 10mg/0.8ml 15mg QL (30 tabs / 30 days) Tomg/0.6ml, 10mg/0.8ml 15mg QL (30 tabs / 30 days) Tomg/0.6ml, 10mg/0.8ml 15mg QL (30 tabs / 30 days) Tomg/0.6ml, 10mg/0.8ml 15mg QL (30 tabs / 30 days) Tomg/0.6ml, 10mg/0.8ml 15mg QL (30			<u> </u>			3
of DITROPAN XL) TB24 60mg/0.6ml, 80mg/0.8ml, 100mg/ml, 120mg/0.8ml, 100mg/ml, 120mg/0.8ml, 150mg/ml, 300mg/3ml oxybutynin chloride (generic Tier 2 of DITROPAN XL) TB24 10mg QL (60 tabs / 30 days) QL (60 tabs / 30 days) Generic of ARIXTRA) oxybutynin chloride TB24 Tier 2 Oxybutynin chloride TB24 Tier 2 (generic of VESICARE) QL (60 tabs / 30 days) Tier 1 (generic of ARIXTRA) solifenacin succinate (generic Tier 3 Oxybutynin chloride TB24 Tier 2 QL QL (30 tabs / 30 days) HEP SOD/NACL INJ Tier 2 (generic of VESICARE) TABS 5mg, 10mg QL (30 tabs / 30 days) QL (30 tabs / 30 days) DOUNT To Dounit/ml, 10000unit/ml, 10000unit/ml, 10000unit/ml, 10000unit/ml, 10000unit/ml DOUNT Tier 2 Dounit/ml in d5w tolterodine tartrate (generic Tier 3 of DETROL) TABS 1mg, 2mg QL (60 tabs / 30 days) QL ST Oxybutynin chloride Tier 2 QL ST Oxybutynin chloride Tier 3 QL ST Oxybutyni	5mg/5ml; TABS 5mg					,
5mg 100mg/ml, 120mg/0.8ml, 150mg/ml, 300mg/3ml oxybutynin chloride (generic Tier 2 of DITROPAN XL) TB24 QL (60 tabs / 30 days) fondaparinux sodium (generic of ARIXTRA) 10mg QL (60 tabs / 30 days) SOLN 2.5mg/0.5ml 0xybutynin chloride TB24 Tier 2 OL 15mg QL (60 tabs / 30 days) (generic of ARIXTRA) Solifenacin succinate Tier 2 (generic of VESICARE) QL (60 tabs / 30 days) Tier 2 (generic of VESICARE) TABS 5mg, 10mg QL (30 tabs / 30 days) 100 unit/ml (porcine) Tier 2 (ponding tartrate (generic Tier 3)	, ,	cTier 2	2 QL			
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oxybutynin chloride (generic Tier 2 of DITROPAN XL) TB24 fondaparinux sodium (generic of ARIXTRA) Tier 3 10mg QL (60 tabs / 30 days) QL (60 tabs / 30 days) SOLN 2.5mg/0.5ml Tier 1 0xybutynin chloride TB24 Tier 2 15mg QL (60 tabs / 30 days) QL (60 tabs / 30 days) QL (generic of ARIXTRA) SOLN 5mg/0.4ml, Tier 1 15mg QL (60 tabs / 30 days) Tier 2 QL (generic of VESICARE) HEP SOD/NACL INJ Tier 2 Tier 2 15mg QL (30 tabs / 30 days) Tier 2 QL (generic Tier 3 OL ST of DETROL LA) CP24 2mg, 4mg QL (30 caps / 30 days) AUST of DETROL TABS 1mg, 2mg QL (60 tabs / 30 days) QL ST of DETROL) TABS 1mg, 2mg QL (60 tabs / 30 days) QL ST of DETROL TABS 1mg, 2mg QL (60 tabs / 30 days) QL ST of DETROL TABS 1mg, 2mg QL (60 tabs / 30 days) QL ST of DETROL TABS 1mg, 2mg Tier 2 QL Augentic of ARIXTRA) (generic of				5 . 5 .		
of DITROPAN XL) TB24 (generic of ARIXTRA) 10mg QL (60 tabs / 30 days) SOLN 2.5mg/0.5ml oxybutynin chloride TB24 Tier 2 QL (generic of ARIXTRA) 15mg SOLN 5mg/0.4ml, Tor 2 QL (60 tabs / 30 days) Tier 2 QL solifenacin succinate Tier 2 QL (generic of VESICARE) Tier 2 25000UNT TABS 5mg, 10mg AL (30 tabs / 30 days) Aparin sodium (porcine) Tier 2 B/D Volterodine tartrate (generic Tier 3 QL ST 5000unit/ml, 10000unit/ml, 5000unit/ml, 10000unit/ml, 1000unit/ml, 1000unit/ml 5000unit/ml 45w tolterodine tartrate (generic Tier 3 QL ST Aparin sodium (porcine) Tier 2 of DETROL) TABS 1mg, 2mg QL (60 tabs / 30 days) Aparin sodium (porcine) Tier 2 TOVIAZ TB24 4mg, 8mg Tier 2 QL						_
10mg		c lier 2	2 QL		Tier 3	3
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oxybutynin chloride TB24 Tier 2 QL (generic of ARIXTRA) 15mg QL (60 tabs / 30 days) 7.5mg/0.6ml, 10mg/0.8ml solifenacin succinate Tier 2 QL (generic of VESICARE) 1 HEP SOD/NACL INJ Tier 2 TABS 5mg, 10mg 2 25000UNT Tier 2 B/D QL (30 tabs / 30 days) SOLN 1000unit/ml, 5000unit/ml, 10000unit/ml, 5000unit/ml, 10000unit/ml, 20000unit/ml 10000unit/ml Tier 2 10000unit/ml Tier 2 40000unit/ml Tier 2 10000unit/ml Tier 2 40000unit/ml Tier 2 40000unit/ml Tier 2 40000unit/ml 40000unit/ml Tier 2 40000unit/ml Tier 2 40000unit/ml 40000unit/ml Tier 2 40000unit/ml 40000unit/m		`				
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QL (60 tabs / 30 days)7.5mg/0.6ml, 10mg/0.8mlsolifenacin succinate (generic of VESICARE)Tier 2 25000UNTTABS 5mg, 10mg QL (30 tabs / 30 days)heparin sodium (porcine) SOLN 1000unit/ml, 5000unit/ml, 10000unit/ml, 20000unit/mlTier 2 B/Dtolterodine tartrate (generic Tier 3 QL (30 caps / 30 days)QL ST 100 unit/ml in d5w5000unit/ml (porcine) 100 unit/ml in d5wtolterodine tartrate (generic Tier 3 of DETROL) TABS 1mg, 2mg 	, ,	i ier z	2 QL			
solifenacin succinate (generic of VESICARE)Tier 2 25000UNTHEP SOD/NACL INJ 25000UNTTier 2 25000UNTTABS 5mg, 10mg QL (30 tabs / 30 days)heparin sodium (porcine) SOLN 1000unit/ml, 5000unit/ml, 10000unit/ml, 20000unit/mlTier 2 B/D4mg QL (30 caps / 30 days)20000unit/ml heparin sodium (porcine) 100 unit/ml in d5wtolterodine tartrate (generic Tier 3 of DETROL) TABS 1mg, 2mg QL (60 tabs / 30 days)QL ST dextrose iv sol 20000 unit/500ml-5%Tier 2 dextrose iv sol 25000TOVIAZ TB24 4mg, 8mgTier 2QL		`				
(generic of VESICARE) 25000UNT TABS 5mg, 10mg heparin sodium (porcine) Tier 2 B/D QL (30 tabs / 30 days) SOLN 1000unit/ml, 5000unit/ml, 10000unit/ml, 5000unit/ml, 10000unit/ml, 10000unit/ml, 10000unit/ml <) OI		Tior	<u> </u>
TABS 5mg, 10mg QL (30 tabs / 30 days) tolterodine tartrate (generic Tier 3 QL ST of DETROL LA) CP24 2mg, 4mg QL (30 caps / 30 days) tolterodine tartrate (generic Tier 3 QL ST of DETROL) TABS 1mg, QL (60 tabs / 30 days) TOVIAZ TB24 4mg, 8mg Tier 2 QL heparin sodium (porcine) SOLN 1000unit/ml, 10000unit/ml, 20000unit/ml, 10000unit/ml, 10000unit/ml		11612	. QL		i iei z	2
QL (30 tabs / 30 days) tolterodine tartrate (generic Tier 3 QL ST of DETROL LA) CP24 2mg, 4mg QL (30 caps / 30 days) tolterodine tartrate (generic Tier 3 QL ST of DETROL) TABS 1mg, 2mg QL (60 tabs / 30 days) TOVIAZ TB24 4mg, 8mg Tier 2 QL SOLN 1000unit/ml, 5000unit/ml, 10000unit/ml, 20000unit/ml in d5w heparin sodium (porcine) 1ier 2 dextrose iv sol 20000 unit/500ml-5% heparin sodium (porcine) Tier 2 dextrose iv sol 25000	,				Tior '	2 B/D
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of DETROL LA) CP24 2mg, 4mg			B QLST			
4mgheparin sodium (porcine)Tier 2QL (30 caps / 30 days)100 unit/ml in d5wtolterodine tartrate (generic Tier 3 of DETROL) TABS 1mg,QL STheparin sodium (porcine)- dextrose iv sol 20000 unit/500ml-5%Tier 2QL (60 tabs / 30 days)heparin sodium (porcine)- unit/500ml-5%Tier 2TOVIAZ TB24 4mg, 8mgTier 2QL						
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of DETROL) TABS 1mg, 2mg QL (60 tabs / 30 days) TOVIAZ TB24 4mg, 8mg Tier 2 QL dextrose iv sol 20000 unit/500ml-5% heparin sodium (porcine)- dextrose iv sol 25000	QL (30 caps / 30 days	•		100 unit/ml in d5w		
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QL (60 tabs / 30 days)heparin sodium (porcine)- dextrose iv sol 25000Tier 2	, -					
TOVIAZ TB24 4mg, 8mg Tier 2 QL dextrose iv sol 25000		`				
			<u> </u>		Tier 2	2
<u>unit/500ml-5%</u>	3 , 3		2 QL			
	QL (30 tabs / 30 days)		unit/500ml-5%		_

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Requirements/ Tier Limits
HEPARIN/NACL INJ 25000UNT	Tier 2)	HAEGARDA SOLR 3000unit	Tier 2QL NM LA PA
jantoven TABS 1mg, 2mg,	Tier 1		QL (20 vials / 30 days	3)
2.5mg, 3mg, 4mg, 5mg,			icatibant acetate (generic d	•
6mg, 7.5mg, 10mg			FIRAZYR) SOLN 30mg/3n	
PRADAXA CAPS 75mg,	Tier 3	3 QL	QL (9 syringes / 30	
150mg			days)	
QL (60 caps / 30 days			pentoxifylline TBCR 400m	V
PRADAXA CAPS 110mg	Tier 3	3 QL	PROMACTA PACK 12.5m	g Tier 2QL NM LA PA
QL (120 caps / 30			QL (360 packets / 30	
days)	T: /		days)	
warfarin sodium TABS	Tier '		PROMACTA PACK 25mg	Tier 2QL NM LA PA
1mg, 2mg, 2.5mg, 3mg,			QL (180 packets / 30	
4mg, 5mg, 6mg, 7.5mg, 10mg			days) PROMACTA TABS	Tier 2QL NM LA PA
XARELTO TABS 2.5mg	Tier 2	QL	12.5mg, 25mg	TIELZQL NIVI LA PA
QL (60 tabs / 30 days)		. QL	QL (30 tabs / 30 days)
XARELTO TABS 10mg,	Tier 2	2 QL	PROMACTA TABS 50mg,	
15mg, 20mg			75mg	1101 2 Q2 14111 27 11 7 1
QL (30 tabs / 30 days))		QL (60 tabs / 30 days)
XARELTO STAR TAB	Tier 2	QL	tranexamic acid (generic o	
15/20MG			CYKLOKAPRON) SOLN	
QL (51 tabs / 30 days)				
HEMATOPOIETIC GRO			tranexamic acid (generic o	f Tier 2
PROCRIT SOLN	Tier 2	NM PA	LYSTEDA) TABS 650mg	
2000unit/ml, 3000unit/ml,			PLATELET AGGREGAT	
4000unit/ml, 10000unit/ml	-		aspirin-dipyridamole cap e	r Tier 3
PROCRIT SOLN	Tier 2	NM PA	12hr 25-200 mg	
20000unit/ml, 40000unit/ml		NIM DA	BRILINTA TABS 60mg,	Tier 3
ZARXIO SOSY	Tier 2	NM PA	90mg	
300mcg/0.5ml, 480mcg/0.8ml			clopidogrel bisulfate	Tier 1
MISCELLANEOUS			(generic of PLAVIX) TABS	
anagrelide hcl CAPS 1mg	Tier 3	<u> </u>	75mg dipyridamole TABS 25mg,	Tier 2 PA
			50mg, 75mg	Heiz FA
anagrelide hcl (generic of AGRYLIN) CAPS .5mg	Tier 3	3	PA if 70 years and older	
BERINERT KIT 500unit	Tior	QL NM LA PA	prasugrel hcl (generic of	Tier 2
QL (24 boxes / 30	1 101 2	QLINIVILATA	EFFIENT) TABS 5mg,	1101 2
days)			10mg	
cilostazol TABS 50mg,	Tier 1		IMMUNOLOGIC AGENT	S
100mg			AUTOIMMUNE AGENTS	3
DOPTELET TABS 20mg	Tier 2	NM LA PA	ENBREL SOLN	Tier 2 QL NM PA
DROXIA CAPS 200mg,	Tier 2	<u> </u>	25mg/0.5ml; SOLR 25mg	
300mg, 400mg			QL (16 vials / 28 days	3)
ENDARI PACK 5gm	Tier 2	NM LA PA	ENBREL SOSY	Tier 2 QL NM PA
HAEGARDA SOLR	Tier 2	QL NM LA PA	25mg/0.5ml	
2000unit			QL (16 syringes / 28	
QL (30 vials / 30 days)		days)	

Drug Name	Drug I Tier	Requirements/ Limits	Drug Name	Drug I Tier	Requirements/ Limits
ENBREL SOSY 50mg/ml QL (8 syringes / 28 days)	Tier 2	QL NM PA	STELARA SOLN 45mg/0.5ml QL (2 vials / 28 days)	Tier 20	QL NM LA PA
ENBREL MINI SOCT 50mg/ml QL (8 cartridges / 28 days)	Tier 2	QL NM PA	STELARA SOSY 45mg/0.5ml, 90mg/ml QL (1 syringe / 28 days)	Tier 2	QL NM PA
ENBREL SURECLICK SOAJ 50mg/ml QL (8 pens / 28 days) HUMIRA PSKT	Tier 2	QL NM PA	TALTZ SOAJ 80mg/ml; SOSY 80mg/ml QL (3 syringes / 28 days)	Tier 20	QL NM LA PA
10mg/0.1ml, 20mg/0.2ml QL (2 syringes / 28	Hel Z	QLINIVIFA	XELJANZ SOLN 1mg/ml QL (240 mL / 24 days)		QL NM PA
days) HUMIRA PSKT 40mg/0.4ml, 40mg/0.8ml	Tier 2	QL NM PA	XELJANZ TABS 5mg, 10mg QL (60 tabs / 30 days)		QL NM PA
QL (6 syringes / 28 days) HUMIRA PEDIA INJ	Tier 2	NM PA	XELJANZ XR TB24 11mg, 22mg	Tier 2	QL NM PA
CROHNS			QL (30 tabs / 30 days) DISEASE-MODIFYING A	NTI-RI	HEUMATIC
HUMIRA PEDIATRIC CROHNS D PSKT 80mg/0.8ml	Tier 2	NM PA	DRUGS (DMARDS) hydroxychloroquine sulfate (generic of PLAQUENIL)	Tier 2	
HUMIRA PEN PNKT 40mg/0.4ml, 40mg/0.8ml QL (6 pens / 28 days)	Tier 2	QL NM PA	TABS 200mg Ieflunomide (generic of ARAVA) TABS 10mg,	Tier 2	QL
HUMIRA PEN PNKT 80mg/0.8ml	Tier 2	QL NM PA	20mg QL (30 tabs / 30 days)		
QL (4 pens / 28 days) HUMIRA PEN KIT PS/UV	Tier 2	NM PA	methotrexate sodium TABS 2.5mg	3 Tier 2	
HUMIRA PEN-CD/UC/HS START PNKT 40mg/0.8ml, 80mg/0.8ml	Tier 2	NM PA	XATMEP SOLN 2.5mg/ml IMMUNOGLOBULINS	Tier 3	B/D
HUMIRA PEN-PEDIATRIC UC S PNKT 80mg/0.8ml	Tier 2	NM PA	BIVIGAM SOLN 5gm/50ml FLEBOGAMMA DIF SOLN 2.5gm/50ml, 5gm/100ml,		NM PA NM PA
HUMIRA PEN-PS/UV STARTER PNKT 40mg/0.8ml	Tier 2	NM PA	5gm/50ml, 10gm/100ml, 10gm/200ml, 20gm/200ml, 20gm/400ml		
RINVOQ TB24 15mg QL (30 tabs / 30 days)		QL NM PA	GAMASTAN INJ GAMMAGARD LIQUID	Tier 3	B/D NM NM PA
SKYRIZI PSKT 75mg/0.83ml QL (7 kits / 365 days) SKYRIZI SOSY 150mg/ml	Tier 2	QL NM PA	SOLN 1gm/10ml, 2.5gm/25ml, 5gm/50ml, 10gm/100ml, 20gm/200ml, 30gm/300ml	rier z	NW PA
QL (7 syringes / year) SKYRIZI PEN SOAJ 150mg/ml QL (7 pens / year)	Tier 2	QL NM PA	GAMMAGARD S/D IGA LESS TH SOLR 5gm, 10gm	Tier 2	NM PA

