

# **WELCOME CITY OF BROCKTON**

#### **GET THE MOST OUT OF YOUR PLAN**







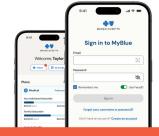












#### INTRODUCING THE NEW MYBLUE APP

The simplest way to tap into your health plan.

Sign in to the MyBlue app.

# **CONTENTS**

#### **PLAN OPTIONS**

MEDICAL: Blue Care Elect Deductible with HCCS

- Summary

MEDICAL: Network Blue NE Deductible with HCCS

**SBC**  $\mathbf{\Psi}$ - Summary

**DENTAL: Dental Blue Freedom Active Employee Plan** 

**Summary** 

Summary

**DENTAL: Dental Blue Freedom Retiree Plan** 

SUPPLEMENTAL: Medex 2 OBRA

Summary

#### **HELPFUL RESOURCES**

- Quick Start PPO with HCCS
- $\overline{\mathbf{\Phi}}$ Quick Start - HMO Blue New England with HCCS
- $\overline{\mathbf{\Lambda}}$ **HCCS Hospital List**
- $\overline{\mathbf{4}}$ **Telehealth Brochure**
- $\overline{\mathbf{\Lambda}}$ **Dental Quick Start for Large Group**
- $\overline{\mathbf{\Lambda}}$ **Dental Accumulated Maximum Rollover**
- $\overline{\mathbf{\Lambda}}$ **Enhanced Dental Benefits**
- $\overline{\mathbf{\Lambda}}$ **Enhanced Dental Benefit Enrollment Form**
- $\overline{\mathbf{\Lambda}}$ **Dental Blue Freedom Fact Sheet**
- $\overline{\mathbf{\Lambda}}$ 2 Tier Opt 32 Formulary\_2025
- BlueMedicareRx\_Summary of  $\mathbf{\Psi}$ Benefits\_Tier2\_OPT32\_2025
- $\overline{\mathbf{\Phi}}$ 24/7 Nurse Line
- $\overline{\mathbf{\Lambda}}$ Mind and Body \$300 Reimbursement
- $\overline{\mathbf{\Lambda}}$ **Fitness Reimbursement**
- Weight-Loss Reimbursement
- $\overline{\mathbf{\Lambda}}$ ahealthyme Rewards Core - Personify Health
- $\overline{\mathbf{\Lambda}}$ **Blue Card Program Brochure**
- $\overline{\mathbf{\Lambda}}$ **Commitment To Confidentiality**
- $\overline{\mathbf{\Lambda}}$ **SBC Glossary Medical Terms**
- $\overline{\mathbf{\Lambda}}$ Summary of Health Plan Payments Guide
- $\overline{\mathbf{\Lambda}}$ **Learn About Tiers**
- $\overline{\mathbf{\Lambda}}$ Maintenance Choice Voluntary Member Fact Sheet
- $\overline{\mathbf{\Lambda}}$ No Cost Generic Medications Medication List
- Mail Service Pharmacy Member Fact Sheet and Order

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# **\$250 DEDUCTIBLE**

WITH HOSPITAL CHOICE COST SHARING

Plan-Year Deductible: \$250/\$500

City of Brockton

#### 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.



#### Where you get care can impact what you pay for care.

#### This health plan option includes a tiered network feature called Hospital Choice Cost Sharing.

As a member in this plan, you will pay different levels of in-network cost share (such as copayments and/or coinsurance) for certain services depending on the preferred general hospital you choose to furnish those covered services. For most preferred general hospitals, you will pay the lowest in-network cost sharing level. However, if you receive certain covered services from any of the preferred general hospitals listed in this Summary of Benefits, you pay the highest in-network cost sharing level. A preferred general hospital's cost sharing level may change from time to time. Overall changes to add another preferred general hospital to the highest cost sharing level will happen no more than once each calendar year. For help in finding a preferred general hospital (not listed in this Summary of Benefits for which you pay the lowest in-network cost sharing level, check the most current provider directory for your health plan option or visit the online provider search tool at bluecrossma.org/hospitalchoice. Then click on the Planning Guide link on the left navigation to download a printable network hospital list or to access the provider search page.



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.

#### 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 certain benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductible is \$250 per member (or \$500 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.

The plan has two levels of hospital benefits for preferred providers. You will pay a higher cost share when you receive inpatient services at or by "higher cost share hospitals," even if your preferred provider refers you. See the chart 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 are referred to is not a preferred provider, you are still covered, but your benefits, in most situations, will be covered at the out-of-network level, even if the preferred provider refers you.

#### **Higher Cost Share Hospitals**

Your cost share will be higher at the hospitals listed below. Blue Cross Blue Shield of Massachusetts will let you know if this list changes.

- Baystate Medical Center
- Brigham and Women's Hospital
- Dana-Farber Cancer Institute
- Massachusetts General Hospital
- Boston Children's Hospital
- Cape Cod Hospital
- Fairview Hospital
- UMass Memorial Medical Center

Note: Some of the general hospitals listed above may have facilities in more than one location. At certain locations, the lowest cost share may apply.