Drug Name	Drug Tier	Requirements/ Limits
GAMMAKED SOLN	Tier 2	NM PA
1gm/10ml, 5gm/50ml,		
10gm/100ml, 20gm/200ml		
GAMMAPLEX SOLN	Tier 2	NM PA
5gm/100ml, 5gm/50ml,		
10gm/100ml, 10gm/200ml,		
20gm/200ml, 20gm/400ml		
GAMUNEX-C SOLN	Tier 2	NM PA
1gm/10ml, 2.5gm/25ml,		
5gm/50ml, 10gm/100ml,		
20gm/200ml, 40gm/400ml		
OCTAGAM SOLN	Tier 2	NM PA
1gm/20ml, 2gm/20ml,		
2.5gm/50ml, 5gm/100ml,		
5gm/50ml, 10gm/100ml,		
10gm/200ml, 20gm/200ml,		
25gm/500ml, 30gm/300ml		
PANZYGA SOLN	Tier 2	NM PA
1gm/10ml, 2.5gm/25ml,		
5gm/50ml, 10gm/100ml,		
20gm/200ml, 30gm/300ml		
PRIVIGEN SOLN	Tier 2	NM PA
5gm/50ml, 10gm/100ml,		
20gm/200ml, 40gm/400ml		
<u>IMMUNOMODULATORS</u>		
ACTIMMUNE SOLN	Tier 2	NM LA PA
2000000unit/0.5ml		
ARCALYST SOLR 220mg	Tier 2	NM PA
INTRON A SOLN 10mu/ml	, Tier 2	B/D NM
6000000unit/ml; SOLR		
50mu		
INTRON A SOLR 10mu	Tier 2	B/D NM
INTRON A SOLR 18mu	Tier 3	B/D NM
<i>IMMUNOSUPPRESSAN</i>	TS	
azathioprine (generic of	Tier 2	B/D
IMURAN) TABS 50mg		
BENLYSTA SOAJ	Tier 2	QL NM PA
200mg/ml; SOSY 200mg/ml		
QL (8 syringes / 28		
days)		
BENLYSTA SOLR 120mg,	Tier 2	NM PA
400mg	_	
cyclosporine (generic of	Tier 3	B/D NM
SANDIMMUNE) CAPS		
25mg, 100mg		

Drug Name	Tier	Requirements/ Limits
cyclosporine modified (for microemulsion) (generic of NEORAL) CAPS 25mg, 100mg; SOLN 100mg/ml	Tier 3	B/D NM
cyclosporine modified (for microemulsion) CAPS 50mg	Tier 3	B/D NM
everolimus (immunosuppressant) (generic of ZORTRESS) TABS .5mg, .75mg	Tier 1	B/D NM
everolimus (immunosuppressant) (generic of ZORTRESS) TABS .25mg	Tier 3	B/D NM
gengraf (generic of NEORAL) CAPS 25mg, 100mg; SOLN 100mg/ml	Tier 3	B/D NM
mycophenolate mofetil (generic of CELLCEPT) CAPS 250mg; TABS 500mg		B/D NM
mycophenolate mofetil (generic of CELLCEPT) SUSR 200mg/ml	Tier 1	B/D NM
mycophenolate sodium (generic of MYFORTIC) TBEC 180mg, 360mg	Tier 3	B/D NM
PROGRAF PACK .2mg, 1mg	Tier 3	B/D NM
SANDIMMUNE SOLN 100mg/ml	Tier 2	B/D NM
sirolimus (generic of RAPAMUNE) SOLN 1mg/ml	Tier 1	B/D NM
sirolimus (generic of RAPAMUNE) TABS .5mg, 1mg, 2mg	Tier 3	B/D NM
tacrolimus (generic of PROGRAF) CAPS .5mg, 1mg, 5mg	Tier 3	B/D NM
ZORTRESS TABS 1mg	Tier 2	B/D NM
VACCINES ACTHIB INJ	Tier 2	
ADACEL INJ	Tier 2	
BCG VACCINE INJ	Tier 3	
BEXSERO INJ	Tier 2	
BOOSTRIX INJ DAPTACEL INJ	Tier 2 Tier 2	
DAI TAGLE INJ	11612	

DIPTET PED INJ 25-5LFU Tier 2	Drug Name	Tier	Requirements/ Limits	Drug Name	Drug Requirements/ Tier Limits
MJECTABLE NJ Tier 3 DZ.SW/NACL INJ 0.45% Tier 2 T20elu/0.5ml, 1440elu/ml Tier 3 DZ.SW/NACL INJ 0.45% Tier 3 DZ.SW/NACL INJ 0.45% Tier 3 DZ.SW/NACL INJ 0.2% Tier 2 DSW/LYTES INJ #48 Tier 3 DIOW/NACL INJ 0.2% Tier 2 dextrose 2.5% w/ sodium Tier 2 dextrose 5% in lactated Tier 2 dextrose 5% in lactated Tier 2 dextrose 5% in lactated Tier 2 dextrose 5% w/ sodium Tier 2					
GARDASIL 9 INJ		Tier 2	B/D		ALS,
HAVRIX SUSP Tier 2 T20elu/0.5ml, 1440elu/ml					
T20elu/0.5ml, 1440elu/ml					
HIBERIX SOLR 10mcg Tier 2 IMOVAX RABIES Tier 3 B/D (H.D.C.V.) INJ 2.5unit/ml Tier 3 JEPO LINJ INACTIVE LINJ Tier 3 JEPO LINJ INACTIVE LINJ Tier 2 JEPO LINJ INACTIVE LINJ Tier 2 JEPO LINJ INACTIVE LINJ Tier 2 JEPO LINJ LI		Tier 2		D5W/LYTES INJ #48	
IMOVAX RABIES		Tion O		D10W/NACL INJ 0.2%	
(H.D.C.V.) INJ 2.5unit/ml INFANRIX INJ Tier 2 IPOL INJ INACTIVE Tier 2 IXIARO INJ IFOR 1 INJ INACTIVE Tier 2 IXIARO INJ IFOR 2 IXIARO INJ IFOR 3 IXIARO INJ Tier 3 IXIARO INJ Tier 3 IXIARO INJ Tier 3 IXIARO INJ Tier 2 M-M-R II INJ Tier 2 MENACTRA INJ Tier 2 MENACTRA INJ Tier 2 MENQUADFI INJ Tier 2 MENOUADFI INJ Tier 3 TEDUAX INJ 0.5ML Tier 3 TIER 2 RABAVERT INJ TIER 3 RECOMBIVAX HB SUSP Tier 2 SHINDRIX SUS Tier 2 TENIVAC INJ 5-2LF Tier 2 TENIVAC INJ 5-2LF Tier 3 TYPHIM VI SOLN TIER 2 TYPHIM VI SOLN TIER 2					Tier 2
IPOL INJ INACTIVE Tier 2		Her 3	B/D	chloride 0.45% (generic of	
IPOL INJ INACTIVE		Tior 2			
IXIARO INJ				,	Tion 0
KINRIX INJ Tier 2					rier Z
M-M-R IIINJ Tier 2					Tior 2
MENACTRA INJ Tier 2					1161 2
MENQUADFI INJ Tier 2 chloride 0.9% MENVEO INJ Tier 2 dextrose 5% w/s odium Tier 2 PEDIARIX INJ 0.5ML Tier 2 dextrose 10% w/sodium Tier 2 PEDVAX HIB SUSP Tier 2 dextrose 10% w/sodium Tier 2 7.5mcg/0.5ml Tier 3 ISOLYTE-P INJ /D5W Tier 3 PENTACEL INJ Tier 3 ISOLYTE-P INJ /D5W Tier 3 PENTACH INJ Tier 3 ISOLYTE-P INJ /D5W Tier 3 PENTACH INJ Tier 3 ISOLYTE-P INJ /D5W Tier 3 PEDIARIX INJ Tier 3 ISOLYTE-P INJ /D5W Tier 3 PROQUAD INJ Tier 3 ISOLYTE-S INJ Tier 3 ROLOTATE INJ Tier 3 B/D dextrose 5% & nacl 0.45% Inj kcl 20 meq/l (0.15%) in Tier 2 dextrose 5% & nacl 0.29% inj KCI 20 meq/l (0.15%) in Tier 2 dextrose 5% & nacl 0.99% inj kcl 20 meq/l (0.15%) in Tier 2 50mcg/0.5ml Tier 2 B/D KCL 20 meq/l (0.15%) in nacl Tier 2 dextrose 5% & nacl 0.45% inj 10					Tier 2
MENVEO INJ Tier 2 dextrose 5% % sodium chloride 0.45% Tier 2 PEDIARIX INJ 0.5ML Tier 2 dextrose 10% w/ sodium chloride 0.45% Tier 2 PEDVAX HIB SUSP Tier 2 7.5mcg/0.5ml Tier 3 ISOLYTE-P INJ /D5W Tier 3 PENTACEL INJ Tier 3 ISOLYTE-S INJ Tier 3 PROQUAD INJ Tier 3 ISOLYTE-S INJ PH 7.4 Tier 3 QUADRACEL INJ Tier 2 kcl 10 meq/l (0.075%) in Tier 2 RABAVERT INJ Tier 3 B/D RECOMBIVAX HB SUSP Tier 2 B/D B/D dextrose 5% & nacl 0.45% inj ROTARIX SUS Tier 2 B/D dextrose 5% & nacl 0.2% inj ROTARIX SUSR Tier 2 Dextrose 5% & nacl 0.2% inj kcl 20 meq/l (0.15%) in Tier 2 SHINGRIX SUSR Tier 2 Dextrose 5% & nacl 0.9% inj kcl 20 meq/l (0.15%) in Tier 2 SOmcg/0.5ml Tier 2 B/D Kcl 20 meq/l (0.15%) in nacl Tier 2 TENIVAC INJ 5-2LF Tier 2 B/D KCL 20 meq/l (0.15%) In nacl Tier 2 TYPHIM VI SOLN Tier 3 Tier 3 Kcl 20 meq/l (0.15%) in nacl Tier 2 TYPHIM VI S					
PEDIARIX INJ 0.5ML Tier 2 Tier 2 Tier 2 Tier 2 Tier 3 Tier 4 Tier 5 Tier 2 Tier 5 Tier 6 Tier 7 Tier 7 Tier 7 Tier 8 Tier 8 Tier 9				dextrose 5% w/ sodium	Tier 2
PEDVAX HIB SUSP Tier 2 Chloride 0.45% Tier 3 Tier 2 Tier 2 Tier 2 Tier 2 Tier 2 Tier 2 Tier 3 Tier 3 Tier 3 Tier 3 Tier 3 Tier 3 Tier 4 Tier 5 Tier 6 Tier 6 Tier 7 Tier 7 Tier 8 Tier 9 Ti				chloride 0.45%	
T.5mcg/0.5ml				dextrose 10% w/ sodium	Tier 2
PENTACEL INJ		Tier 2			
PROQUAD INJ Tier 3		T : 0		ISOLYTE-P INJ /D5W	Tier 3
QUADRACEL INJ Tier 2 kcl 10 meq/l (0.075%) in dextrose 5% & nacl 0.45% Tier 2 dextrose 5% & nacl 0.45% RECOMBIVAX HB SUSP 5mcg/0.5ml, 10mcg/ml, 40mcg/ml 40mcg/ml kcl 20 meq/l (0.15%) in Tier 2 dextrose 5% & nacl 0.2% inj ROTARIX SUS Tier 2 kcl 20 meq/l (0.15%) in Tier 2 dextrose 5% & nacl 0.2% inj SHINGRIX SUSR Tier 2 QL kcl 20 meq/l (0.15%) in Tier 2 dextrose 5% & nacl 0.9% inj SHINGRIX SUSR Tier 2 QL kcl 20 meq/l (0.15%) in nocl Tier 2 dextrose 5% & nacl 0.45% SOmcg/0.5ml QL (2 vials per lifetime) kcl 20 meq/l (0.15%) in nacl Tier 2 dextrose 5% & nacl 0.45% TENIVAC INJ 5-2LF Tier 2 B/D KCL 20 MEQ/L (0.15%) IN Tier 3 nacl Tier 2 dextrose 5% & nacl 0.45% inj (generic of POTASSIUM CHLORIDE/SODIUM) VAQTA SUSP 25unit/0.5ml, Tier 2 50unit/ml CHLORIDE/SODIUM) VAQTA SUSP 25unit/0.5ml Tier 2 dextrose 5% & nacl 0.45% inj (generic of POTASSIUM CHLORIDE/SODIUM) VARIVAX INJ Tier 3 dextrose 5% & nacl 0.45% inj (dextrose 5% & nacl 0.45% i				ISOLYTE-S INJ	Tier 3
RABAVERT INJ Tier 3 B/D RECOMBIVAX HB SUSP Tier 2 B/D 5mcg/0.5ml, 10mcg/ml, 40mcg/ml ROTARIX SUS Tier 2 Tier 2 Tier 2 Tier 2 Tier 2 B/D Shing Tier 2 Constant Tier 2 Constant Tier 2 Constant Tier 2 Constant				ISOLYTE-S INJ PH 7.4	Tier 3
RECOMBIVAX HB SUSP Tier 2 B/D 5mcg/0.5ml, 10mcg/ml, 40mcg/ml ROTARIX SUS Tier 2 Tier 2 Cextrose 5% & nacl 0.2% inj ROTARIX SUSR Tier 2 Cextrose 5% & nacl 0.9% inj ROTARIX SUSR Tier 2 Cextrose 5% & nacl 0.9% inj Rotation Cextra Cextrose 5% & nacl 0.9% inj Cextrose 5% & nacl 0.45% inj Cextrose 5% & nacl 0.4				• ` ` `	Tier 2
Smcg/0.5ml, 10mcg/ml, 40mcg/ml ROTARIX SUS Tier 2 dextrose 5% & nacl 0.2% inj					
40mcg/ml dextrose 5% & nacl 0.2% inj ROTARIX SUS Tier 2 kcl 20 meq/l (0.15%) in Tier 2 ROTATEQ SOL Tier 2 dextrose 5% & nacl 0.9% inj SHINGRIX SUSR Tier 2 QL 50mcg/0.5ml GL (2 vials per lifetime) kcl 20 meq/l (0.15%) in Tier 2 TDVAX INJ 2-2 LF Tier 2 B/D TENIVAC INJ 5-2 LF Tier 2 B/D TRUMENBA INJ Tier 2 MCL 20 MEQ/L (0.15%) IN Tier 3 TYPHIM VI SOLN Tier 3 NACL 0.45% INJ VAQTA SUSP 25unit/0.5ml, Tier 2 50unit/ml CHLORIDE/SODIUM) VAQTA SUSP 25unit/0.5ml CHLORIDE/SODIUM) VAQTA SUSP 25unit/0.5ml kcl 30 meq/l (0.224%) in Tier 2 1350pfu/0.5ml Tier 2 YF-VAX INJ Tier 3		Tier 2	B/D		
ROTARIX SUS Tier 2 kcl 20 meq/l (0.15%) in Tier 2 ROTATEQ SOL Tier 2 dextrose 5% & nacl 0.9% inj SHINGRIX SUSR Tier 2 QL 50mcg/0.5ml QL (2 vials per lifetime) dextrose 5% & nacl 0.45% inj QL (2 vials per lifetime) kcl 20 meq/l (0.15%) in nacl Tier 2 TDVAX INJ 2-2 LF Tier 2 B/D TENIVAC INJ 5-2LF Tier 2 B/D TRUMENBA INJ Tier 2 B/D TWINRIX INJ Tier 3 KCL 20 MEQ/L (0.15%) IN Tier 3 TYPHIM VI SOLN Tier 3 kcl 20 meq/l (0.15%) in nacl Tier 2 0.45% inj (generic of POTASSIUM CHLORIDE/SODIUM) CHLORIDE/SODIUM) VAQTA SUSP 25unit/0.5ml, Tier 2 CHLORIDE/SODIUM) VARIVAX INJ Tier 2 1350pfu/0.5ml Tier 3 YF-VAX INJ Tier 3 Rotations R					
ROTATEQ SOL Tier 2 dextrose 5% & nacl 0.9% inj		Tior 2			
SHINGRIX SUSR Tier 2 QL 50mcg/0.5ml QL (2 vials per lifetime) kcl 20 meq/l (0.15%) in Tier 2 dextrose 5% & nacl 0.45% inj kcl 20 meq/l (0.15%) in nacl Tier 2 0.9% inj kcl 20 meq/l (0.15%) in nacl Tier 2 0.9% inj kcl 20 meq/l (0.15%) IN Tier 3 TRUMENBA INJ Tier 2 TWINRIX INJ Tier 3 NACL 0.45% INJ kcl 20 meq/l (0.15%) in nacl Tier 2 0.45% inj (generic of POTASSIUM CHLORIDE/SODIUM) kcl 30 meq/l (0.224%) in Tier 2 dextrose 5% & nacl 0.45% inj kcl 40 meq/l (0.3%) in Tier 2 dextrose 5% & nacl 0.45% inj kcl 40 meq/l (0.3%) in Tier 2 dextrose 5% & nacl 0.45% inj kcl 40 meq/l (0.3%) in Tier 2 dextrose 5% & nacl 0.45% Tier 2 dextrose					-
50mcg/0.5ml dextrose 5% & nacl 0.45% QL (2 vials per lifetime) kcl 20 meq/l (0.15%) in nacl Tier 2 TDVAX INJ 2-2 LF Tier 2 B/D TENIVAC INJ 5-2LF Tier 2 B/D TRUMENBA INJ Tier 2 KCL 20 MEQ/L (0.15%) IN Tier 3 TWINRIX INJ Tier 3 NACL 0.45% INJ TYPHIM VI SOLN Tier 3 kcl 20 meq/l (0.15%) in nacl Tier 2 25mcg/0.5ml 0.45% inj (generic of POTASSIUM CHLORIDE/SODIUM) VAQTA SUSP 25unit/0.5ml, Tier 2 CHLORIDE/SODIUM) VARIVAX INJ Tier 2 1350pfu/0.5ml Tier 3 YF-VAX INJ Tier 3					
Color Colo		rier z	QL		1161 2
Ilifetime					
TDVAX INJ 2-2 LF Tier 2 B/D TENIVAC INJ 5-2LF Tier 2 B/D TRUMENBA INJ Tier 2 KCL 20 MEQ/L (0.15%) IN Tier 3 TWINRIX INJ Tier 3 NACL 0.45% INJ TYPHIM VI SOLN Tier 3 kcl 20 meq/l (0.15%) in nacl Tier 2 25mcg/0.5ml POTASSIUM VAQTA SUSP 25unit/0.5ml, Tier 2 CHLORIDE/SODIUM) VARIVAX INJ Tier 2 1350pfu/0.5ml kcl 30 meq/l (0.224%) in ting ing VF-VAX INJ Tier 3 ### CHANGE OF THE PROPERTY OF THE PROPE	` .				Tier 2
TENIVAC INJ 5-2LF Tier 2 B/D KCL 20 MEQ/L (0.15%) IN Tier 3 TRUMENBA INJ Tier 2 NACL 0.45% INJ TWINRIX INJ Tier 3 kcl 20 meq/l (0.15%) in nacl Tier 2 TYPHIM VI SOLN Tier 3 0.45% inj (generic of POTASSIUM CHLORIDE/SODIUM) VAQTA SUSP 25unit/0.5ml CHLORIDE/SODIUM) VARIVAX INJ Tier 2 dextrose 5% & nacl 0.45% inj 1350pfu/0.5ml Tier 3 kcl 40 meq/l (0.3%) in Tier 2 dextrose 5% & nacl 0.45%		Tier 2	B/D	,	
TRUMENBA INJ Tier 2 NACL 0.45% INJ TWINRIX INJ Tier 3 kcl 20 meq/l (0.15%) in nacl Tier 2 TYPHIM VI SOLN Tier 3 0.45% inj (generic of POTASSIUM CHLORIDE/SODIUM) VAQTA SUSP 25unit/0.5ml, Tier 2 kcl 30 meq/l (0.224%) in Tier 2 50unit/ml kcl 30 meq/l (0.224%) in Tier 2 VARIVAX INJ Tier 2 1350pfu/0.5ml kcl 40 meq/l (0.3%) in Tier 2 YF-VAX INJ Tier 3				KCL 20 MEQ/L (0.15%) IN	Tier 3
TYPHIM VI_SOLN	TRUMENBA INJ			NACL 0.45% INJ	
POTASSIUM CHLORIDE/SODIUM CHLORIDE/SODIUM CHLORIDE/SODIUM CHLORIDE/SODIUM CHLORIDE/SODIUM kcl 30 meq/l (0.224%) in dextrose 5% & nacl 0.45% inj kcl 40 meq/l (0.3%) in Tier 2 dextrose 5% & nacl 0.45% Tier 2 dextrose 5% & na	TWINRIX INJ	Tier 3			Tier 2
25mcg/0.5ml	TYPHIM VI_SOLN	Tier 3			
VAQTA SUSP 25th II/0.5ff, Tier 2 50unit/ml VARIVAX INJ Tier 2 1350pf u/0.5ml kcl 30 meq/l (0.224%) in dextrose 5% & nacl 0.45% inj kcl 40 meq/l (0.3%) in dextrose 5% & nacl 0.45%					
VARIVAX INJ Tier 2 1350pfu/0.5ml inj YF-VAX INJ Tier 3 dextrose 5% & nacl 0.45% inj kcl 40 meq/l (0.3%) in Tier 2 dextrose 5% & nacl 0.45%	VAQTA SUSP 25unit/0.5ml	, Tier 2		,	T: 0
VARIVAX INJ Tier 2 1350pfu/0.5ml inj YF-VAX INJ Tier 3 kcl 40 meq/l (0.3%) in dextrose 5% & nacl 0.45%	50unit/ml				Her 2
YF-VAX INJ Tier 3		Tier 2			
dextrose 5% & nacl 0.45%					Tier 2
	YF-VAX INJ	Tier 3		• • •	1101 2
				inj	

Drug Name	Drug Tier	Requirements/ Limits
KCL 40 MEQ/L (0.3%) IN NACL 0.9% INJ	Tier 3	3
KCL/D5W/NACL INJ 0.3/0.9%	Tier 3	3
lactated ringer's solution	Tier 2)
MAGNESIUM SULFATE	Tier 2	
SOLN 2gm/50ml,		
4gm/100ml, 4gm/50ml,		
20gm/500ml, 40gm/1000ml		
magnesium sulfate (generic	Tier 2	<u>)</u>
of MAGNESIUM SULFATE)	1	
SOLN 2gm/50ml,		
4gm/100ml, 4gm/50ml,		
20gm/500ml, 40gm/1000ml		
magnesium sulfate SOLN	Tier 2	2
50%		
magnesium sulfate in	Tier 2	<u>}</u>
dextrose 5% iv soln 1		
gm/100ml (generic of		
MAGNESIUM SULFATE IN		
D5W)	Tion	<u> </u>
MG SO4/D5W INJ 10MG/ML	Tier 2	<u> </u>
PLASMA-LYTE INJ -148	Tier 3	•
PLASMA-LYTE INJ -A	Tier 3	
potassium chloride SOLN	Tier 2	
2meq/ml	1161 2	-
POTASSIUM CHLORIDE	Tier 3	<u> </u>
SOLN 10meq/50ml,	11010	,
20meq/50ml		
potassium chloride SOLN	Tier 3	3
10meg/100ml,		
20meq/100ml, 40meq/100m	1	
potassium chloride 20 meg/		<u> </u>
(0.15%) in dextrose 5% inj		
sodium chloride SOLN	Tier 2	2
.45%, .9%, 2.5meq/ml, 3%,		
5%		
TPN ELECTROL INJ	Tier 3	B B/D
ELECTROLYTES/MINER ORAL	ALS/	VITAMINS,
klor-con PACK 20meg	Tier 3	3
klor-con 8 TBCR 8meq	Tier 1	
klor-con 10 TBCR 10meq	Tier 1	
klor-con m10 TBCR 10meq		
klor-con m15 TBCR 15meq		
klor-con m20 TBCR 20meq	i i ier 1	

Drug Name	Drug Tier	Requirements/ Limits
M-NATAL PLUS TAB	Tier 2	2
potassium chloride CPCR 8meq, 10meq	Tier 2	2
potassium chloride PACK 20meq; SOLN 10%, 20%	Tier 3	3
potassium chloride TBCR 8meq	Tier 1	
potassium chloride (generic of K-TAB) TBCR 10meq, 20meq	Tier 1	
potassium chloride microencapsulated crystals	Tier 1	
er TBCR 10meq, 20meq PRENATAL TAB 27-1MG	Tier 2	2
PRENATAL TAB PLUS	Tier 2	
PRENATAL VIT TAB LOW IRON	Tier 2	2
sodium fluoride chew; tab; 1.1 (0.5 f) mg/ml soln	Tier 1	
TRICARE TAB PRENATAL	Tier 2	-
IV NUTRITION		
AMINOSYN-PF INJ 7%	Tier 3	
CLINIMIX INJ 4.25/D5W	Tier 3	
CLINIMIX INJ 4.25/D10 CLINIMIX INJ 5%/D15W	Tier 3	
CLINIMIX INJ 5%/D20W	Tier 3	
CLINIMIX INJ 6/5	Tier 3	
CLINIMIX INJ 8/10	Tier 3	
CLINIMIX INJ 8/14	Tier 3	
clinisol sf 15%	Tier 3	
CLINOLIPID EMU 20%	Tier 3	
dextrose SOLN 5%, 10%	Tier 2	
dextrose SOLN 50%, 70%	Tier 2	2 B/D
FREAMINE HBC INJ 6.9%	Tier 3	
FREAMINE III INJ 10%	Tier 3	B/D
hepatamine	Tier 3	B/D
INTRALIPID EMUL 20gm/100ml, 30gm/100ml	Tier 3	B B/D
NUTRILIPID EMUL 20gm/100ml	Tier 3	B/D
plenamine	Tier 3	B/D
PREMASOL SOL 10%	Tier 3	
PROCALAMINE INJ 3%	Tier 3	
PROSOL INJ 20%	Tier 3	
TRAVASOL INJ 10%	Tier 3	
TROPHAMINE INJ 10%	Tier 3	

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
OPHTHALMIC ANTI-INFECTIVE/ANTI-II	IFLA	MMATORY _	ofloxacin (ophth) (generic of OCUFLOX) SOLN .3%	Tier 1	
bacitracin-polymyxin- neomycin-hc ophth oint 1% BLEPHAMIDE OIN S.O.P. neomycin-polymyxin-	Tier :	3	polymyxin b-trimethoprim ophth soln 10000 unit/ml- 0.1% (generic of POLYTRIM)	Tier 1	
dexamethasone ophth oint 0.1% (generic of	TICI	' -	sulfacetamide sodium (ophth) OINT 10%	Tier 2	
MAXITROL) neomycin-polymyxin- dexamethasone ophth susp	Tier	 1 -	sulfacetamide sodium (ophth) (generic of BLEPH- 10) SOLN 10%	Tier 2	
0.1% (generic of MAXITROL)			tobramycin (ophth) (generic of TOBREX) SOLN .3%		
sulfacetamide sodium- prednisolone ophth soln 10-	Tier	1 -	trifluridine SOLN 1% ZIRGAN GEL .15%	Tier 3	
0.23(0.25)%			ANTI-INFLAMMATORIES		
	Tier		ALREX SUSP .2%	Tier 2	
tobramycin-dexamethasone	Tier:	3	BROMSITE SOLN .075%	Tier 3	3
ophth susp 0.3-0.1% (generic of TOBRADEX)	T:		dexamethasone sodium phosphate (ophth) SOLN	Tier 2	2
ZYLET SUS 0.5-0.3%	Tier	<u> </u>	.1%		
ANTI-INFECTIVES bacitracin (ophthalmic)	Tier	2	diclofenac sodium (ophth) SOLN .1%	Tier 1	
OINT 500unit/gm		<u> </u>	DUREZOL EMUL .05%	Tier 2	<u> </u>
bacitracin-polymyxin b ophtl	Tier	1	FLAREX SUSP .1%	Tier 3	3
oint		<u> </u>	fluorometholone (ophth)	Tier 2)
BESIVANCE SUSP .6%	Tier		SUSP .1%		
CILOXAN OINT .3%	Tier		flurbiprofen sodium SOLN	Tier 2	2
ciprofloxacin hcl (ophth) (generic of CILOXAN)	Tier	· -	.03%	Tier 2	<u> </u>
SOLN .3%		-	ILEVRO SUSP .3%		
erythromycin (ophth) OINT 5mg/gm			ketorolac tromethamine (ophth) (generic of ACULAR LS) SOLN .4%	Tier 2	•
gentak OINT .3%	Tier	2	ketorolac tromethamine	Tier 1	
gentamicin sulfate (ophth) SOLN .3%	Tier	1	(ophth) (generic of ACULAR) SOLN .5%		
moxifloxacin hcl (ophth)	Tier	2	LOTEMAX OINT .5%	Tier 2	2
(generic of VIGAMOX) SOLN .5%	T: 1		prednisolone acetate (ophth) (generic of PRED	Tier 2	2
NATACYN SUSP 5%	Tier:		FORTE) SUSP 1%	-	
neomycin-bacitrac zn- polymyx 5(3.5)mg-400unt-	Tier	<u> -</u>	PREDNISOLONE SODIUM PHOSP SOLN 1%		
10000unt op oin			PROLENSA SOLN.07%	Tier 2	<u> </u>
neomycin-polymy-gramicid		2	ANTIALLERGICS		
op sol 1.75-10000-0.025mg _unt-mg/ml	•		azelastine hcl (ophth) SOLN .05%	Tier 2	2

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
bepotastine besilate	Tier 2	2	VYZULTA SOLN .024%	Tier 3	
(generic of BEPREVE)			MISCELLANEOUS		
SOLN 1.5%			ATROPINE SULFATE	Tier 2	
BEPREVE SOLN 1.5%	Tier 2		SOLN 1%		
cromolyn sodium (ophth)	Tier '	1	CYSTADROPS SOLN	Tier 2	NM LA PA
SOLN 4%			.37%		
LASTACAFT SOLN .25%	Tier 3		CYSTARAN SOLN.44%	Tier 2	NM LA PA
olopatadine hcl SOLN .1%			ISOPTO ATROPINE SOLN	l Tier 2	
ZERVIATE SOLN .24%	Tier 3	3	1%	· - · -	
ANTIGLAUCOMA			proparacaine hcl (generic o	f Lier 2	
ALPHAGAN P SOLN .1%	Tier 2	2	ALCAINE) SOLN .5%	T: 0	
betaxolol hcl (ophth) SOLN	V Tier 2	2	RESTASIS EMUL .05%	Tier 2	
.5%			RESTASIS MULTIDOSE	Tier 2	
BETOPTIC-S SUSP .25%	Tier 2	2	EMUL .05%		
brimonidine tartrate SOLN	Tier '	1	OTIC		
.2%			OTIC AGENTS	T: 0	
brimonidine tartrate (generi	icTier 3	3	acetic acid (otic) SOLN 2%		
of ALPHAGAN P) SOLN			ciprofloxacin-	Tier 3	
.15%	T:		dexamethasone otic susp		
brinzolamide (generic of	Tier 3	3	0.3-0.1% (generic of CIPRODEX)		
AZOPT) SUSP 1%	LTion	 1	neomycin-polymyxin-hc otic	Tier 2	
carteolol hcl (ophth) SOLN 1%	ı i iei	I	soln 1%	7 1101 2	
COMBIGAN SOL 0.2/0.5%	Tier '	2	neomycin-polymyxin-hc otic	Tier 2	
dorzolamide hcl (generic of			susp 3.5 mg/ml-10000		
TRUSOPT) SOLN 2%	Hei	ı	unit/ml-1%		
dorzolamide hcl-timolol	Tier '	1	ofloxacin (otic) SOLN .3%	Tier 3	
maleate ophth soln 22.3-6.			RESPIRATORY		
mg/ml (generic of COSOPT			ANTICHOLINERGIC/BE	TA AG	ONIST
latanoprost (generic of	Tier '	1	COMBINATIONS		
XALATAN) SOLN .005%			ANORO ELLIPT AER 62.5-	Tier 2	QL
levobunolol hcl SOLN .5%	Tier '	1	25		
LUMIGAN SOLN .01%	Tier 2	2	QL (60 blisters / 30		
pilocarpine hcl (generic of	Tier 2	2	days)		
ISOPTO CARPINE) SOLN			BEVESPI AER 9-4.8MCG	Tier 2	QL
1%, 2%, 4%			QL (1 inhaler / 30		
RHOPRESSA SOLN.02%	Tier 2	2	days)	T: 0	01
SIMBRINZA SUS 1-0.2%	Tier 2	2	BREZTRI AERO AER	Tier 2	QL
timolol maleate (ophth)	Tier 3	3	SPHERE QL (1 inhaler / 30		
(generic of TIMOPTIC-XE)			days)		
SOLG .25%, .5%			BREZTRI AERO AER	Tier 2	QL
timolol maleate (ophth)	Tier '	1	SPHERE (INSTITUTIONAL		X L
(generic of TIMOPTIC)			PACK)	=	
SOLN .25%, .5%	T: 1		QL (4 inhalers / 28		
timolol maleate (ophth)	Tier 3)	days)		
once-daily (generic of ISTALOL) SOLN .5%					
ISTALOLI SOLIVISIO					