#### 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 benefit description. 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 \$1,200 per member (or \$2,400 per family) for in-network and out-of-network services combined. Your out-of-pocket maximum for prescription drug benefits is \$5,400 per member (or \$10,800 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). 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 benefit description 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 dependent's financial dependency, student status, or employment status. See your benefit description (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:  • Ten 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
Mental health wellness exams (at least one per calendar year)	Nothing, no deductible	Nothing, no 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	\$100 per visit, no deductible (waived if admitted or for an observation stay)	\$100 per visit, no deductible (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, licensed dietitian nutritionist, optometrist, 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	\$20 per visit, no deductible	20% coinsurance after deductible 20% coinsurance after deductible
specialty care	\$25 per visit, no deductible	20 % Coll isul al ice alter deductible
Mental health or substance use treatment	\$20 per visit, no deductible	20% coinsurance after deductible
Outpatient telehealth services  With a covered provider  With the in-network designated telehealth vendor	Same as in-person visit \$20 per visit, no deductible	Same as in-person visit Only applicable in-network
Chiropractors' office visits	\$20 per visit, no deductible	20% coinsurance after deductible
Acupuncture visits (up to 12 visits per calendar year)	\$25 per visit, no deductible	20% coinsurance after deductible
Short-term rehabilitation therapy—physical and occupational (up to 60 visits per calendar year*)	\$20 per visit, no deductible	20% coinsurance after deductible
Speech, hearing, and language disorder treatment—speech therapy	\$20 per visit, no deductible	20% coinsurance after deductible
Diagnostic x-rays and lab tests	Nothing after deductible	20% coinsurance after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	\$100 per category per service date 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	\$20 per visit***, no deductible	20% coinsurance after deductible
Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	\$25 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	\$150 per admission after deductible	20% coinsurance after deductible
npatient Care (including maternity care) in:		
Other general hospitals (as many days as medically necessary) In-network higher cost share hospitals (as many days as medically necessary)	\$150 per admission after deductible <sup>†</sup> \$450 per admission after deductible <sup>†</sup>	20% coinsurance after deductible Only applicable in-network
Chronic disease hospital care (as many days as medically necessary)	\$150 per admission after deductible	20% coinsurance after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	\$150 per admission 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

<sup>\*</sup> 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, including supplies (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.

† This cost share applies to mental health admissions in a general hospital.

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 \$10 for Tier 1 \$25 for Tier 2 \$45 for Tier 3	Not covered
Through the designated mail service or designated retail pharmacy (up to a 90-day formulary supply for each prescription or refill)**	No deductible \$20 for Tier 1 \$50 for Tier 2 \$90 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.

Cost share may be waived, reduced, or increased for certain covered drugs and supplies.

Get the Most from Your Plan: Visit us at bluecrossma.org or call 1-800-782-3675 to learn about discounts, savings, resources, and special programs 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 benefit description for details.)	\$150 per calendar year per policy
Weight Loss Reimbursement: a program that rewards participation in a qualified weight loss program (See your benefit description for details.)	\$150 per calendar year per policy
Mind and Body Wellness Program Reimbursement for participation in the Mind and Body Wellness Program (See your benefit description for details.)	\$300 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 1-800-782-3675, or visit us online at bluecrossma.org.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your benefit description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the benefit description 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 benefit description and riders. Note: Blue Cross and Blue Shield of Massachusetts, Inc. administers claims payment only and does not assume financial risk for claims.

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Blue Care Elect \$250 Deductible with HCCS: City of Brockton Coverage for: Individual and Family | Plan Type: PPO Tiered

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 <u>www.com</u>. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms, see the Glossary. You can view the Glossary at <u>bluecrossma.org/sbcglossary</u> or call 1-800-782-3675 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$250 member / \$500 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 deductible?	Yes. In-network preventive and prenatal care, most office visits, mental health visits, therapy visits, prescription drugs; emergency room.	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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
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, \$1,200 member / \$2,400 family; and for prescription drug benefits, \$5,400 member / \$10,800 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 limit</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 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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 / visit	20% <u>coinsurance</u>	Deductible applies first for out-of- network; family or general practitioner, internist, OB/GYN physician, pediatrician, geriatric specialist, nurse midwife, licensed dietitian nutritionist, optometrist, limited services clinic, multi-specialty provider group, or by a physician assistant or nurse practitioner designated as primary care; a telehealth cost share may be applicable
	<u>Specialist</u> visit	\$25 / visit; \$20 / chiropractor visit; \$25 / acupuncture visit	20% coinsurance; 20% coinsurance / chiropractor visit; 20% coinsurance / 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; cost share waived for at least one mental health wellness exam per calendar year; 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.