Drug Name	Drug Re	equirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
COMBIVENT AER 20-100	Tier 3	QL	levocetirizine	Tier 2	2
QL (2 inhalers / 30			dihydrochloride TABS 5mg		
days)	Tior 2	B/D	BETA AGONISTS	T: 6	
ipratropium-albuterol nebu	Her Z	D/D	albuterol sulfate AERS	Tier 2	2 QL
soln 0.5-2.5(3) mg/3ml TRELEGY AER ELLIPTA	Tier 2	QL	108mcg/act		
100-62.5-25 MCG	TICI Z	QL	QL (2 inhalers / 30 days)		
QL (60 blisters / 30			(generic of Ventolin HFA	١	
days)			albuterol sulfate (generic of		2 QL
TRELEGY AER ELLIPTA	Tier 2	QL	PROAIR HFA) AERS	1101 2	- QL
200-62.5-25 MCG			108mcg/act		
QL (60 blisters / 30			QL (2 inhalers / 30		
days)			days)		
ANTICHOLINERGICS			(generic of Proair HFA)		
ATROVENT HFA AERS	Tier 3	QL	albuterol sulfate (generic of	Tier 2	2 QL
17mcg/act			PROVENTIL HFA) AERS		
QL (2 inhalers / 30			108mcg/act		
days)			QL (2 inhalers / 30		
INCRUSE ELLIPTA AEPB	Tier 2	QL	days)	. \	
62.5mcg/inh			(generic of Proventil HFA		D/D
QL (30 blisters / 30			albuterol sulfate NEBU	Tier 2	2 B/D
days)	I Tior 1	B/D	.63mg/3ml, 1.25mg/3ml, 2.5mg/0.5ml		
ipratropium bromide SOLN .02%	ı ilei i	Β / D	albuterol sulfate NEBU	Tier 1	I B/D
ipratropium bromide (nasal)) Tier 2		.083%	1101	
SOLN .03%, .06%	/ 11012		albuterol sulfate SYRP	Tier 1	 1
ANTIHISTAMINES			2mg/5ml		•
azelastine hcl SOLN .1%,	Tier 2		albuterol sulfate TABS	Tier 3	3
.15%	1101 2		2mg, 4mg		
cetirizine hcl SOLN 1mg/m	l Tier 1		levalbuterol tartrate AERO	Tier 2	2 QL
cyproheptadine hcl SYRP	Tier 2	PA	45mcg/act		
2mg/5ml; TABS 4mg			QL (2 inhalers / 30		
PA if 70 years and older			days)	· -· -	
diphenhydramine hcl SOLN	VTier 2		SEREVENT DISKUS AEPE	3 Her 2	2 QL
_50mg/ml			50mcg/dose	_	
hydroxyzine hcl SOLN	Tier 3	PA	QL (60 inhalations / 30	J	
25mg/ml, 50mg/ml			days) terbutaline sulfate TABS	Tier 3	2
PA if 70 years and older			2.5mg, 5mg	1161	,
hydroxyzine hcl SYRP	Tier 2	PA	VENTOLIN HFA AERS	Tier 2	2 QL
10mg/5ml			108mcg/act	1101 2	L QL
PA if 70 years and older	T' 4		QL (2 inhalers / 30		
hydroxyzine hcl TABS	Tier 1	PA	days)		
10mg, 25mg, 50mg			VENTOLIN HFA	Tier 2	2 QL
PA if 70 years and older hydroxyzine pamoate	Tier 1	PA	(INSTITUTIONAL PACK)		
(generic of VISTARIL)	1 101 1	FΛ	ÀERS 108mcg/act		
CAPS 25mg, 50mg			QL (6 inhalers / 30		
PA if 70 years and older			days)		
77 Th 70 yours and side					_

Drug Name	Drug Tier	Requirements/ Limits
LEUKOTRIENE MODULA	ATORS	<u> </u>
montelukast sodium	Tier 2	
(generic of SINGULAIR)		
CHEW 4mg, 5mg		
montelukast sodium	Tier 3	
(generic of SINGULAIR)		
PACK 4mg	Tier 1	
montelukast sodium	Herm	
(generic of SINGULAIR)		
TABS 10mg	Tior 2	
zafirlukast (generic of	Tier 2	
ACCOLATE) TABS 10mg,		
20mg		
MISCELLANEOUS	Tior 2	D/D
acetylcysteine SOLN 10%, 20%	rier z	B/D
ARALAST NP SOLR	Tier 2	NM LA PA
500mg, 1000mg		
cromolyn sodium NEBU	Tier 2	B/D
20mg/2ml		
DALIRESP TABS 250mcg,	Tier 3	
500mcg		
epinephrine (anaphylaxis)	Tier 2	
(generic of EPIPEN 2-PAK)		
SOAJ .3mg/0.3ml		
(generic of EpiPen)		
epinephrine (anaphylaxis)	Tier 2	
(generic of EPIPEN-JR 2-		
PAK) SOAJ .15mg/0.3ml		
(generic of EpiPen)		
epinephrine (anaphylaxis)	Tier 2	
SOAJ .15mg/0.15ml,		
.3mg/0.3ml		
(generic of Adrenaclick)		
ESBRIET CAPS 267mg	Tier 2	QL NM PA
QL (270 caps / 30		
days)		
ESBRIET TABS 267mg	Tier 2	QL NM PA
QL (270 tabs / 30		
days)		
ESBRIET TABS 801mg	Tier 2	QL NM PA
QL (90 tabs / 30 days)		
FASENRA SOSY 30mg/ml		
FASENRA PEN SOAJ	Tier 2	NM LA PA
30mg/ml		

Drug Name	Drug Requirements/ Tier Limits
KALYDECO PACK 25mg,	Tier 2 QL NM PA
50mg, 75mg	
QL (56 packs / 28	
days)	T' 0 01 NINA DA
KALYDECO TABS 150mg QL (60 tabs / 30 days)	Tier 2 QL NM PA
OFEV CAPS 100mg,	Tier 2 QL NM PA
150mg	
QL (60 caps / 30 days)	
ORKAMBI GRA 100-125	Tier 2 QL NM PA
QL (56 packs / 28	
days)	Tiano OLNIM DA
ORKAMBI GRA 150-188	Tier 2 QL NM PA
QL (56 packs / 28	
days)	Tion OL NIM DA
ORKAMBI TAB 100-125	Tier 2 QL NM PA
QL (112 tabs / 28	
days)	Tiano OLNIM DA
ORKAMBI TAB 200-125	Tier 2 QL NM PA
QL (112 tabs / 28	
days)	Tion O NIMI A DA
PROLASTIN-C SOLN	Tier 2 NM LA PA
1000mg/20ml; SOLR	
1000mg PULMOZYME SOLN	Tier 2 NM PA
1mg/ml	Herz INIVIPA
SYMDEKO TAB 50-75MG	Tier 2QL NM LA PA
QL (56 tabs / 28 days)	HEI ZQL NIVI LA FA
SYMDEKO TAB 100-150	Tier 2QL NM LA PA
QL (56 tabs / 28 days)	HEI ZQL NIVI LA PA
SYMJEPI SOSY	Tier 3
.15mg/0.3ml, .3mg/0.3ml	Hel 3
theophylline TB12 300mg,	Tior 3
450mg	TICI 3
theophylline TB24 400mg,	Tior 2
600mg	TICI Z
TRIKAFTA TAB 50-25-	Tier 2QL NM LA PA
37.5MG & 75MG	HEI ZQL NIVI LA I A
QL (84 tabs / 28 days)	
TRIKAFTA TAB 100-50-	Tier 2QL NM LA PA
75MG & 150MG	TIOI Z Q L I TIMI L/ (I / (
QL (84 tabs / 28 days)	
XOLAIR SOLR 150mg;	Tier 2 NM LA PA
SOSY 75mg/0.5ml,	I HIVI E/ (I/ (
150mg/ml	
ZEMAIRA SOLR 1000mg	Tier 2 NM LA PA

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug f Tier	Requirements/ Limits
NASAL STEROIDS			ADVAIR DISKU AER	Tier 2	QL
flunisolide (nasal) SOLN	Tier 2	QL	500/50		
.025%			QL (60 inhalations / 3	0	
QL (3 bottles / 30			days)		
days)			ADVAIR HFA AER 45/21	Tier 2	QL
fluticasone propionate	Tier 1	QL	QL (1 inhaler / 30		
(nasal) SUSP 50mcg/act			days)		
QL (1 bottle / 30 days)		ADVAIR HFA AER 115/21	Tier 2	QL
STEROID INHALANTS			QL (1 inhaler / 30		
ARNUITY ELLIPTA AEPB	Tier 2	QL	days)	T : 0	
50mcg/act, 100mcg/act,			ADVAIR HFA AER 230/21	Tier 2	QL
200mcg/act			QL (1 inhaler / 30		
QL (30 inhalations / 3	0		days)	- T: 0	
days)			BREO ELLIPTA INH 100-2	5 Her 2	QL
budesonide (inhalation)	Tier 3	B/D	QL (60 blisters / 30		
(generic of PULMICORT)			days)	ΓT: Ω	
SUSP .25mg/2ml, .5mg/2m			BREO ELLIPTA INH 200-2	5 Her 2	QL
FLOVENT DISKUS AEPB	Tier 2	QL	QL (60 blisters / 30		
50mcg/blist			days) SYMBICORT AER 80-4.5	Tior 2	QL
QL (180 inhalations /			QL (1 inhaler / 30	Tier 2	QL
30 days)	T: 0	<u> </u>	days)		
FLOVENT DISKUS AEPB	Tier 2	QL	SYMBICORT AER 160-4.5	Tior 2	QL
100mcg/blist, 250mcg/blist			QL (1 inhaler / 30	11612	QL
QL (240 inhalations /			days)		
30 days) FLOVENT HFA AERO	Tier 2	QL	TOPICAL		
44mcg/act, 110mcg/act,	1161 2	QL	DERMATOLOGY, ACNE	=	
220mcg/act				Tier 3	PA
QL (2 inhalers / 30			accutane CAPS 20mg,	i iei 3	PA
days)			30mg, 40mg amnesteem CAPS 10mg,	Tier 3	PA
PULMICORT FLEXHALER	Tier 3	QL	20mg, 40mg	11613	ГД
AEPB 90mcg/act	11010	QL	avita (generic of RETIN-A)	Tier 3	QL PA
QL (3 inhalers / 30			CREA .025%	11613	QLFA
days)			QL (45 gm / 30 days)		
PULMICORT FLEXHALER	Tier 3	QL	avita GEL .025%	Tier 3	QL PA
AEPB 180mcg/act			QL (45 gm / 30 days)	11010	QLIA
QL (2 inhalers / 30			claravis CAPS 10mg,	Tier 3	PA
days)			20mg, 30mg, 40mg	11010	170
STEROID/BETA-AGON	IST		clindamycin phosphate	Tier 3	QL
COMBINATIONS			(topical) GEL 1%	1101 0	QL.
ADVAIR DISKU AER	Tier 2	QL	QL (75 gm / 30 days)		
100/50			clindamycin phosphate	Tier 2	QL
QL (60 inhalations / 3	0		(topical) (generic of		
days)			CLEOCIN-T) LOTN 1%		
ADVAIR DISKU AER	Tier 2	QL	QL (60 mL / 30 days)		
250/50			clindamycin phosphate	Tier 2	QL
QL (60 inhalations / 3	0		(topical) SOLN 1%		
days)			QL (60 mL / 30 days)		

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
erythromycin (acne aid) SOLN 2%	Tier 2	QL	nystatin (topical) CREA 100000unit/gm; OINT 100000unit/gm	Tier 2	2 QL
QL (60 mL / 30 days) isotretinoin CAPS 10mg,	Tier 3	PA	QL (30 gm / 30 days)		
20mg, 30mg, 40mg myorisan CAPS 10mg,	Tier 3		nystatin (topical) POWD 100000unit/gm	Tier 2	2 QL
20mg, 30mg, 40mg	1101 0		QL (60 gm / 30 days)		
sulfacetamide sodium (acne) (generic of KLARON LOTN 10%	Tier 3 N)	QL	nystop POWD 100000unit/gm QL (60 gm / 30 days)	Tier 2	2 QL
QL (118 mL / 30 days	;)		DERMATOLOGY, ANTIF	SOR	IATICS
tretinoin (generic of RETIN A) CREA .025%, .05%, .1%; GEL .01%, .025%		QL PA	acitretin (generic of SORIATANE) CAPS 10mg. 25mg	Tier 3	
QL (45 gm / 30 days)			acitretin CAPS 17.5mg	Tier 3	
zenatane CAPS 10mg, 20mg, 30mg, 40mg	Tier 3	PA	calcipotriene SOLN .005% QL (120 mL / 30 days)		3 QL PA
DERMATOLOGY, ANTI			tazarotene (generic of	Tier 2	2 QL PA
gentamicin sulfate (topical)	Tier 3	QL	TAZORAC) CREA.1%		
CREA .1%			QL (60 gm / 30 days)	Tion	0. 0. 0.
QL (30 gm / 30 days) gentamicin sulfate (topical)	Tier 2	QL	TAZORAC CREA .05% QL (60 gm / 30 days)	Tier 3	3 QL PA
OINT .1%	11012	QL	DERMATOLOGY, ANTIS	SEBO	RRHEICS
QL (30 gm / 30 days)			ketoconazole (topical)	Tier '	
mupirocin OINT 2% QL (220 gm / 30 days	Tier 1	QL	SHAM 2% QL (120 mL / 30 days))	
silver sulfadiazine (generic of SILVADENE) CREA 1%		_	selenium sulfide LOTN 2.5%	Tier '	1
ssd (generic of	Tier 1		DERMATOLOGY, CORT	icos	TEROIDS
SILVADENE) CREA 1%			ala-cort CREA 1%, 2.5%	Tier '	
SULFAMYLON CREA	Tier 3	QL	alclometasone dipropionate	Tier 2	2 QL
85mg/gm QL (453.6 gm / 30			CREA .05%; OINT .05%		
days)			QL (60 gm / 30 days)	aTiar (01
DERMATOLOGY, ANTI	FUNG/	LS	betamethasone dipropionat (topical) CREA .05%	enerz	2 QL
clotrimazole (topical) CRE	ATier 2	QL	QL (120 gm / 30 days))	
1%			betamethasone dipropionat		2 QL
QL (45 gm / 30 days)	Tier 2	QL	(topical) LOTN .05%		
betamethasone cream 1-	i iei z	QL	QL (120 mL / 30 days)		
0.05% QL (45 gm / 30 days)			betamethasone dipropionat (topical) OINT .05% QL (120 gm / 30 days)		3 QL
ketoconazole (topical)	Tier 2	QL	betamethasone dipropionat		l QL
CREA 2% QL (60 gm / 30 days)			augmented (generic of DIPROLENE AF) CREA		
nyamyc POWD	Tier 2	QL	.05%		
100000unit/gm			QL (120 gm / 30 days)		
QL (60 gm / 30 days)					

Drug Name	Drug Tier	Requirements/ Limits
betamethasone dipropionat	eTier 3	QL
augmented GEL .05%		
QL (120 gm / 30 days))	
betamethasone dipropionat	eTier 3	QL
augmented LOTN .05%		
QL (120 mL / 30 days))	
betamethasone dipropionat	eTier 3	QL
augmented (generic of		
DIPROLENE) OINT .05%		
QL (120 gm / 30 days)		
betamethasone valerate	Tier 2	. QL
CREA .1%; OINT .1%		
QL (120 gm / 30 days)		
betamethasone valerate	Tier 2	. QL
LOTN .1%		
QL (120 mL / 30 days)		
clobetasol propionate	Tier 2	. QL
(generic of TEMOVATE)		
CREA .05%; OINT .05%		
QL (60 gm / 30 days)		
clobetasol propionate GEL	Tier 3	QL
.05%		
QL (60 gm / 30 days)		
clobetasol propionate	Tier 2	: QL
SOLN .05%		
QL (50 mL / 30 days)		
clobetasol propionate e	Tier 2	. QL
CREA .05%		
QL (60 gm / 30 days) ENSTILAR AER		
	Tier 3	QL PA
QL (120 gm / 30 days)		
fluocinolone acetonide	Tier 3	QL
CREA .01%		
QL (60 gm / 30 days)		
fluocinolone acetonide	Tier 3	QL
(generic of SYNALAR)		
CREA .025%		
QL (120 gm / 30 days)		
fluocinolone acetonide	Tier 2	. QL
(generic of DERMA-		
SMOOTHE/FS BODY) OIL		
.01%		
QL (118.28 mL / 30		
days)		

	Drug Name	Drug Tier	Requirements/ Limits
	fluocinolone acetonide	Tier 2	. QL
	(generic of DERMA-		
	SMOOTHE/FS SCALP) OIL .01%	-	
	QL (118.28 mL / 30 days)		
_	fluocinolone acetonide	Tier 2	. QL
	(generic of SYNALAR)		
	OINT .025%		
	QL (120 gm / 30 days)		
	fluocinolone acetonide	Tier 3	S QL
	(generic of SYNALAR)		
	SOLN .01%		
_	QL (90 mL / 30 days)		
	fluocinonide CREA .05%	Tier 2	. QL
_	QL (120 gm / 30 days)		
	fluocinonide GEL .05%;	Tier 3	S QL
	OINT .05%		
_	QL (60 gm / 30 days)		
	fluocinonide SOLN .05% QL (60 mL / 30 days)	Tier 2	. QL
_	fluocinonide emulsified base	Tier 2	. QL
	CREA .05%		
_	QL (120 gm / 30 days)		
	fluticasone propionate CREA .05%; OINT .005%	Tier 2	
_	halobetasol propionate	Tier 3	QL
	CREA .05%; OINT .05%		
_	QL (50 gm / 30 days)		
_	hydrocortisone (topical)	Tier 1	
	CREA 1%, 2.5%; LOTN		
	2.5%; OINT 2.5%		
	mometasone furoate CREA .1%; OINT .1%; SOLN .1%	Tier 2	
-	triamcinolone acetonide	Tier 1	QL
	(topical) CREA .1%		
	QL (454 gm / 30 days)		
-	triamcinolone acetonide	Tier 1	
	(topical) CREA .025%, .5%;		
	OINT .025%, .1%, .5%		
	triamcinolone acetonide	Tier 2	
	(topical) LOTN .025%, .1%		
_	triderm CREA .5%	Tier 1	
_	DERMATOLOGY, LOCA	L ANE	STHETICS
_	glydo PRSY 2%	Tier 3	
	QL (60 mL / 30 days)		
	lidocaine OINT 5%	Tier 3	QL PA
_	QL (50 gm / 30 days)		

Drug Name	Drug R Tier	equirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
lidocaine (generic of LIDODERM) PTCH 5%	Tier 3	QL PA	proctozone-hc (gene ANUSOL-HC) CRE		2
QL (3 patches / 1 day lidocaine hcl GEL 2%	Tier 3	QL PA	RECTIV OINT .4% QL (30 gm / 30	Tier (3 QL
QL (30 mL / 30 days)	1101 0	QL:/\	rosadan (generic of	Tier:	3 QL
lidocaine hcl SOLN 4% QL (50 mL / 30 days)	Tier 2	QL PA	METROCREAM) CI .75%		
lidocaine-prilocaine cream		QL PA	QL (45 gm / 30	days)	
2.5-2.5% QL (30 gm / 30 days)			tacrolimus (topical) (of PROTOPIC) OIN		3 QL
DERMATOLOGY, MISC		OUS SKIN	.1%	,	
AND MUCOUS MEMBR			QL (100 gm / 3		_
diclofenac sodium (topical)	Tier 2	QL PA	TARGRETIN GEL 1		2 QL NM PA
(generic of VOLTAREN)			QL (60 gm / 30		
GEL 1%			VALCHLOR GEL .0		2QL NM LA PA
QL (1000 gm / 30			QL (60 gm / 30 DERMATOLOGY,		ES AND
days) fluorouracil (topical) (gene	ricTion 3	QL	PEDICULIDES	SCADICIDE	.S AND
of EFUDEX) CREA 5%	ic Hei 3	QL	malathion LOTN .59	% Tier:	3 QL
QL (40 gm / 30 days)			QL (59 mL / 30		J QL
fluorouracil (topical) SOLN	Tier 2	QL	permethrin CREA 5		2 QL
2%, 5%			QL (60 gm / 30		
QL (10 mL / 30 days)			DERMATOLOGY,	WOUND CA	RE AGENTS
hydrocortisone (rectal)	Tier 1		REGRANEX GEL.0		
(generic of ANUSOL-HC)			QL (30 gm / 30		
CREA 2.5%	Tier 2	QL	SANTYL OINT 250		3 QL
imiquimod (generic of ALDARA) CREA 5%	i iei z	QL	QL (180 gm / 3		
QL (24 packets / 30			sodium chloride (gu SOLN .9%		
days) lactic acid (ammonium	Tier 1		water for irrigation, s	terile Tier	1
lactate) CREA 12%	1161 1		irrigation soln	/DENITAL A	OFNTO
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lactate) LOTN 12%			chlorhexidine glucor (mouth-throat) (gene		I
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QL (7 mL / 28 days) procto-med hc (generic of	Tier 2		periogard (generic o		1
ANUSOL-HC) CREA 2.5%			PERIDEX) SOLN .1		
procto-pak (generic of	Tier 2		pilocarpine hcl (oral)		2
PROCTOCORT) CREA 19			(generic of SALAGE TABS 5mg, 7.5mg	IN)	
,			TADO SITIY, 1.SITIY		

Blue MedicareRx 3-Tier Select 2022 Comprehensive Drug List effective 01/01/2022

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diphenhydramine hcl52	see <i>naproxen</i> 1	hydrochlorothiazide tab
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25000UNT44	acetaminophen soln 7.5-	IMBRUVICA12
heparin sodium (porcine) 44	325 mg/15ml2	imipenem-cilastatin
heparin sodium (porcine)	hydrocodone-	intravenous for soln 250
	acetaminophen tab 10-	mg3
heparin sodium (porcine)-	325 mg2	imipenem-cilastatin
dextrose iv sol 20000	hydrocodone-	intravenous for soln 500
unit/500ml-5%44	acetaminophen tab 5-325	mg
heparin sodium (porcine)-	<i>m</i> g2	imipramine hcl25
dextrose iv sol 25000	hydrocodone-	imiquimod57
unit/500ml-5%44	acetaminophen tab 7.5-	IMITREX
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25000UNT45	hydrocodone-ibuprofen tab	see sumatriptan
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46	100-12.5 mg	see propranolol hcl18
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INTRALIPID49	IXIARO INJ 48	KALETRA TAB 200-50MG7
INTRON A47	J	KALYDECO53
introvale37	JADENU	kariva37
INTUNIV	see deferasirox36	kcl 10 meq/l (0.075%) in
see guanfacine hcl	JADENU SPRINKLE	dextrose 5% & nacl
(adhd)30	see deferasirox36	<i>0.45% inj</i> 48
INVANZ	JAKAFI 12	kcl 20 meq/l (0.15%) in
see ertapenem sodium3	jantoven45	dextrose 5% & nacl 0.2%
INVEGA	JANUMET TAB 50-1000 33	inj48
see <i>paliperidone</i> 28	JANUMET TAB 50-500MG	kcl 20 meq/l (0.15%) in
INVEGA SUSTENNA28	33	dextrose 5% & nacl
INVEGA TRINZA28	JANUMET XR TAB 100-	<i>0.45% inj</i> 48
INVIRASE6	1000 33	kcl 20 meq/l (0.15%) in
IPOL INJ INACTIVE48	JANUMET XR TAB 50-	dextrose 5% & nacl 0.9%
ipratropium bromide52	1000 33	inj48
ipratropium bromide (nasal)	JANUMET XR TAB 50-	kcl 20 meq/l (0.15%) in nac
52	500MG 33	<i>0.45% inj</i> 48
ipratropium-albuterol nebu	JANUVIA 33	KCL 20 MÉQ/L (0.15%) IN
soln 0.5-2.5(3) mg/3ml.52	JARDIANCE33	NACL 0.45% INJ48
irbesartan16	jasmiel37	kcl 20 meq/l (0.15%) in nac
irbesartan-	JENTADUETO TAB 2.5-	0.9% inj48
hydrochlorothiazide tab	1000 34	kcl 30 meq/l (0.224%) in
150-12.5 mg15	JENTADUETO TAB 2.5-	dextrose 5% & nacl
irbesartan-	500 33	<i>0.45% inj</i> 48
hydrochlorothiazide tab	JENTADUETO TAB 2.5-	kcl 40 meq/l (0.3%) in
300-12.5 mg15	850 33	dextrose 5% & nacl
IRESSA12	JENTADUETO TAB XR	<i>0.45% inj</i> 48
ISENTRESS6	2.5-1000MG34	KCL 40 MEQ/L (0.3%) IN
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20	KALETRA	(ophth)50
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isosorbide mononitrate20	soln 400-100 mg/5ml	KISQALI 200 DOSE12
isotretinoin55	(80-20 mg/ml)7	KISQALI 200 PAK
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(ophth) once-daily51	see lopinavir-ritonavir tab	KISQALI 400 PAK
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150-300 mg7	sodium chloride iv soln	see escitalopram oxalate
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mg43	40 mg 14	see magnesium sulfate in
LONSURF TAB 15-6.1410	see amlodipine besylate-	dextrose 5% iv soln 1
LONSURF TAB 20-8.1910	benazepril hcl cap 5-10	<i>gm/100ml</i> 49
loperamide hcl43	<i>mg</i> 14	5
LOPID	<u>-</u>	

magnesium sulfate in	medroxyprogesterone	metoprolol &
dextrose 5% iv soln 1	acetate 41	hydrochlorothiazide tab
<i>gm/100ml</i> 49	medroxyprogesterone	100-25 mg17
MALARONE	acetate (contraceptive) 37	metoprolol &
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	•	macro
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oxycodone w/	PEN NEEDLES:	permethrin5
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<i>325 mg</i> 3	EN/TRIVIDIA 35	PERSERIS2
oxycodone w/	penicillamine 36	pfizerpen
acetaminophen tab 5-325	penicillin g potassium 9	phenelzine sulfate2
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see tranylcypromine	see endocet tab 7.5-	piperacillin sod-tazobactam
<i>sulfate</i> 25	<i>325mg</i> 2	na for inj 3.375 gm (3-
paromomycin sulfate4	see oxycodone w/	0.375 gm)
paroxetine hcl25	acetaminophen tab 10-	piperacillin sod-tazobactan
PASER7	<i>325 mg</i> 3	sod for inj 13.5 gm (12-
PAXIL25	see oxycodone w/	<i>1.5 gm)</i> 1
see paroxetine hcl25	acetaminophen tab	piperacillin sod-tazobactan
PEDIARIX INJ 0.5ML48	2.5-325 mg 3	sod for inj 2.25 gm (2-
PEDVAX HIB48	see oxycodone w/	0.25 gm)
peg 3350-kcl-na bicarb-	acetaminophen tab 5-	piperacillin sod-tazobactan
nacl-na sulfate for soln	<i>325 mg</i> 3	sod for inj 4.5 gm (4-0.5
236 gm43	see oxycodone w/	<i>gm)</i> 1
peg 3350-kcl-sod bicarb-	acetaminophen tab	piperacillin sod-tazobactan
nacl for soln 420 gm43	7.5-325 mg 3	sod for inj 40.5 gm (36-
PEGASYS7	PERIDEX	<i>4.5 gm)</i> 1
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P.O. Box 30011, Pittsburgh, PA 15222-0330

This formulary was updated on 09/13/2021. For more recent information or other questions, please contact Blue MedicareRx, at 1-888-543-4917 or, for TTY/TDD users, 711, 24 hours a day, 7 days a week, or visit Groups.RxMedicarePlans.com.

You can get prescription drugs shipped to your home through our network mail order delivery program which is called CVS Caremark Mail Service Pharmacy.

You also have the option to enroll your prescriptions in an automatic refill program. Under this program, we will start to process your next refill automatically when our records show that you should be close to running out of your drug. And, when your prescription is going to expire or is out of refills, we'll contact your doctor for a new one. We'll contact you by phone, text message or email (your choice) before we mail your medication.

For new prescriptions we'll let you know before we send the first fill of your medication. There may be times when Medicare requires us to get your approval before sending your prescription to you. On every order, you'll have time to make changes or cancel and you won't be charged until it ships. You can start or stop automatic refills at any time.

Typically, you should expect to receive your prescription drugs within 10 calendar days from the time that the mail order pharmacy receives the order. If you do not receive your prescription drug(s) within this time, please contact us at 1-888-543-4917. TTY/TDD users should call 711.

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EVERYTHING YOU NEED TO LIVE A HEALTHIER LIFE





If you want to know more about your health and how to make it better, ahealthyme is a great place to start. With just a few clicks, we'll show you just what you need to live a healthier life. From a health assessment to wellness workshops and interactive tools, ahealthyme is your personal online resource.

WITH AHEALTHYME, MANAGING YOUR HEALTH CAN BE AS EASY AS 1, 2, 3:

Start with your health assessment

Taking your health assessment is easy and rewarding. Simply answer questions about eight areas of your health. When done, we'll give you a detailed look at your health today and recommend tools and programs that will help improve it, based on your answers.

Take a wellness workshop

Our self-paced wellness workshops are a fun way to be smart about your health. You'll gain insight on health topics that relate to you and get closer to your wellness goal.

Learn about:

- · Healthy eating
- Physical fitness
- Quitting smoking
- Much more
- Stress management

Stay motivated and stick to your goals

Maintaining good eating and exercise habits can help keep you on track. With ahealthyme, you can record and track your activities on any computer or smartphone and see how you're doing in real time.

Get Started Now

Go to ahealthyme.com/login and sign up to begin your journey to healthier living.



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NURSES RIGHT NOW

When you call our 24/7 Nurse Line, you can speak to a registered nurse, when you need to, day or night. Because guidance and advice should be available around the clock.



YES, YOUR PLAN COVERS IT!



GET CONNECTED DIRECTLY TO A NURSE



365 DAYS A YEAR, INCLUDING HOLIDAYS



THERE'S NO ADDITIONAL COST

KNOW WHEN TO CALL

Nurses can give you advice on:

- Treating a fever, cut, headache, or diarrhea
- · Managing a new diagnosis
- Recognizing signs of a concussion after a head injury
- Taking over-the-counter medications or prescriptions
- Upcoming medical tests or appointments
- Deciding if you need immediate care
- Caring for a sick child or family member

In the case of a life-threatening emergency, call 911 or go to the nearest emergency room.

Call Our 24/7 Nurse Line

Nurses are ready around the clock to answer your questions. Call 1-888-247-BLUE (2583).

We partner with Carenet Health, an independent health care engagement company, to administer this service. Before you can email a nurse, you'll need to create a Carenet Health account using your nine-digit Blue Cross member ID number (without the letter prefix).



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WELLNESS WORKSHOPS

Looking for Support to Reach Your Wellness Goals?





Our interactive, self-paced wellness workshops are designed to help you understand and make healthy choices. These workshops are easy to use and they're available on our secure ahealthyme website. We hope you'll take advantage of them!

HOW DO I SIGN UP FOR A WELLNESS WORKSHOP?

- Sign in to ahealthyme.com/login, then go to Wellness Workshops in the top navigation bar and select Sign Up for a Workshop from the drop-down list.
- Select the wellness workshop title you'd like to enroll in under Add, and then click Sign Up.*
- To begin, click the workshop title when it appears active.

Get Started Now

Go to ahealthyme.com/login and sign up to follow the path to healthier living.

^{*}If Sign Up is grayed out, that means you're active in another workshop, and you should click Add to Queue.

The queued workshop will become active after you complete the active workshop.

WHAT YOU'LL LEARN

Our wellness workshops encourage, inspire, and teach you how to better manage your health. Topics include:

- Breathe Easy—Tobacco Cessation Wellness Workshop
- Fight the Flu-Wellness Workshop
- Finding the Right Balance—Weight Management Wellness Workshop
- Fit for Life—Physical Activity Wellness Workshop
- Smart Choices—Healthy Eating Wellness Workshop
- Take a Break-Stress Management Wellness Workshop
- Mindful Living-Mind and Body Connection Workshop
- Rest and Recharge—Sleep Wellness Workshop
- Smart Spending and Saving—Financial Wellness Workshop
- Healthy Mouth, Happy Smile-Dental Wellness Workshop
- Prediabetes Prevention-Wellness Workshop
- Advance Care Planning—Wellness Workshop

HOW IT WORKS

Every week, you'll be assigned articles, videos, trackers, and other tools to help you create and follow a plan to get healthier. You can complete all the tasks at once, or over the course of several days—whichever works best with your schedule. Reminder emails will help to keep you on track toward meeting your goals.

TRACKING PROGRESS

You can view your workshop To-Do list on the home page of the secure ahealthyme website (ahealthyme.com/login). Once a task you complete a task, it appears under Completed at the bottom of your To-Do list.



TAKE A STEP TOWARD BETTER HEALTH

Sign up for a wellness workshop!

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FITNESS REIMBURSEMENT

Get rewarded for your healthy habits!

Save up to

\$150





Qualified for Reimbursement:

- A full service health club with cardiovascular and strength-training equipment like treadmills, bikes, weight machines, and free weights
- A fitness studio with instructor-led group classes such as yoga, Pilates, Zumba*, kickboxing, indoor cycling/ spinning, and other exercise programs
- Online fitness memberships, subscriptions, programs, or classes
- Cardiovascular and strength-training equipment for fitness that is purchased for use in the home, such as stationary bikes, weights, exercise bands, treadmills, fitness machines



Not Qualified for Reimbursement:

- One-time initiation or termination fees
- Fees paid for gymnastics, tennis, pool-only facilities, martial arts schools, instructional dance studios, country clubs or social clubs, sports teams or leagues
- Personal trainer sessions
- Fitness clothing

Get Started

To submit your reimbursement, sign in to MyBlue at bluecrossma.org.

Your reimbursement is waiting!



FITNESS REIMBURSEMENT REQUEST

Please print all information clearly. To verify that this reimbursement is offered within your plan, or for more information, you can sign in to MyBlue at bluecrossma.org or call the Member Service number on your ID card.

All fitness reimbursement requests must be submitted by March 31 of the following year.

Subscriber Information (Policyholder)							
Identification Number on Subscriber ID Card (including first 3 characters)		Subscriber's Last Name	First Name	Middle Initial			
Address – Number and Street		City	State	ZIP Code			
Employer's Name							
Claim Information							
Member's Last Name	First Name		Middle Initial	Date of Birth//			
Claim is for (choose one and color in the entire box): Subscriber (policyholder) Spouse (of policyholder) Ex-Spouse	Name, Address, a	and Phone Number of Quali	fied Fitness Expense				
Dependent (up to age 26)	Total Dollars requested for Qualified Fitness Expense: \$						
☐ Other (specify):	Calendar year that fees were paid:						
Blue Cross Blue Shield of Massachusetts will make a reimbursement decision within 30 calendar days of receiving a completed request form. Reimbursement is sent to the member's address on file with Blue Cross. Reimbursement may be considered taxable income, so you should consult your tax advisor.							
Certification and Authorization (This form must be signed and dated below.) I certify that the information provided in support of this submission is complete and correct, and that I have not previously submitted for these services. I enrolled in the qualified program with the full intention of using such program. I understand that Blue Cross Blue Shield of Massachusetts may require proof of payment for a reimbursement decision. I authorize the release of any information about my qualified fitness program to Blue Cross Blue Shield of Massachusetts.							
Subscriber's or Member's Signature: Date://_							
Complete this form and mail it to: Blue Cross Blue Shield of Massachusetts, Local Claims Department, PO Box 986030, Boston, MA 02298							

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WEIGHT-LOSS REIMBURSEMENT

Your reward for healthy behavior:

Receive up to \$150 annually when you participate in a qualified weight-loss program.¹





Qualified for Weight-Loss Reimbursement

Participation fees for:

- Hospital-based programs and Weight Watchers[®] in-person
- Weight Watchers online and other non-hospital programs (in-person or online) that combine healthy eating, exercise, and coaching sessions with certified health professionals such as nutritionists, registered dietitians, or exercise physiologists.