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
	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	<u>Deductible</u> applies first; <u>pre-</u> <u>authorization</u> may be required
If you have a test	Imaging (CT/PET scans, MRIs)	\$100	20% coinsurance	<u>Deductible</u> applies first; <u>copayment</u> applies per category of test / day; <u>pre-</u> <u>authorization</u> may be required
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at bluecrossma.org/medication	Generic drugs	\$10 / retail supply or \$20 / designated retail or mail service supply	Not covered	Up to 30-day retail (90-day
	Preferred brand drugs	\$25 / retail supply or \$50 / designated retail or mail service supply	Not covered	designated retail or mail service) supply; cost share may be waived, reduced, or increased for certain covered drugs and supplies; pre- authorization required for certain drugs  When obtained from a designated specialty pharmacy; cost share may be waived, reduced, or increased for certain covered drugs and supplies; pre-authorization required for certain drugs
	Non-preferred brand drugs	\$45 / retail supply or \$90 / designated retail or mail service supply	Not covered	
	Specialty drugs	Applicable <u>cost share</u> (generic, preferred, non-preferred)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$150 / admission	20% coinsurance	<u>Deductible</u> applies first; <u>pre-</u> <u>authorization</u> required for certain services
	Physician/surgeon fees	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
If you need immediate	Emergency room care	\$100 / visit; <u>deductible</u> does not apply	\$100 / visit; <u>deductible</u> does not apply	Copayment 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>	\$25 / 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)	\$150 / admission; \$450 / admission for certain hospitals	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-</u> <u>authorization</u> / authorization required for certain services
	Physician/surgeon fees	No charge	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-</u> <u>authorization</u> / authorization required for certain services
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 / 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	\$150 / admission; \$450 / admission for certain hospitals	20% <u>coinsurance</u>	<u>Deductible</u> applies first; <u>pre-</u> <u>authorization</u> / authorization required for certain services
	Office visits	No charge	20% coinsurance	Deductible applies first except for in-
If you are pregnant	Childbirth/delivery professional services	No charge	20% coinsurance	network prenatal care; cost sharing
	Childbirth/delivery facility services	\$150 / admission; \$450 / admission for certain hospitals	20% <u>coinsurance</u>	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 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 for certain services
If you need help recovering or have other special health needs	Rehabilitation services	\$20 / 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 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	\$20 / 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% coinsurance	<u>Deductible</u> applies first; in-network <u>cost share</u> waived for one breast pump per birth, including supplies (20% <u>coinsurance</u> for out-of-network)
	Hospice services	No charge	20% <u>coinsurance</u>	<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	Children's glasses	Not covered	Not covered	None
or eye care	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 <a href="www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a> and the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or <a href="www.cciio.cms.gov">www.cciio.cms.gov</a>. 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 <a href="www.mass.gov/doi">www.mass.gov/doi</a>. Other coverage options may be available to you too, including buying individual insurance coverage through the <a href="Health Insurance Marketplace">Health Insurance Marketplace</a>. For more information about the <a href="Marketplace">Marketplace</a>, visit <a href="www.HealthCare.gov">www.HealthCare.gov</a> or call 1-800-318-2596. For more information about possibly buying individual coverage through a state exchange, you can contact your state's <a href="marketplace">marketplace</a>, if applicable. If you are a Massachusetts resident, contact the Massachusetts Health Connector by visiting <a href="www.mahealthconnector.org">www.mahealthconnector.org</a>. For more information on your rights to continue your employer coverage, contact your <a href="marketplace">plan</a> 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 1-800-782-3675 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.)

#### 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 <u>plan</u> doesn't meet the <u>Minimum Value Standards</u>, you may be eligible for a <u>premium tax credit</u> to help you pay for a <u>plan</u> through the <u>Marketplace</u>.

**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 <u>plan</u> 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 <u>plans</u>. 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	\$250
■ Delivery fee copay	\$0
■ Facility fee copay	\$150
■ 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:	
Cost sharing	
<u>Deductibles</u>	\$250
Copayments	\$200
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$510

#### Managing Joe's Type 2 Diabetes (a year of routine in-network care of a wellcontrolled condition)

■ The plan's overall deductible	\$250
■ Specialist visit copay	\$25
■ Primary care visit copay	\$20
■ Diagnostic tests copay	\$0

#### This EXAMPLE event includes services like:

Primary care physician office visits (including disease education)

Diagnostic tests (blood work)

Prescription drugs

Durable medical equipment (glucose meter)

Total Example Cost	\$5,600
In this example, Joe would pay:	
<u>Cost sharing</u>	
Deductibles	\$100
Copayments	\$1,100
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,220

#### **Mia's Simple Fracture**

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

■The plan's overall deductible	\$250
■ Specialist visit copay	\$25
■ Emergency room <u>copay</u>	\$100
■ Ambulance services copay	\$0

#### This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (*x-ray*)

Durable medical equipment (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$2,800
In this example, Mia would pay:	
<u>Cost sharing</u>	
<u>Deductibles</u>	\$250
Copayments	\$200
Coinsurance	\$0
What isn't covered	·
Limits or exclusions	\$0
The total Mia would pay is	\$450







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.





This health plan option includes a tiered network feature called Hospital Choice Cost Sharing. As a member in this plan, you will pay different levels of in-network cost share (such as copayments and coinsurance) for certain services depending on the preferred general hospital you choose to furnish those covered services. For most preferred general hospitals, you will pay the lowest in-network cost sharing level. However, if you receive certain covered services from some preferred general hospitals, you pay the highest in-network cost sharing level. A preferred general hospital's cost sharing level may change from time to time. Overall changes to add another preferred general hospital to the highest cost sharing level will happen no more than once each calendar year. For help in finding a preferred general hospital for which you pay the lowest in-network cost sharing level, check the most current provider directory for your health plan option or visit the online provider search tool at bluecrossma.org/hospitalchoice.

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# PREFERRED BLUE® PPO WITH HOSPITAL CHOICE COST SHARING

#### IMPORTANT INFORMATION ABOUT YOUR PLAN

Your health plan lets you get care from providers who participate in the Blue Cross Blue Shield PPO Network with Hospital Choice Cost Sharing, as well as from providers who are out of our network. You'll pay a lower cost for care when you see an in-network provider, and a higher cost when you see an out-of-network provider.

This plan has a Hospital Choice Cost Sharing feature, which means you'll pay different costs depending on where you receive certain services.\*



#### **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 managing your plan. Use it to 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 care. 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?