Not Qualified for Weight-Loss Reimbursement

- One-time initiation or termination fees
- Food, supplements, books, scales, or exercise equipment
- Individual nutrition counseling sessions, doctor/nurse visits, lab tests, or other services that are covered benefits under your medical plan

GET REIMBURSED IN THREE EASY STEPS

1

Choose

Start by picking a qualified weight-loss program.

2

Complete

Once you pay for the program, fill out the attached form, or sign in to MyBlue to submit online at member.bluecrossma.com/login.

3

Mail

Send the completed form to the address listed.

Be sure to check with your doctor before starting any weight-loss program.

Questions?

Contact Member Service by calling the phone number on your member ID card.

To verify this reimbursement is offered for your plan, or for more information, sign in to MyBlue at bluecrossma.com/myblue or call the Member Service number on your ID card. Most plans offer the reimbursement shown, but refer to your plan information for specific details.

WEIGHT-LOSS REIMBURSEMENT REQUEST

Please Print All Information Clearly: To verify this reimbursement is offered within your plan, or for more information, please sign in to MyBlue at bluecrossma.com/myblue or call the Member Service number on your ID card.

All weight-loss reimbursement requests must be submitted by March 31 of the following year.

Complete this form and mail it to: Blue Cross Blue Shield of Massachusetts, Local Claims Department, PO Box 986030, Boston, MA 02298

Subscriber Information (Policyholder)							
Identification Number on Subscriber ID Card (including first 3 characters)		Subscriber's Last Name	First Name	Middle Initial			
Address - Number and Street		City	State	Zip Code			
Employer's Name							
Claim Information							
Member Last Name	First Name	Middle Initial	Gender (color in the entire box) Male Female	Date of Birth//			
Claim is for (choose one and color in the entire box): Subscriber (policyholder) Spouse (of policyholder) Ex-Spouse Dependent (up to age 26) Other (specify):	Name, Address, and Phone Number of Qualified Weight-Loss Program Total dollars requested: \$ Monthly program participation fee: \$ Calendar Year://						
Blue Cross Blue Shield of Massachusetts will make a reimbursement decision within 30 calendar days of receiving a completed request form. Reimbursement is sent to the member's address on file with Blue Cross. Reimbursement may be considered taxable income, so consult your tax advisor. Certification and Authorization (This form must be signed and dated below.) I certify that the information provided in support of this submission is complete and correct and that I have not previously submitted for these services. I understand that Blue Cross Blue Shield of Massachusetts may require proof of payment for a reimbursement decision. I authorize the release of any information about my qualified weight-loss program to Blue Cross Blue Shield of Massachusetts.							
Subscriber's or Member's Signature: Date:/_							

Important Information:

- Weight-loss reimbursement can be granted for any single member or combination of members enrolled under the same Blue Cross Blue Shield of Massachusetts health plan. Blue Cross will make a reimbursement decision within 30 days of receiving a completed request.
- Reimbursement requests must be submitted by March 31 of the following year.
- Keep copies of proof of payment in case we request it from you. Proof of payment includes:
 - Receipts (cash/check/credit/electronic) for participation fees clearly documenting your name, the weight-loss program name, and individual amounts charged with date paid.
 - Your weight-loss program membership or participation agreement clearly documenting your name and date of enrollment/participation.
- $^{\bullet}\,$ Your reimbursement may be considered taxable income, so consult a tax advisor.

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).

ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: 711).



Worldwide Coverage

For Foreign and Domestic Travelers



Get quality health care no matter where you are in the world.

Whether you're traveling within the United States or abroad, BlueCard®' and Blue Cross Blue Shield Global® Core make sure you have access to top doctors and hospitals and concierge-level service.

Call 1-800-810-BLUE (2583)

for a list of participating doctors and hospitals, or to obtain an international claim form.



Take this reference card with you when you travel.

When you need care, you'll be prepared.

TEAR HERE

Urgent Care

- Call 1-800-810-BLUE (2583), or visit bcbs.com to find nearby doctors and hospitals anywhere in the world that participate in the Blue Cross Blue Shield network.
- 2. Show your member ID card when you get care.
- 3. If you're admitted, or if you have questions about your coverage, call Member Service at the number on the front of your ID card.

Your Passport to Good Health

Always carry your Blue Cross Blue Shield of Massachusetts ID card.

FOLD HERE

Emergency Care

For emergency services, call the local emergency number or go to the nearest hospital immediately.

Getting Care in the United States

More than 85 percent of all doctors and hospitals in the United States participate in the BlueCard program. If you need care outside your plan's service area, call **1-800-810-BLUE** (**2583**), or visit **bcbs.com** to find a doctor near you. Be sure to show your ID card before you receive service.

When you get service:

- There's no paperwork
- · Participating doctors and hospitals submit claims for you
- All you pay is the copayment, co-insurance, or deductible
- If you receive care from a non-participating doctor or hospital, you may need to pay for the services up front and submit a claim for reimbursement

BlueCard PPO Members Only: If you see this symbol, PPO, on your ID card, you're a BlueCard PPO member. To save the most money when getting service, use a participating BlueCard PPO doctor or hospital.

In Case of Emergency

For emergency services, call the local emergency number or go to the nearest hospital immediately.

Getting Care Outside the United States

The Blue Cross Blue Shield Global® Core network gives you access to doctors and hospitals around the world. If you need care, call the Service Center at **1-800-810-BLUE** (2583), or call collect at **1-804-673-1177**, 24 hours a day, 7 days a week. An assistance coordinator, along with a medical professional, will arrange a doctor's appointment or hospitalization if necessary. You can also visit **bcbsglobalcore.com**.

TEAR HERE



An Association of Independent Blue Cross and Blue Shield Plans

FOLD HERE

Doctor's Phone:

Doctor's Hospital Affiliation:

Your Blue Cross Blue Shield Member ID:

Primary Care Provider's Name:

Member Service Phone Number (from your ID card):

For Inpatient Services:

- Call the Service Center at 1-800-810-BLUE (2583), or Member Service at the number on your ID card, for precertification or preauthorization
- In most cases, all you pay is the copayment, co-insurance, or deductible
- The hospital should submit the claim on your behalf

For Outpatient Services:

- Show your ID card
- · Pay the doctor or hospital
- Fill out a Blue Cross Blue Shield Global® Core International Claim form for reimbursement (Call 1-800-810-BLUE (2583) or visit bcbsglobalcore.com for the form)
- You're only responsible for copayments, co-insurance, or deductible when seeing in-network doctors and hospitals
- You'll pay more when seeing out-of-network doctors and hospitals

Doctors and Hospitals

In most cases, participating doctors and hospitals will file the claim for you. If they need information about eligibility or your coverage, have them call **1-800-676-BLUE** (2583).

Your Member Responsibilities

As a Blue Cross Blue Shield of Massachusetts member, you're still responsible for any copayments, co-insurance, deductible, or non-covered services. For out-of-country services, Blue Cross Blue Shield of Massachusetts payments will be based on the provider's charge.

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or cender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID Card (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).

ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: **711**).

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32-5885 (02/18)



OUR COMMITMENT TO CONFIDENTIALITY (NOTICE OF PRIVACY PRACTICES) AND WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) NOTICE

This notice describes how medical and dental information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Commitment: We respect your right to privacy. We will not disclose personally identifiable information about you without your permission, unless the disclosure is necessary to provide our services to you or is otherwise in accordance with the law.

Collection of Information

We collect only the information about you that we need to operate our business. We collect information from other parties, such as your health care providers and employers. Examples of the information we collect are (i) medical and dental information from health care providers when they submit claims for services and (ii) personal information such as name, address, and date of birth, which is most often supplied by you or your employer when you enroll in a plan.

USE AND DISCLOSURE OF INFORMATION

We are required by law to protect the confidentiality of information about you and to notify you in case of a breach affecting your information. We may use and disclose information about you without your written authorization for the following purposes, to the extent otherwise permitted or required by law:

You or Your Representatives—to you or your "personal representative" upon request or to help you (or your personal representative) understand treatment options, benefits, or the rights available to you. Your "personal representative" is a person who has legal authority to make health-related decisions on your behalf, such as a person with a health-care power of attorney. Your request must be in writing. Please complete the Documentation of Legal Representative Status for Members form available on our website. You also may designate a family member or friend to receive information and interact with us on your behalf. Your designation and any subsequent revocation must be in writing. Please complete the Member's Designation of an Authorized Representative form available on our website. You may also call Member Service for a copy of these forms.

- Treatment—to help health care providers manage or coordinate your health care and related services.
 For example, we may use and disclose information about you to inform providers of medications you take or to remind you of appointments.
- Payment—to obtain payment for your coverage, pay claims for your health benefits, or help another health plan or health care provider in its payment activities.
 For example, we may use or disclose information about you to make coverage determinations, administer claims, or coordinate benefits with other coverage you may have.
- Health Care Operations—to perform other activities necessary for the operation of our business, including customer service, disease management, and determining how to improve the quality of care. For example, we may use or disclose information about you to respond to your call to customer service, arrange for medical review of your claims, or conduct quality assessment and improvement activities.

- Legal Compliance—to comply with applicable law.
 For example, we may be required to use or disclose information about you to respond to regulatory authorities responsible for oversight of government benefit programs or our business operations; to parties or courts in the course of judicial or administrative proceedings; or pursuant to workers' compensation laws.
- Government Agencies—under limited circumstances established by law, to public health authorities, coroners or medical examiners, law enforcement, or other government officials
- Research—for health-related research studies that meet legal standards for protection of the individuals involved in the studies and their personal information. We may also create a database of our members' information that does not include individual identifiers and use the database for research or other purposes, provided that the information cannot be traced back to specific members.
- To Your Employer (or other plan sponsor), if applicable, for administration of its health plan. This applies only if you receive coverage through an employer-sponsored plan (or plan sponsored by your union or other entity).
 For example, we may disclose information about you to your employer (or other plan sponsor) to confirm

enrollment in the plan or (if the employer or other plan sponsor is self-insured) for claim review and audits. We will disclose your information only to designated individuals. That, along with legal prohibitions on use of your personal information for discriminatory purposes, helps protect your information from unauthorized use.

To carry out these purposes, we share information with entities that perform functions for us subject to contracts that limit use and disclosure for intended purposes. We use physical, electronic, and procedural safeguards to protect your privacy. Even when allowed, we limit uses and disclosures of your information to the minimum amount reasonably necessary for the intended task.

The Health Insurance Portability and Accountability Act (HIPAA) generally does not override other laws that give people greater privacy protections. As a result, we must comply with any state or federal privacy laws that require us to provide you with more privacy protections. For example, federal law provides special protections for substance use disorder information; Massachusetts state law restricts the disclosure of HIV and AIDS related information. In addition, we will not use (and are prohibited from using) your genetic information for underwriting purposes.

OTHER DISCLOSURES REQUIRE YOUR WRITTEN AUTHORIZATION

Except as provided in this notice, we will not use or disclose information about you without your written authorization. For example, we must have your written authorization to use or disclose your information for marketing purposes or (in most cases) to use or disclose psychotherapy notes. Although we would need written authorization to sell information about you, we do not sell members' information.

You may revoke your authorization at any time. Your authorization must be in writing. Your revocation will not affect any action that we have already taken in reliance on your authorization. If you would like us to disclose information about you to a third party, please complete the Permission for One-Time Disclosure of Information form available on our website or call Member Service for a copy of the form.

YOUR PRIVACY RIGHTS

You have the following rights with respect to information about you. You may exercise any of these rights by calling the Member Service number listed on your member ID card or contacting us at the address listed at the end of this notice. The forms listed below are also available on our website.

- You have the right to receive information about privacy protections. Your member-education materials include a notice of your rights, and you may request a paper copy of this notice at any time.
- You have the right to inspect and get copies of information that we use to make decisions about you. This is your designated record set. Your request must be in writing. We may charge a reasonable fee for copying and mailing you this information. Please complete the Request for Access to Copies of Protected Health Information in Designated Record Set form to request copies of your information.
- You have the right to receive an accounting of certain disclosures that we make of information about you.
 Your request must be in writing. Please complete the Members Request for an Accounting of Disclosures form.
 Our response will exclude any disclosures made in support

Our response will exclude any disclosures made in support of treatment, payment, and health care operations or that you authorized (among others). An example of a disclosure that would be reported to you is our disclosure of your information in response to a court order.

You have the right to ask us to correct or amend information you believe to be incorrect. Your request to correct or amend information must be in writing. Please complete the Members Request to Amend Protected Health Information form. If we deny your request, you may ask us to make your request part of your records. • You have the right to ask that we restrict or refuse the disclosure of information about you and that we direct communications to you by alternative means or to alternative locations. While we may not always be able to agree to your request, we will make reasonable efforts to accommodate requests. Unless you've notified us to request a different mailing address, Summary of Health Plan Payments statements for the subscriber, and all members listed on the subscriber's plan, are generally delivered to the subscriber's address. Under certain circumstances, you can request to not receive statements for a particular service, or to have statements delivered through an alternate method or to an alternate address, when required by state law. If you have concerns about protecting the privacy of your medical information in your

statements, you can have these statements delivered to an address other than the plan subscriber's address, or have them delivered only via electronic means. For help understanding your delivery options, please call Member Service at the number listed on your member ID card. Your request and any subsequent revocation must be in writing.

If you believe your privacy rights have been violated, you have the right to complain to us using the grievance process outlined in your benefit materials, or to the Secretary of the U.S. Department of Health and Human Services, without fear of retaliation.

ABOUT THIS NOTICE

The original effective date of this notice was April 14, 2003. The effective date of the most recent revision is indicated in the footer of this notice. We are required by law to provide you with this notice of our legal duties and privacy practices and to abide by the notice for as long as it is in effect. We reserve the right to change this notice. Any changes will apply to all information that we maintain, regardless of when it was created or received. If we make a material change to this notice, we will post the revised notice on our website and notify you of the change and how to obtain the revised notice in our next regular mailing to you. If you have any questions, please call the Member Service number listed on your member ID card, or write us at:

Blue Cross Blue Shield of Massachusetts Privacy Officer 101 Huntington Ave. Suite 1300 Boston, MA 02199-7611

WHCRA NOTICE

Did you know that your medical plan provides benefits for many mastectomy-related services? This is the case even if you were not covered by Blue Cross Blue Shield of Massachusetts at the time of the mastectomy. It's required by the Women's Health and Cancer Rights Act of 1998. If you are covered for a mastectomy and elect breast reconstruction in connection with a mastectomy, then benefits are also provided for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Coverage will be provided as determined in consultation with you and your attending doctor. The costs that you pay for these services are the same as those you pay for other services in the same category. To learn more, please call the Member Service number on your member ID card.

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you.

Call Member Service at the number on your ID card (TTY: 711).

Spanish/Español: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).

Portuguese/Português: ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: 711).

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Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are
 intended to be educational and may be different from the terms and definitions in your <u>plan</u> or <u>health insurance</u>
 policy. Some of these terms also might not have exactly the same meaning when used in your policy or <u>plan</u>, and in
 any case, the policy or <u>plan</u> governs. (See your Summary of Benefits and Coverage for information on how to get a
 copy of your policy or <u>plan</u> document.)
- <u>Underlined</u> text indicates a term defined in this Glossary.
- See page 6 for an example showing how <u>deductibles</u>, <u>coinsurance</u> and <u>out-of-pocket limits</u> work together in a real life situation.

Allowed Amount

This is the maximum payment the <u>plan</u> will pay for a covered health care service. May also be called "eligible expense," "payment allowance," or "negotiated rate."

Appeal

A request that your health insurer or <u>plan</u> review a decision that denies a benefit or payment (either in whole or in part).

Balance Billing

When a <u>provider</u> bills you for the balance remaining on the bill that your <u>plan</u> doesn't cover. This amount is the difference between the actual billed amount and the <u>allowed amount</u>. For example, if the provider's charge is \$200 and the allowed amount is \$110, the provider may bill you for the remaining \$90. This happens most often when you see an <u>out-of-network provider</u> (<u>non-preferred provider</u>). A <u>network provider</u> (<u>preferred provider</u>) may not balance bill you for covered services.

Claim

A request for a benefit (including reimbursement of a health care expense) made by you or your health care <u>provider</u> to your health insurer or <u>plan</u> for items or services you think are covered.

Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance *plus* any <u>deductibles</u> you



(See page 6 for a detailed example.)

owe. (For example, if the <u>health insurance</u> or <u>plan's</u> allowed amount for an office visit is \$100 and you've met your <u>deductible</u>, your coinsurance payment of 20% would be \$20. The <u>health insurance</u> or <u>plan</u> pays the rest of the allowed amount.)

Complications of Pregnancy

Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren't complications of pregnancy.

Copayment

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service (sometimes called "copay"). The amount can vary by the type of covered health care service.

Cost Sharing

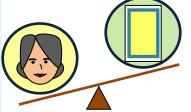
Your share of costs for services that a <u>plan</u> covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are <u>copayments</u>, <u>deductibles</u>, and <u>coinsurance</u>. Family cost sharing is the share of cost for <u>deductibles</u> and <u>out-of-pocket</u> costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your <u>premiums</u>, penalties you may have to pay, or the cost of care a <u>plan</u> doesn't cover usually aren't considered cost sharing.

Cost-sharing Reductions

Discounts that reduce the amount you pay for certain services covered by an individual <u>plan</u> you buy through the <u>Marketplace</u>. You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may



Jane pays 100%

Her plan pays 0%

(See page 6 for a detailed example.)

also have separate deductibles that apply to specific services or groups of services. A <u>plan</u> may also have only separate deductibles. (For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible for covered health care services subject to the deductible.)

Diagnostic Test

Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care <u>provider</u> for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

Emergency Medical Condition

An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: I) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Emergency Medical Transportation

Ambulance services for an <u>emergency medical condition</u>. Types of emergency medical transportation may include transportation by air, land, or sea. Your <u>plan</u> may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care / Emergency Services

Services to check for an <u>emergency medical condition</u> and treat you to keep an <u>emergency medical condition</u> from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for <u>emergency medical conditions</u>.

Excluded Services

Health care services that your <u>plan</u> doesn't pay for or cover.

Formulary

A list of drugs your <u>plan</u> covers. A formulary may include how much your share of the cost is for each drug. Your <u>plan</u> may put drugs in different <u>cost-sharing</u> levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different <u>cost-sharing</u> amounts will apply to each tier.

Grievance

A complaint that you communicate to your health insurer or plan,

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires a health insurer to pay some or all of your health care costs in exchange for a <u>premium</u>. A health insurance contract may also be called a "policy" or "<u>plan</u>."

Home Health Care

Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care <u>providers</u>. Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some <u>plans</u> may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

In-network Coinsurance

Your share (for example, 20%) of the <u>allowed amount</u> for covered health care services. Your share is usually lower for in-network covered services.

In-network Copayment

A fixed amount (for example, \$15) you pay for covered health care services to <u>providers</u> who contract with your <u>health insurance</u> or <u>plan</u>. In-network copayments usually are less than <u>out-of-network copayments</u>.

Marketplace

A marketplace for health insurance where individuals, families and small businesses can learn about their plan options; compare plans based on costs, benefits and other important features; apply for and receive financial help with premiums and cost sharing based on income; and choose a plan and enroll in coverage. Also known as an "Exchange." The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children's Health Insurance Program (CHIP). Available online, by phone, and in-person.

Maximum Out-of-pocket Limit

Yearly amount the federal government sets as the most each individual or family can be required to pay in <u>cost sharing</u> during the <u>plan</u> year for covered, in-network services. Applies to most types of health <u>plans</u> and insurance. This amount may be higher than the <u>out-of-pocket limits</u> stated for your <u>plan</u>.

Medically Necessary

Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

Minimum Essential Coverage

Minimum essential coverage generally includes <u>plans</u>, <u>health insurance</u> available through the <u>Marketplace</u> or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of minimum essential coverage, you may not be eligible for the <u>premium tax credit</u>.

Minimum Value Standard

A basic standard to measure the percent of permitted costs the <u>plan</u> covers. If you're offered an employer <u>plan</u> that pays for at least 60% of the total allowed costs of benefits, the <u>plan</u> offers minimum value and you may not qualify for <u>premium tax credits</u> and <u>cost-sharing reductions</u> to buy a <u>plan</u> from the <u>Marketplace</u>.

Network

The facilities, <u>providers</u> and suppliers your health insurer or <u>plan</u> has contracted with to provide health care services.

Network Provider (Preferred Provider)

A <u>provider</u> who has a contract with your <u>health insurer</u> or <u>plan</u> who has agreed to provide services to members of a <u>plan</u>. You will pay less if you see a <u>provider</u> in the <u>network</u>. Also called "preferred provider" or "participating provider."

Orthotics and Prosthetics

Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.

Out-of-network Coinsurance

Your share (for example, 40%) of the <u>allowed amount</u> for covered health care services to <u>providers</u> who don't contract with your <u>health insurance</u> or <u>plan</u>. Out-of-network coinsurance usually costs you more than <u>innetwork coinsurance</u>.

Out-of-network Copayment

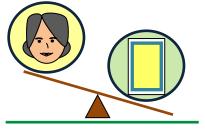
A fixed amount (for example, \$30) you pay for covered health care services from <u>providers</u> who do **not** contract with your <u>health insurance</u> or <u>plan</u>. Out-of-network copayments usually are more than <u>in-network</u> <u>copayments</u>.

Out-of-network Provider (Non-Preferred Provider)

A <u>provider</u> who doesn't have a contract with your <u>plan</u> to provide services. If your <u>plan</u> covers out-of-network services, you'll usually pay more to see an out-of-network provider than a <u>preferred provider</u>. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-participating" instead of "out-of-network provider."

Out-of-pocket Limit

The most you *could* pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the <u>plan</u> will usually pay 100% of the <u>allowed amount</u>. This limit helps you plan for



Jane pays 0%

Her plan pays 100%

(See page 6 for a detailed example.)

health care costs. This limit never includes your <u>premium</u>, <u>balance-billed</u> charges or health care your <u>plan</u> doesn't cover. Some <u>plans</u> don't count all of your <u>copayments</u>, <u>deductibles</u>, <u>coinsurance</u> payments, out-of-network payments, or other expenses toward this limit.

Physician Services

Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

Plan

Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called "health insurance plan," "policy," "health insurance policy," or "health insurance."

Preauthorization

A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called "prior authorization," "prior approval," or "precertification." Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Premium

The amount that must be paid for your <u>health insurance</u> or <u>plan</u>. You and/or your employer usually pay it monthly, quarterly, or yearly.

Premium Tax Credits

Financial help that lowers your taxes to help you and your family pay for private <u>health insurance</u>. You can get this help if you get <u>health insurance</u> through the <u>Marketplace</u> and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly <u>premium</u> costs.

Prescription Drug Coverage

Coverage under a <u>plan</u> that helps pay for <u>prescription</u> <u>drugs</u>. If the plan's <u>formulary</u> uses "tiers" (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in <u>cost sharing</u> will be different for each "tier" of covered <u>prescription drugs</u>.

Prescription Drugs

Drugs and medications that by law require a prescription.

Preventive Care (Preventive Service)

Routine health care, including <u>screenings</u>, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

Primary Care Provider

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the plan, who provides, coordinates, or helps you access a range of health care services.

Provider

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.

Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Referral

A written order from your <u>primary care provider</u> for you to see a <u>specialist</u> or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your <u>primary care provider</u>. If you don't get a referral first, the <u>plan</u> may not pay for the services.

Rehabilitation Services

Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Screening

A type of <u>preventive care</u> that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Skilled Nursing Care

Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is **not** the same as "skilled care services," which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist

A <u>provider</u> focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drug

A type of <u>prescription drug</u> that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a <u>formulary</u>.

UCR (Usual, Customary and Reasonable)

The amount paid for a medical service in a geographic area based on what <u>providers</u> in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the <u>allowed amount</u>.

Urgent Care

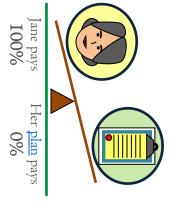
Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require <u>emergency room care</u>.

How You and Your Insurer Share Costs - Example

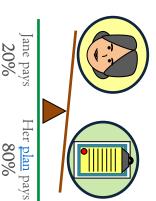
Jane's Plan Deductible: \$1,500 Coinsurance: 20% Out-of-Pocket Limit: \$5,000

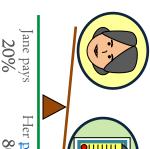
Beginning of Coverage Period

End of Coverage Period December 31st







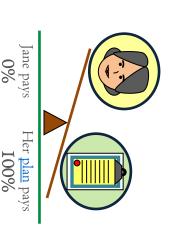


쿈

costs more







costs more

deductible, coinsurance begins Jane reaches her \$1,500

\$1,500 deductible yet Jane hasn't reached her

Her plan doesn't pay any of the costs.

Office visit costs: \$125

Her plan pays: \$0

Jane pays: \$125

costs for her next visit. deductible. So her plan pays some of the paid \$1,500 in total, reaching her Jane has seen a doctor several times and

Office visit costs: \$125

Her plan pays: 80% of \$125 = \$100Jane pays: 20% of \$125 = \$25

Jane reaches her \$5,000 out-of-pocket limit

cost of her covered health care services \$5,000 in total. Her plan pays the full for the rest of the year. Jane has seen the doctor often and paid

Office visit costs: \$125

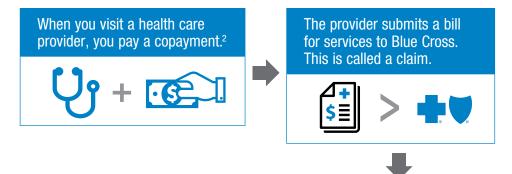
Her plan pays: \$125 Jane pays: \$0

the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, collection is 0938-I146. The time required to complete this information collection is estimated to average 0.08 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information

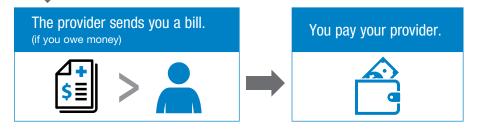
A Guide to Your Summary of Health Plan Payments¹

The Summary of Health Plan Payments shows you how we process claims for medical services you've received. This statement is not a bill.

How the Payment Process Works



You'll get a Summary of Health Plan Payments if there's a balance remaining after we process the claim and pay our share of the costs. Your provider will send you a bill if you owe any money. Copayments Your copayments (also known as a This is copay) are the fixed dollar amount you pay each time you see a provider² or fill a not a bill. prescription. Look for your copay amount Payment overview* on your member ID card. \$5,000.00 Allowed amount Deductible If your plan has a deductible, this is the **Amount covered** \$3,700.00 amount of money you pay out-of-pocket for health care services, such as blood Amount covered you owe \$0.00 Copaymentstests and x-rays, before Blue Cross starts by Blue Cross to pay for them. Deductible \$1,000,00 e the glossary on the previous page to find out more \$0.00 Co-insurance -Co-insurance about the terms included in the If your plan has co-insurance, you're \$300.00 payment overview and payment Not Covered details pages. responsible for paying a predetermined \$1,300.00 percentage of your medical expenses once your deductible has been met. **Amount you owe** (if any) Tip: See the glossary on page 2 of your statement for the meaning of any unfamiliar terms.



- 1. Medex members receive statements called Explanation of Benefits.
- Except for certain plans, preventive services are fully covered. Some plans may require co-insurance.

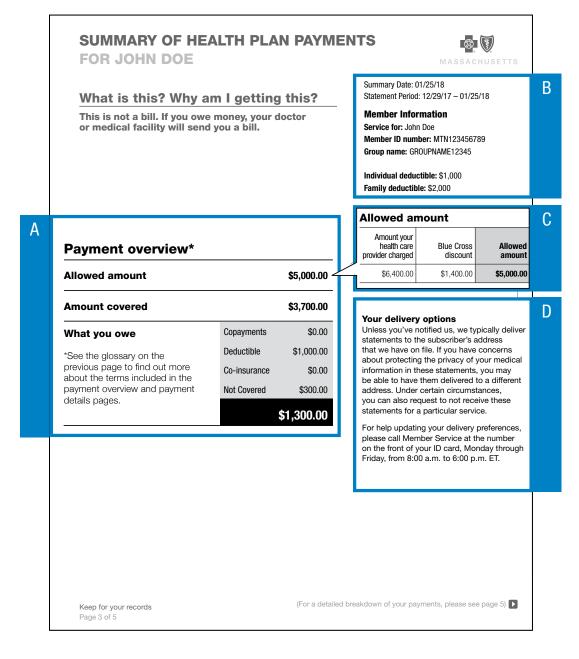
Financial accounts can help cover costs.

If your plan has a Health Reimbursement Arrangement, Health Savings Account, or Flexible Spending Account, you can use it to pay medical expenses, such as your deductible and copayments. You can also use these accounts to pay for eyeglasses and dental services.



Your Summary of Health Plan Payments

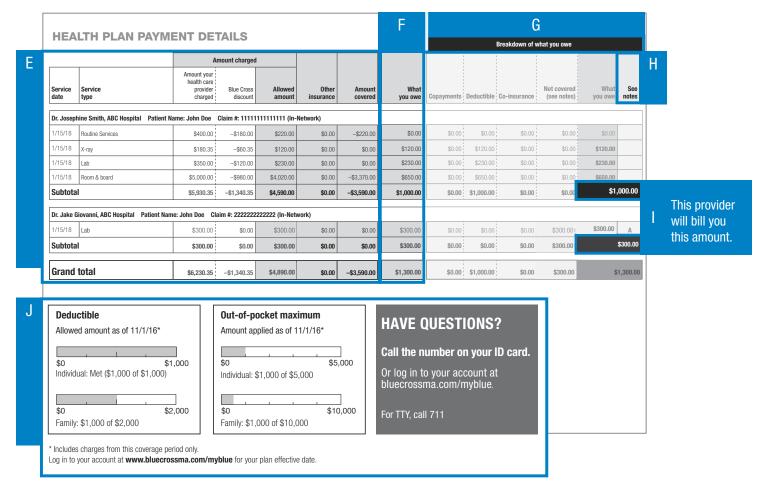
Payment Overview Page



- The payment overview shows the amount charged to Blue Cross, the amount we covered, and what you owe (if anything).
- B Up here, you'll find your account information, including your plan's deductible. A deductible is the amount you pay for medical services before your insurance begins to pay.
- This section shows how the allowed amount was calculated.
- Pour delivery options describes how these statements are delivered and how you can update your preferences.

Your Summary of Health Plan Payments

Payment Details Page



- Your recent claims, including dates of service, names of providers, the amounts charged, and payment details.
- The amount you owe for each service.
- How we determined what you owe, including copayments, deductible, and co-insurance.

- Additional information on how we processed your claims.
- The final amount you'll owe your provider for services after we cover our share of the cost. If you have additional insurance, this doesn't apply to you.
- A detailed breakdown of your deductible and outof-pocket maximum, including the amounts you've previously applied towards these.

View your plan information and recent claims at bluecrossma.com/myblue.

Questions?

Call us at the number on your ID card or log in to your account at **bluecrossma.com/myblue**, click **Contact Us**, then enter your question using the **secure inquiry form** in the Member Service section.





Thank you for choosing a Blue Cross Blue Shield plan.

Please take a few minutes to help us set up your membership by filling out the attached enrollment form.

Before You Begin

Please carefully read the instructions below.

For members of HMO Blue, Network Blue, Blue Choice, HMO Blue New England, or Blue Choice New England You're required to choose a primary care physician (PCP) when you enroll. Please choose a PCP from your plan's provider directory. Be sure to read "PCP ID #" in Section 2. List your PCP choice on your enrollment form. The PCP ID number can also be found by visiting bluecrossma.com and selecting Find a Doctor.

For Access BlueSM Members: Although you're not required to choose a PCP, we recommend you choose one by following the instructions in Section 2 on the back of this page.

Important: Are you covered by Medicare or other insurance? We need to know if you or any family member listed have Medicare and/or other insurance in addition to your Blue Cross Blue Shield of Massachusetts plan. Please be sure to check either Y (for yes) or N (for no) in the correct box. This information will help us accurately coordinate your benefits. Please follow the instructions in Sections 2 and 3.

Please print two copies of your completed application. Keep one for your records and give the other to your employer to sign and mail to Blue Cross Blue Shield of Massachusetts. In order to complete your enrollment request, your employer is required to sign the application.

Special Instructions for Student Coverage: If you're seeking coverage for a full-time student dependent over age 19, you may need to fill out a Student Certificate form. Check with your employer to see if this coverage is available.

Blue Cross Blue Shield of Massachusetts P.O. Box 986001 Boston, MA 02298 Fax: 1-617-246-7531

Instructions

Section 1 To Be Filled Out By Your Employer

Your employer will fill out this section.

Type of Transaction—Check the box(es) that apply.

Subscriber Cancellation Codes. If the subscriber won't be continuing any Blue Cross Blue Shield coverage, carefully select one of the following and indicate the three-digit code on the form.

Code #	Reason for Canceling
041	Changing to other health plan
	Voluntary termination
	COBRA cancellation (under 18 months or nonpayment)
042	• Over 65, changing to Group Medex® plan. (Requires Medicare A and B)
	• Over 65, changing to direct-pay Medex plan. (Requires Medicare A and B)
	Over 65, changing to Medicare supplement other than Medex plans.
043	• Medicare (age =< 65)
043	• Medicare (age =< 65)

Code #	Reason for Canceling								
061	Left employment								
	COBRA ending								
063	• Transfer								
064	Cancellation as of original effective date								
070	• Deceased								
071	Moved out of state (out of HMO service area)								
076	Military service								

Note: If your subscribers are adding or dropping one benefit only (medical/dental), please indicate "add medical," "add dental," "cancel medical," or "cancel dental" in the "Remarks" section.

If your new hires are subject to a probationary period, please indicate the time frame in the "Remarks" section, as well as the qualifying events for new enrollees. If a subscriber is being moved from an active group to a retiree group (within the same account), this is a transfer and not a termination. Please include the Medical or Dental Group # transferring to.

Cancellation date will be the first day of no coverage.

Qualifying Events—Remarks:

To assist in the enrollment process, please use check boxes or write in applicable information in the "Remarks" section of the form.

- Open Enrollment—Check this box for open enrollment.
- New Hire—Check this box for new hires to the company.
- COBRA—Check this box if person is continuing coverage under COBRA.
- Add Spouse—Check this box if spouse is being added. Ensure date of marriage is within approved retroactive period.
- Add Dependent—Check this box if adding any dependent.
- Loss of Coverage—Check this box if employee lost coverage through spouse or parent. Please include HIPAA Continuous of Coverage Letter from prior company/insurer. If you have questions, contact your account service representative.
- Other—Check this box if change to family requires additional explanation. Please write in the reason for change (e.g., court order, adoption, New Dependent Law under HCR, legal guardianship, etc.). Include supporting documentation. If you have questions, contact your account service representative.