1. Go to bluecrossma.org. 2. Click Find a Doctor under Find Care.

3. Enter a provider or type of care, then select PPO Network with Hospital Choice Cost Sharing.

<sup>\*</sup>Members pay different costs (copayments, co-insurance, and deductibles) depending on the benefits tier of the general hospital furnishing the services, and the type of service being provided. A hospital's tier may change; however, overall changes to the tiers of providers will happen no more than once each calendar year.

To determine a hospital's tier, use the **Find a Doctor** tool.

#### **ACCESSING CARE**

The Importance of Receiving In-Network Care: To pay the lowest cost, you should see in-network doctors. You can also see out-of-network doctors, but you'll pay higher out-of-pocket costs. When selecting a doctor, consider the hospital where that doctor has admitting privileges. You can use the Find a Doctor tool to look up this information.

Routine Health Checkups: You don't have to choose a primary care provider (PCP) to help manage your care. However, routine health checkups with your PCP are one of the best ways you can stay on top of your health.

Seeing a Specialist: If you need to see a specialist, you don't need a referral from your PCP. 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**

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.

<sup>†</sup>As of January 1, 2022, your ID card also includes 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).

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# NETWORK BLUE® NEW ENGLAND \$250 DEDUCTIBLE

City of Brockton

WITH HOSPITAL CHOICE COST SHARING

Plan-Year Deductible: \$250/\$500

#### 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.



Where you get care can impact what you pay for care.

This health plan option includes a tiered network feature called Hospital Choice Cost Sharing.

As a member in this plan, you will pay different levels of cost share (such as copayments and/or coinsurance) for certain services depending on the network general hospital you choose to furnish those covered services. For most network general hospitals, you will pay the lowest cost sharing level. However, if you receive certain covered services from any of the network general hospitals listed in this Summary of Benefits, you pay the highest cost sharing level. A network general hospital's cost sharing level may change from time to time. Overall changes to add another network general hospital to the highest cost sharing level will happen no more than once each calendar year. For help in finding a network general hospital (not listed in this Summary of Benefits) for which you pay the lowest cost sharing level, check the most current provider directory for your health plan option or visit the online provider search tool at bluecrossma.org/hospitalchoice. Then click on the Planning Guide link on the left navigation to download a printable network hospital list or to access the provider search page.



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.

#### 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 benefit description.

#### Your Cost Share

This plan has two levels of hospital benefits. You will pay a higher cost share when you receive inpatient services at or by "higher cost share hospitals," even if your PCP refers you. See the chart for your cost share.

#### **Higher Cost Share Hospitals**

Your cost share will be higher at the hospitals listed below. Blue Cross Blue Shield of Massachusetts will let you know if this list changes.

- Baystate Medical Center
- Boston Children's Hospital
- Brigham and Women's Hospital
- Cape Cod Hospital
- Dana-Farber Cancer Institute
- Fairview Hospital
- Massachusetts General Hospital
- UMass Memorial Medical Center

All other network hospitals will carry the lower cost share, including network hospitals outside of Massachusetts.

Note: Some of the general hospitals listed above may have facilities in more than one location. At certain locations, the lowest cost sharing level may apply.

#### Your Deductible

Your deductible is the amount of money you pay out-of-pocket each plan year before you can receive coverage for certain benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductible is \$250 per member (or \$500 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 \$1,200 per member (or \$2,400 per family). Your out-of-pocket maximum for prescription drug benefits is \$5,400 per member (or \$10,800 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). You pay a copayment per visit for emergency room services. This 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.

#### 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 are 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 benefit description 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 benefit description (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
Mental health wellness exams (at least 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	\$100 per visit, no deductible (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	\$20 per visit, no deductible
Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	\$25 per visit, no deductible
Mental health or substance use treatment	\$20 per visit, no deductible
Outpatient telehealth services  With a covered provider  With the designated telehealth vendor	Same as in-person visit \$20 per visit, no deductible
Chiropractors' office visits	\$20 per visit, no deductible
Acupuncture visits (up to 12 visits per calendar year)	\$25 per visit, no deductible
Short-term rehabilitation therapy—physical and occupational (up to 60 visits per calendar year*)	\$20 per visit, no deductible
Speech, hearing, and language disorder treatment—speech therapy	\$20 per visit, no deductible
Diagnostic x-rays and lab tests	Nothing after deductible
CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	\$100 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
<ul> <li>Surgery and related anesthesia in an office or health center, when performed by:</li> <li>Your PCP, OB/GYN physician, nurse midwife, or by a physician assistant or nurse practitioner designated as primary care</li> </ul>	\$20 per visit***, no deductible
Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	\$25 per visit***, no deductible
Surgery and related anesthesia in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	\$150 per admission after deductible
Inpatient Care (including maternity care) in:	
Other general hospitals (as many days as medically necessary)     Higher cost share hospitals (as many days as medically necessary)	\$150 per admission after deductible <sup>†</sup> \$450 per admission after deductible <sup>†</sup>
Chronic disease hospital care (as many days as medically necessary)	\$150 per admission after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	\$150 per admission after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing after deductible
Skilled nursing facility care (up to 100 days per calendar year)	Nothing after deductible
* No visit limit applies when short-tarm rehabilitation thereas; is furnished as not of covered home beauty and a second home.	as treatment of autism spectrum disorders

- \* 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, including supplies.

  \*\*\* 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.

  † This cost share applies to mental health admissions in a general hospital.

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 \$10 for Tier 1 \$25 for Tier 2 \$45 for Tier 3
Through the designated mail service or designated retail pharmacy (up to a 90-day formulary supply for each prescription or refill)**	No deductible \$20 for Tier 1 \$50 for Tier 2 \$90 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 1–800–782–3675 to learn about discounts, savings, resources, and special programs 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 benefit description for details.)	\$150 per calendar year per policy
Weight Loss Reimbursement: a program that rewards participation in a qualified weight loss program (See your benefit description for details.)	\$150 per calendar year per policy
Mind and Body Wellness Program Reimbursement for participation in the Mind and Body Wellness Program (See your benefit description for details.)	\$300 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 1-800-782-3675, or visit us online at bluecrossma.org.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your benefit description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the benefit description 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 benefit description and riders. Note: Blue Cross and Blue Shield of Massachusetts, Inc. administers claims payment only and does not assume financial risk for claims.

Cost share may be waived, reduced, or increased for certain covered drugs and supplies.

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Network Blue® New England \$250 Deductible with HCCS: City of Brockton Coverage for: Individual and Family | Plan Type: Managed Tiered

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 www. .com. 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 1-800-782-3675 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$250 member / \$500 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, emergency room, <u>prescription drugs</u> , most office visits, mental health visits, and therapy 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
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, \$1,200 member / \$2,400 family; and for prescription drug benefits, \$5,400 member / \$10,800 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 limit</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> ?	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 **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** 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	\$20 / visit	Not covered	A telehealth <u>cost share</u> may be applicable
If you visit a health care provider's office or clinic	<u>Specialist</u> visit	\$25 / visit; \$20 / chiropractor visit; \$25 / 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)	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-</u> <u>authorization</u> required for certain services
	Imaging (CT/PET scans, MRIs)	\$100	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
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at bluecrossma.org/medication	Generic drugs	\$10 / retail supply or \$20 / designated retail or mail service supply	Not covered	Up to 30-day retail (90-day designated retail or mail service) supply; cost share may be waived, reduced, or increased for certain covered drugs and supplies; preauthorization required for certain drugs
	Preferred brand drugs	\$25 / retail supply or \$50 / designated retail or mail service supply	Not covered	
	Non-preferred brand drugs	\$45 / retail supply or \$90 / designated retail or mail service supply	Not covered	
	Specialty drugs	Applicable <u>cost share</u> (generic, preferred, non-preferred)	Not covered	When obtained from a designated specialty pharmacy; cost share may be waived, reduced, or increased for certain covered drugs and supplies; pre-authorization required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$150 / 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	\$100 / visit; deductible does not apply	\$100 / visit; <u>deductible</u> does not apply	Copayment waived if admitted or for observation stay
	Emergency medical transportation	No charge	No charge	Deductible applies first
	<u>Urgent care</u>	\$25 / visit	\$25 / 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 hospital stay	Facility fee (e.g., hospital room)	\$150 / admission; \$450 / admission for certain hospitals	Not covered	<u>Deductible</u> applies first; <u>pre-</u> <u>authorization</u> / authorization required for certain services
	Physician/surgeon fees	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-</u> <u>authorization</u> / authorization required for certain services
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 / visit	Not covered	A telehealth <u>cost share</u> may be applicable; <u>pre-authorization</u> required for certain services
	Inpatient services	\$150 / admission; \$450 / admission for certain hospitals	Not covered	<u>Deductible</u> applies first; <u>pre-</u> <u>authorization</u> / authorization required for certain services
	Office visits	No charge	Not covered	Deductible applies first except for
If you are pregnant	Childbirth/delivery professional services	No charge	Not covered	prenatal care; cost sharing does not
	Childbirth/delivery facility services	\$150 / admission; \$450 / admission for certain hospitals	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

	Services You May Need	What You Will Pay		
Common Medical Event		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 for certain services
If you need help recovering or have other special health needs	Rehabilitation services	\$20 / visit for outpatient services; No charge for inpatient services	Not covered	Deductible applies first except for outpatient services; 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	\$20 / visit	Not covered	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; pre-authorization required for certain services
	Skilled nursing care	No charge	Not covered	<u>Deductible</u> applies first; limited to 100 days per calendar year; <u>pre-authorization</u> required
	Durable medical equipment	20% <u>coinsurance</u>	Not covered	<u>Deductible</u> applies first; <u>cost share</u> waived for one breast pump per birth, including supplies
	Hospice services	No charge	Not covered	<u>Deductible</u> applies first; <u>pre-</u> <u>authorization</u> required for certain services
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to one exam every 24 months
	Children's glasses	Not covered	Not covered	None
	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 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
- 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 <a href="www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a> and the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or <a href="www.cciio.cms.gov">www.cciio.cms.gov</a>. 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 <a href="www.mass.gov/doi">www.mass.gov/doi</a>. Other coverage options may be available to you too, including buying individual insurance coverage through the <a href="Health Insurance Marketplace">Health Insurance Marketplace</a>. For more information about the <a href="Marketplace">Marketplace</a>, visit <a href="www.HealthCare.gov">www.HealthCare.gov</a> or call 1-800-318-2596. For more information about possibly buying individual coverage through a state exchange, you can contact your state's <a href="marketplace">marketplace</a>, if applicable. If you are a Massachusetts resident, contact the Massachusetts Health Connector by visiting <a href="www.mahealthconnector.org">www.mahealthconnector.org</a>. For more information on your rights to continue your employer coverage, contact your plan 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 1-800-782-3675 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.)