Section 2 Yourself (Member 1)

Please fill in all information that applies to you. (REQUIRED)*

PCP ID#—If your health plan requires you to choose a primary care physician (PCP), please fill in this section. Write the PCP ID number (not the telephone number) of the doctor you have chosen to coordinate your health care. You'll find the doctor's PCP ID number in the provider directory for your health plan. If you need help choosing a PCP, please call our Physician Selection Service at 1-800-821-1388. A representative will be happy to help you select a doctor. PCP ID number can be found at bluecrossma.com. select Find a Doctor.

Other Insurance—Do you have other health insurance or Medicare in addition to your Blue Cross Blue Shield plan? Please be sure to circle either Y (for yes) or N (for no) in the correct box. If you have other insurance, please write the name of the other insurance company and your member identification number.

To Add or Delete a Member—Are you adding or deleting a member under your existing membership? If yes, please fill in the areas in Sections 1 and 2. You may need help from your employer to fill in Section 1. Then, give us the details about the members you're adding or deleting in Section 3 and/or Section 4.

Section 3 Member 2

If you choose a Family membership, please fill in this section if you want Member 2 to be covered. (REQUIRED)* (Note: Member 2 cannot be covered under an Individual membership.)

Other Insurance—Does your spouse have other health insurance or Medicare? Please be sure to circle either Y (for yes) or N (for no) in the correct box. If your spouse or partner has other insurance, please write the name of the other insurance company and your member identification number.

Section 4 Your Eligible Dependents (Members 3, 4, and 5)

If you choose a Family membership, please fill in this section for all children or other eligible dependents you want to be covered. (REQUIRED)* (Note: dependents cannot be covered under an Individual membership.)

If you have more than three dependents to be covered, please use additional Enrollment Forms as needed. Please indicate on the form that additional forms have been used and write in the total number of dependents you want to be enrolled.

Section 5 Personal Savings Account

Your employer may have chosen to offer a personal savings account alongside your medical offering. Please consult your open enrollment materials and/or your HR department to determine if this applies to you.

For each option:

Start Date: Your start date will be considered established for tax purposes as of the start date of your medical plan, provided that you have signed, dated, and submitted the completed application for these accounts on or before that date.

End Date: Your end date is the date you choose to stop deposits into the selected financial account. If you have any questions, please see your employer.

Note: If you are transferring from one medical/dental plan to another plan, please complete Section 5 of the Enrollment and Change Form to let us know that you will be continuing your personal savings account..

Section 6 Signatures (Employer & Employee)

Employee: Please sign and date the application and return it to your employer. Employer: Please sign and date the application and return to Blue Cross Blue Shieldof Massachusetts. Please mail to:

P.O. Box 986001 Boston, MA 02298 or fax to 1-617-246-7531

Registered Marks of the Blue Cross and Blue Shield Association.
 2017 Blue Cross and Blue Shield of Massachusetts. Inc., and Blue Cross and Blue Shield of Massachusetts HMO Blue. Inc.

^{*} Under the Affordable Care Act, we are required to collect the Social Security number for you and any dependent enrolling in your plan.

Please Read the Instructions Before Filling Out This Form.

Please TYPE OR PRINT CLEARLY using blue or black ink to avoid coverage delay or type in information



Enrollment and Change Form

Please mail to: P.O. Box 986001 Boston, MA 02298 or fax to **1-617-246-7531**

1. To Be Filled Out by Your Employer														
Company Name					Current Medical Group #:					Medical Group # Transfering To:				
Current BCBS ID 7	rent BCBS ID #, If any Requested Effective Date Date of Hi				re Current Dental Group #:					Dental Group # Transferring				sferring To
MM DD YYYY MM DD YYYY														
Type of Transaction Remarks: (i.e., qualifying event for a new add, change to family or other instruction)														
□ ADD □ CANCEL □ CHANGE Three digit □ □ Open Enrollment Change to Family □ Loss of Coverage (HIPAA Continuation of Coverage Letter required)														
☐ TRANSFER termination code ☐ ☐ Soprat Emination code ☐ ☐ COBRA				Add Spouse Add Dependent										
2. Yourself (Member 1)														
What														
First M.I.				M.I.	Las	st		Baver Blue Britan					Date of Birth	
				Apt. #	Name City/ Town					State			Zip Code	
P.O. Box # Home			Cel	1	10	WII		1	Email					
Phone ()		Pho	one ()									
Social Security # Other Insurance $?^2$ Other Insurance Company Name Member Identification Number $(REQUIRED)^1$ $Y \square / N \square$														
PCP ID # (see instructions)		Nar PCl	me of P				•	City / State				Is this your co	urrent PCP?
Are you covered by Medicare? ²	Part A Eff	ective Date	Part B Ef	fective Date	Pa	art D Effect	ive Date	N	ledicare #				+ Disabled	□ESRD
VΠ/NΠ	V 0.6	DD MAN		DD	17777			1777/ A	otivole, Woule	.i.,) V 🗖 /	NO	If Ret Date	tired,	
3. Member 2	MM	DD YYYY use Check One:		DD Domestic	Partne				ctively Work			L	al 🗖 Dental	
First Name	1 100	ise direct one. B	Броизс	M.I.	Las		леец Бро	ouse (eoc	irt ordered)	, 1 1411 1,1	Sex		Date of Birth	
Social Security # (REQUIRED) ¹			Phone)	IVa	Other Ins		Other In	surance Con	npany Nan	ne N	Membe	er Identification	n Number
PCP ID #				me of		Y 🗖 / N		C	ity / State				Is this your cr	urrent PCP?
(see instructions Are you covered		ective Date	PCI Part B Eff	fective Date	Pa	art D Effect	ive Date	N	ledicare #			☐ 65±	+ Disabled	I □ ESRD
by Medicare? ² Y□ / N□	MM	DD YYYY	MM	DD	yyyy M	M Di	D	YYYY A	ctively Work	ing? Y □ /	N□	If Ret Date		
4. Your Eligible Dependents (Member 3, 4 and 5)														
Dependent's First l		······································		M.I.	La: Na						Sex		Date of Birth	
Social Security # (REQUIRED) ¹			PCP ID #	(N	ame of							
Is this your current	PCP? Y	J / N 🗖 Full-tii		t and aged 19	or older [ed 26 or o	lder 🗖	Plan Typ	e: □ N	Medica	al 🗖 Dental	
Dependent's First l	Name			M.I.	La: Na	st me					Sex		Date of Birth	
Social Security # (REQUIRED) ¹			PCP ID #	*	•		ame of CP							
Is this your current PCP? Y / N / Full-time student and aged 19					or older Disabled and aged 26 or older Plan T						Type:			
Dependent's First l 5.)	Name			M.I.	Las Na	st me					Sex		Date of Birth	
Social Security # (REQUIRED) ¹			PCP ID #	*			ame of CP							
Is this your current	PCP? Y	J / N 🗖 Full-ti	me studen	t and aged 19	or older [J Disable	ed and age	ed 26 or o	lder 🗖	Plan Typ	e: 🗖 l	Medica	al 🗖 Dental	
Please check if yo	ou are usi	ng separate forms	for addit	ional depend	lent chil	dren 🔲		Total # 0	of depende	ents:				
5. Personal Savings	Account													
HSA: Health Savings Account Start Da				ate			End Date			FSA Goal Amount (Please see instructions for limits.): \$				
FSA: Health Flexible Spending Account Start Da							End Date			Health: \$				
FSA: Dependent Care Reimbursement Account Start Date							End Date De					pendent Care: \$		
6. Signature (Empl		· · ·												
The information here is complete and true. I understand that Blue Cross and Blue Shield will rely on this information to enroll me and my dependents or to make changes to my membership. I understand that I should read the subscriber certificate or benefit booklet provided by my employer to understand my benefits and any restrictions that apply to my health care plan. I understand that Blue Cross and Blue Shield may obtain personal and medical information about me to carry out its business, and that it may use and disclose that information in accordance with law. I acknowledge that I may obtain further information about the collection, use, and disclosure of my information in "Our Commitment to Confidentiality," Blue Cross and Blue Shield's notice of privacy practices.														
Employee's SignatureDat			Date	e Employer's Signature						Date				



MyBlue® Member App

Meet the MyBlue Member App

Simple, Secure, Convenient

Get Health Care Information Quickly and Easily

The MyBlue Member App gives members instant access to their personal health care information anytime they need it. A simple tap connects them to their doctor, recent prescriptions, and claims history.



Personalized health care, right at their fingertips:



Use the digital ID card to direct-dial important numbers, email a PDF version to a doctor, or save a digital card to their phone.



Get access to recent claims history and see copayment amounts.



View financial account balances, like HealthEquity® or Blue Cross

Additional MyBlue Member App features:



See prescription history, including dosage and who prescribed it.



Look up and get directions to nearby doctors, dentists, and hospitals.



Receive push notifications and view important information in the Message Center.

Available On





The MyBlue Member App is not available for members with Federal Employee Program (FEP), Blue Benefit Administrators (BBA), Ancillary (Indigo®), Medicare Advantage or standalone Part D plans. Those with standalone dental, vision, or wellness coverage cannot register for the app at this time.

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID Card (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).

ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: 711).





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Coordination of Benefits

What Is Coordination of Benefits?

If you have more than one medical or dental insurance plan, you are required to provide this information for your plans to work together, so your claims can be processed correctly and you can get the most out of your coverage.

You May Need Coordination of Benefits If:

- You and your spouse each have a separate insurance plan through your employers
- Your child has an insurance plan through his or her school, and also through you or an employer
- Your child has multiple plans as the result of a divorce or custody arrangement
- You or a family member also have coverage with Medicare.

When you have more than one insurance plan, one plan is designated as your primary plan and will pay your claims first. The other plan(s) will pay toward the remaining cost, according to your benefits. Federal and state rules typically determine which plan is primary.

If You Have More Than One Medical and Dental Plan

- Call each insurer to let them know that you have more than one plan. They can tell you which is primary and which is secondary. Be sure you have your ID cards ready.
- When you visit a doctor, dentist, or hospital, present all of your insurance cards to the office on the day of your visit. They'll need this information to determine which company to bill primary and which to bill secondary.
- If one of your insurance plans is canceled, you will need to inform the other plan(s).

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: 711).

If You Have Ouestions

For Coordination of Benefits, please call 1-888-799-1888.

If You're Turning 65 Years Old and Thinking About Medicare:

- Call Medicare directly at 1-800-MEDICARE (1-800-633-4227).
- If you sign up, call 1-800-839-8991 to submit your Medicare information. If you don't, your claims could be delayed or processed incorrectly.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).

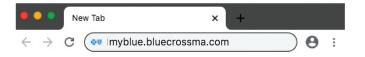
ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do úmero no seu cartão ID (TTY: 711).



HOW TO FIND YOUR PRIMARY CARE PROVIDER'S ID NUMBER

Instructions for Using Our Find a Doctor & Estimate Costs Tool

If your plan requires you to choose a primary care provider (PCP), you'll need to enter your PCP's ID number on your enrollment form. You can find this number in your plan's provider directory, or by following these steps:



Go to MyBlue at myblue.bluecrossma.com.
You can create a new account, sign in to your
personalized MyBlue account, or continue
without signing in.



Click Find a Doctor & Estimate Costs.

Find a Doctor & Estimate Costs

Questions?

Call Member Service at **1-888-456-1351**. You can also find this number on the front of your ID card and in your Summary of Benefits.

Find a Doctor & Estimate Costs Enter all fields to see results Doctor, hospital, Specialty Q 02170 - Quincy, MA Enter a Network Search

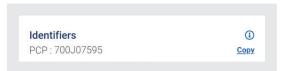
Enter your doctor's name, and your location.
Select Search to bring up your doctor's
profile page. When you sign in to MyBlue, your
network information will appear. Otherwise,
members with an HMO plan or Blue Choice®
should select HMO Blue as the network.

Find a Doctor & Estimate Costs Enter all fields to see results Doctor, hospital, Specialty Q 02170 - Quincy, MA Enter a Network Search

If you don't have a PCP, you can search for one by entering Primary Care in the Specialty field. You can then sort based on location, ratings, languages spoken, or other attributes listed along the left-hand side of the page.



To find details about a provider, click the provider's name. Clicking on Provider Details will show the Identifiers, including the PCP's ID number.





Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).

ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: 711).



Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. It does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

BLUE CROSS BLUE SHIELD OF MASSACHUSETTS PROVIDES:

- Free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print or other formats).
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, call Member Service at the number on your ID card.

If you believe that Blue Cross Blue Shield of Massachusetts has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with the Civil Rights Coordinator by mail at Civil Rights Coordinator, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126; phone at 1-800-472-2689 (TTY: 711); fax at 1-617-246-3616; or email at civilrightscoordinator@bcbsma.com.

If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, online at **ocrportal.hhs.gov**; by mail at U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, DC 20201; by phone at **1-800-368-1019** or **1-800-537-7697** (TDD).

Complaint forms are available at hhs.gov.



PROFICIENCY OF LANGUAGE ASSISTANCE SERVICES

Spanish/Español: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: **711**).

Portuguese/Português: ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: **711**).

Chinese/简体中文: 注意:如果您讲中文,我们可向您免费提供语言协助服务。请拨打您 □ 卡上的号码联系会员服务部(TTY 号码:**711**)。

Haitian Creole/Kreyòl Ayisyen: ATANSYON: Si ou pale kreyòl ayisyen, sèvis asistans nan lang disponib pou ou gratis. Rele nimewo Sèvis Manm nan ki sou kat Idantitifkasyon w lan (Sèvis pou Malantandan TTY: 711).

Vietnamese/Tiếng Việt: LƯU Ý: Nếu quý vị nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ được cung cấp cho quý vị miễn phí. Gọi cho Dịch vụ Hội viên theo số trên thẻ ID của quý vị (TTY: **711**).

Russian/Русский: ВНИМАНИЕ: если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Позвоните в отдел обслуживания клиентов по номеру, указанному в Вашей идентификационной карте (телетайп: **711**).

Arabic/ةيبر:

انتباه: إذا كنت تتحدث اللغة العربية، فتتوفر خدمات المساعدة اللغوية مجانًا بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هُويتك (جهاز الهاتف النصى للصم والدكم "٢٦٦": 711).

Mon-Khmer, Cambodian/ខ្មែរ: ការជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសា ខ្មែរ សេវាជំនួយភាសាឥតគិតថ្លៃ គឺអាចរកបានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅផ្នែកសេវាសមាជិកតាមលេខ នៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នក (TTY: **711**)។

French/Français: ATTENTION: si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le Service adhérents au numéro indiqué sur votre carte d'assuré (TTY: 711).

Italian/Italiano: ATTENZIONE: se parlate italiano, sono disponibili per voi servizi gratuiti di assistenza linguistica. Chiamate il Servizio per i membri al numero riportato sulla vostra scheda identificativa (TTY: **711**).

Korean/한국어: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드에 있는 전화번호(TTY: **711**)를 사용하여 회원 서비스에 전화하십시오.

Greek/Ελληνικά: ΠΡΟΣΟΧΗ: Εάν μιλάτε Ελληνικά, διατίθενται για σας υπηρεσίες γλωσσικής βοήθειας, δωρεάν. Καλέστε την Υπηρεσία Εξυπηρέτησης Μελών στον αριθμό της κάρτας μέλους σας (ID Card) (TTY: **711**).

Polish/Polski: UWAGA: Osoby posługujące się językiem polskim mogą bezpłatnie skorzystać z pomocy językowej. Należy zadzwonić do Działu obsługi ubezpieczonych pod numer podany na identyfikatorze (TTY: **711**).

Hindi/हिंदी: ध्यान दें: यदि आप हिन्दी बोलते हैं, तो भाषा सहायता सेवाएँ, आप के लिए नि:शुल्क उपलब्ध हैं। सदस्य सेवाओं को आपके आई.डी. कार्ड पर दिए गए नंबर पर कॉल करें (टी.टी.वाई.: 711).

Gujarati/ગુજરાતી: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો, તો તમને ભાષાકીય સહાયતા સેવાઓ વિના મૂલ્યે ઉપલબ્ધ છે. તમારા આઈડી કાર્ડ પર આપેલા નંબર પર Member Service ને કૉલ કરો (□TY: **711**).

Tagalog/Tagalog: PAUNAWA: Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyo para sa tulong sa wika. Tawagan ang Mga Serbisyo sa Miyembro sa numerong nasa iyong ID Card (TTY: **711**).

Japanese/日本語: お知らせ:日本語をお話しになる方は無料の言語アシスタンスサービスをご利用いただけます。IDカードに記載の電話番号を使用してメンバーサービスまでお電話ください (TTY: **711**)。

German/Deutsch: ACHTUNG: Wenn Sie Deutsche sprechen, steht Ihnen kostenlos fremdsprachliche Unterstützung zur Verfügung. Rufen Sie den Mitgliederdienst unter der Nummer auf Ihrer ID-Karte an (TTY: **711**).

:یارسیان/Persian

توج: اگر زبان شما فارسی است، خدمات کمک زبانی ب صورت رایگان در اختیار شما قرار می گیرد. با شمار تلفن مندرج بر روی کارت شناسایی خود با بخش «خدمات اعضا» تماس بگیرید (TTY: 711).

Lao/ພາສາລາວ: ຂໍ້ຄວນໃສ່ໃຈ: ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍ ບໍ່ເສຍຄ່າ. ໂທຫາຝ່າຍບໍລິການສະມາຊິກທີ່ໝາຍເລກໂທລະສັບຢູ່ໃນບັດຂອງທ່ານ (□Y: **711**).

Navajo/Diné Bizaad: BAA ÁKOHWIINDZIN DOOÍGÍ: Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Díí bee anítahígí ninaaltsoos bine'déé' nóomba biká'ígíiji' béésh bee hodíílnih (TTY: 711).