#### Does this plan provide Minimum Essential Coverage? Yes.

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 premium tax credit.

#### Does this <u>plan</u> 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 <u>plan</u> 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 <u>plans</u>. 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	\$250
■ Delivery fee copay	\$0
■ Facility fee copay	\$150
■ 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:	
Cost sharing	
<u>Deductibles</u>	\$250
Copayments	\$200
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$510

# Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-

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

■ The plan's overall deductible	\$250
■ Specialist visit copay	\$25
■ Primary care visit <u>copay</u>	\$20
■ 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

Total Example Cost

Durable medical equipment (glucose meter)

	\$5,600
ld pay:	
sharin <u>g</u>	
	\$100
	\$1,100
	\$0
't covered	
	\$20
	\$1,220
	haring

#### Mia's Simple Fracture

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

■ The plan's overall deductible	\$250
■ <u>Specialist</u> visit <u>copay</u>	\$25
<b>■</b> Emergency room <u>copay</u>	\$100
■ Ambulance services copay	\$0

#### This EXAMPLE event includes services like:

<u>Emergency room care</u> (including medical supplies)

Diagnostic test (x-ray)

**Total Example Cost** 

Durable medical equipment (crutches)

Rehabilitation services (physical therapy)

· · · · · · · · · · · · · · · · · · ·	7-,000
In this example, Mia would pay:	
<u>Cost sharing</u>	
<u>Deductibles</u>	\$250
Copayments	\$200
Coinsurance	\$0
What isn't covered	·
Limits or exclusions	\$0
The total Mia would pay is	\$450

\$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.





This health plan option includes a tiered network feature called Hospital Choice Cost Sharing. As a member in this plan, you will pay different levels of cost share (such as copayments and coinsurance) for certain services depending on the network general hospital you choose to furnish those covered services. For most network general hospitals, you will pay the lowest cost sharing level. However, if you receive certain covered services from some network general hospitals, you pay the highest cost sharing level. A network general hospital's cost sharing level may change from time to time. Overall changes to add another network general hospital to the highest cost sharing level will happen no more than once each calendar year. For help in finding a network general hospital for which you pay the lowest cost sharing level, check the most current provider directory for your health plan option or visit the online provider search tool at bluecrossma.org/hospitalchoice.



# HMO BLUE NEW ENGLAND WITH HOSPITAL CHOICE COST SHARING

## IMPORTANT INFORMATION ABOUT YOUR PLAN

Your health plan lets you get care from providers who participate in the HMO Blue New England Network with Hospital Choice Cost Sharing. Under this plan, you're required to choose a primary care provider (PCP) to manage your care and refer you to specialists. This plan has a Hospital Choice Cost Sharing feature, which means you'll pay different costs depending on where you get certain services.\*



# **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 Network** with **Hospital Choice Cost Sharing**.

### **ACCESSING CARE**

The Importance of a Primary Care Provider (PCP): 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.

\*Services include inpatient admissions, outpatient diagnostic lab tests and X-rays, outpatient surgery, outpatient short-term rehabilitation therapy, and outpatient diagnostic high-tech radiology.

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® FREEDOM

City of Brockton

# UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:







Sign in

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



### **DENTAL BLUE FREEDOM**

Preventive Benefit Group	Basic Benefit Group	Major Benefit Group
	No Deductible	
Full Coverage*	80% Coverage*	50% Coverage*

#### \$2,000 Per Member Calendar-Year Benefit Maximum (in-network and out-of-network combined)

#### 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
- General anesthesia when administered in conjunction with covered surgical services
- Emergency dental care to treat acute pain or to prevent permanent harm to a member

#### Prosthodontics (teeth replacement)

- Complete or partial dentures (including services to fabricate, measure, fit, and adjust them) once each 60 months for each arch
- Fixed bridges (including services to fabricate, measure, fit, and adjust them) once each 60 months for each tooth
- Replacement of dentures and bridges once each 60 months when the existing appliance can't be made serviceable
- · Adding teeth to an existing bridge
- Temporary partial dentures to replace any of the six upper or six lower front teeth (only covered if they are installed immediately following the loss of teeth and during the period of healing)

#### Major Restorative (members age 16 or older)

- Crowns, once each 60 months for each tooth
- Metallic, porcelain, and composite resin inlays.
  Benefits are provided for an amalgam filling toward
  the cost of a metallic, porcelain, or composite resin
  inlay, once each 60 months for each tooth. You pay
  any balance.
- Metallic, porcelain, and composite resin onlays, once each 60 months for each tooth
- Replacement of crowns, once each 60 months for each tooth
- Replacement of metallic, porcelain, and composite resin inlays. Benefits are provided for an amalgam filling toward the cost of a metallic, porcelain, or composite resin inlay, once each 60 months for each tooth. You pay any balance.
- Replacement of metallic, porcelain, and composite resin onlays, once each 60 months for each tooth
- Post and core or crown buildup, once each 60 months for each tooth

#### Implants (members age 16 or older)

 Single tooth dental endosteal implants (the fixture and abutment portion) in addition to the allowance for the crown for the implant, once each 60 month period, when the implant replaces permanent teeth through the second molars

<sup>\*</sup> Benefits are reduced by 20 percent when services are received from an out-of-network dentist

# WELCOME TO DENTAL BLUE FREEDOM,

A DENTAL PLAN DESIGNED TO MANAGE THE COST OF DENTAL SERVICES.

#### Your Dentist

Dental Blue Freedom offers a large network of dentists, including participating dentists in Massachusetts and nationwide. When searching for a network dentist, Dental Blue Freedom members can choose from the Dental Blue PPO (Preferred Dentist) or Dental Blue (Participating Dentist) networks. Using a network dentist will minimize your out-of-pocket expenses.

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 Renefits

You will receive the greatest value if you visit a preferred dentist, because you will maximize the amount of benefits received under your plan.

The dental benefits your plan covers are subject to the coinsurance (if applicable) and calendar-year 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 Network Dentists Are Paid - Preferred Dentists

For dentists who have a preferred provider contract with Blue Cross Blue Shield, benefits are calculated based on the provisions of the preferred dentist's payment agreement and the dentist's allowed charge that is in effect at the time the covered dental service is provided. Preferred dentists agree to accept the allowed charge as payment in full. You pay your coinsurance (if applicable) and any allowed charges beyond your calendar-year benefit maximum.

#### How Network Dentists Are Paid - Participating Dentists

For dentists who participate with Blue Cross Blue Shield, but do not have a Blue Cross Blue Shield preferred provider contract, benefits are calculated at the same benefit level that applies when the same covered dental services are provided by a preferred dentist. These dentists agree to accept the allowed charge as payment in full. You pay your coinsurance (if applicable) and any allowed charges beyond your calendar-year benefit maximum.

# How Out-of-Network Dentists Are Paid - Non-Preferred or Non-Participating Dentists

Benefits for covered services by a non-preferred or non-participating dentist are provided based on the allowed charge or the dentist's actual charge, whichever is less. The allowed charge is based on a schedule of charges. You may be responsible for any difference between the dentist's actual charge or the allowed charge, whichever is less. You are also responsible for your 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

Network 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 an out-of-network 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 1-800-782-3675, 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. **Note:** Blue Cross and Blue Shield of Massachusetts, Inc. administers claims payment only and does not assume financial risk for claims.



# 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

<sup>\*</sup>This is not a flexible spending account (FSA). The amount reflects your benefit maximum for a given year.

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® FREEDOM

City of Brockton Retirees

# 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.



### **DENTAL BLUE FREEDOM**

#### For members under age 13, benefits are covered in full up to the calendar-year benefit maximum.

Preventive Benefit Group	Basic Benefit Group	Major Benefit Group
	No Deductible	
Full Coverage*	80% Coverage*	50% Coverage*

#### \$2,000 Per Member Calendar-Year Benefit Maximum (in-network and out-of-network combined)

#### 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
- General anesthesia when administered in conjunction with covered surgical services
- Emergency dental care to treat acute pain or to prevent permanent harm to a member\*\*

#### Prosthodontics (teeth replacement)

- Complete or partial dentures (including services to fabricate, measure, fit, and adjust them) once each 60 months for each arch
- Fixed bridges (including services to fabricate, measure, fit, and adjust them) once each 60 months for each tooth
- Replacement of dentures and bridges once each 60 months when the existing appliance can't be made serviceable
- · Adding teeth to an existing bridge
- Temporary partial dentures to replace any of the six upper or six lower front teeth (only covered if they are installed immediately following the loss of teeth and during the period of healing)

#### Major Restorative (members age 16 or older)

- Crowns, once each 60 months for each tooth
- Metallic, porcelain, and composite resin inlays.
   Benefits are provided for an amalgam filling toward the cost of a metallic, porcelain, or composite resin inlay, once each 60 months for each tooth. You pay any balance.
- Metallic, porcelain, and composite resin onlays, once each 60 months for each tooth
- Replacement of crowns, once each 60 months for each tooth
- Replacement of metallic, porcelain, and composite resin inlays. Benefits are provided for an amalgam filling toward the cost of a metallic, porcelain, or composite resin inlay, once each 60 months for each tooth. You pay any balance.
- Replacement of metallic, porcelain, and composite resin onlays, once each 60 months for each tooth
- Post and core or crown buildup, once each 60 months for each tooth

#### Implants (members age 16 or older)

 Single tooth dental endosteal implants (the fixture and abutment portion) in addition to the allowance for the crown for the implant, once each 60 month period, when the implant replaces permanent teeth through the second molars

- Benefits are reduced by 20 percent when services are received from an out-of-network dentist.
- \*\* When you require emergency care by an out-of-network dentist, benefits are provided at the same level as an in-network dentist.

# WELCOME TO DENTAL BLUE FREEDOM,

#### A DENTAL PLAN DESIGNED TO MANAGE THE COST OF DENTAL SERVICES.

#### Your Dentist

Dental Blue Freedom offers a large network of dentists, including participating dentists in Massachusetts and nationwide. When searching for a network dentist, Dental Blue Freedom members can choose from the Dental Blue PPO (Preferred Dentist) or Dental Blue (Participating Dentist) networks. Using a network dentist will minimize your out-of-pocket expenses.

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**

You will receive the greatest value if you visit a preferred dentist, because you will maximize the amount of benefits received under your plan.

The dental benefits your plan covers are subject to the coinsurance (if applicable) and calendar-year benefit maximum amounts shown in the chart. For members under age 13, these benefits are covered in full up until the calendar-year benefit maximum. 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 Network Dentists Are Paid - Preferred Dentists

You will receive the greatest value if you visit a preferred dentist, because you will maximize the amount of benefits received under your plan.

Payments are calculated based on the provisions of the Blue Cross Blue Shield preferred dentist's payment agreement and the dentist's allowed charge that is in effect at the time the covered dental service is provided. Preferred dentists agree to accept the allowed charge as payment in full. You pay your coinsurance (if applicable) and any allowed charges beyond your calendar-year benefit maximum.

#### How Network Dentists Are Paid - Participating Dentists

For dentists who participate with Blue Cross Blue Shield, but do not have a Blue Cross Blue Shield preferred provider contract, benefits are calculated based on the provisions of the participating dentist's payment agreement and the dentist's allowed charge. These dentists agree to accept the allowed charge as payment in full. You pay your coinsurance (if applicable) and any allowed charges beyond your calendar-year benefit maximum.

# How Out-of-Network Dentists Are Paid - Non-Preferred or Non-Participating Dentists

Benefits for covered services by a non-preferred or non-participating dentist are provided based on the allowed charge or the dentist's actual charge, whichever is less. The allowed charge is based on a schedule of charges. You may be responsible for any difference between the dentist's actual charge or the allowed charge, whichever is less. You are also responsible for your 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

Network 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 an out-of-network 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 1-888-714-0189, 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

<sup>\*</sup>This is not a flexible spending account (FSA). The amount reflects your benefit maximum for a given year.

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.

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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).



# MEDEX® 2

City of Brockton

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:



\$

**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 lab tests, anesthesia, drugs and medications, and intensive care services	<ul> <li>Coverage for days 1–60 per benefit period after Part A deductible</li> <li>Coverage for days 61–90 after daily Part A coinsurance</li> <li>Coverage for an additional 60 lifetime reserve days after daily Part A coinsurance</li> </ul>	<ul> <li>Full coverage of Medicare deductible and coinsurance</li> <li>Full coverage of lifetime reserve day coinsurance</li> <li>Full coverage up to a lifetime maximum of 365 additional hospital days when Medicare benefits are used up<sup>†</sup></li> </ul>
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*	<ul> <li>Full coverage for days 1–20</li> <li>Coverage for days 21–100 after daily Part A coinsurance</li> </ul>	<ul> <li>Full coverage of Medicare daily coinsurance for days 21–100</li> <li>\$16 daily for days 101–365</li> </ul>
Skilled nursing facility— not participating with Medicare*	No benefits	\$16 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 T	Mental Health and Substance Use Treatment				
Biologically based mental conditions**	Biologically based mental conditions**				
Inpatient admissions in a general or mental hospital	<ul> <li>Coverage for days 1–60 per benefit period after Part A deductible</li> <li>Coverage for days 61–90 after daily Part A coinsurance</li> <li>Coverage for an additional 60 lifetime reserve days after daily Part A coinsurance</li> <li>Coverage for mental hospital admissions is limited to a 190 day lifetime maximum</li> </ul>	<ul> <li>Full coverage of Medicare deductible and coinsurance</li> <li>Full coverage of lifetime reserve day coinsurance</li> <li>Full coverage up to a lifetime maximum of 365 additional hospital days when Medicare benefits are used up<sup>†</sup></li> </ul>			
Outpatient visits	80% of approved charges after annual Part B deductible	<ul> <li>When covered by Medicare, full coverage of Medicare deductible and coinsurance with no visit maximum</li> <li>When visits are not covered by Medicare, full coverage with no visit maximum</li> </ul>			
Non-biologically based mental condition	Non-biologically based mental conditions				
Inpatient admissions in a general hospital	<ul> <li>Coverage for days 1–60 per benefit period after Part A deductible</li> <li>Coverage for days 61–90 after daily Part A coinsurance</li> <li>Coverage for an additional 60 lifetime reserve days after daily Part A coinsurance</li> </ul>	<ul> <li>Full coverage of Medicare deductible and coinsurance</li> <li>Full coverage of lifetime reserve day coinsurance</li> <li>Full coverage up to a lifetime maximum of 365 additional hospital days when Medicare benefits are used up<sup>†</sup></li> </ul>			
Inpatient admissions in a mental hospital	Same coverage as a general hospital, but coverage is limited to a 190 day lifetime maximum	<ul> <li>Full coverage of Medicare deductible and coinsurance</li> <li>Full coverage of lifetime reserve day coinsurance</li> <li>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)<sup>†</sup></li> </ul>			
Outpatient visits	80% of approved charges after annual Part B deductible	<ul> <li>When covered by Medicare, full coverage of Medicare deductible and coinsurance with no visit maximum</li> <li>When not covered by Medicare, full coverage up to 24 visits per calendar year</li> </ul>			

<sup>†</sup> 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 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.

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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# HOSPITAL CHOICE COST SHARING

Your medical plan gives you an opportunity to control your share of medical costs for hospital care. What you pay depends on the hospital or related facility you choose.





#### **LOWER COST SHARE**

Lower Cost Share (\$) applies to hospitals and related facilities that have met our quality benchmarks and are lower in cost. You pay less when you get care at these hospitals.



#### HIGHER COST SHARE

Higher Cost Share (\$\$) applies to hospitals and related facilities that are higher in cost.. You pay more when you get care at these hospitals.

# **HOW HOSPITAL CHOICE COST SHARING WORKS**

These costs apply to inpatient care, outpatient day surgery, outpatient high-tech radiology, outpatient diagnostic lab tests, outpatient diagnostic X-rays and other imaging tests, and outpatient short-term rehabilitation therapy.

This guide can help you get the highest value from your plan. Just follow the simple steps on the next page to review your hospitals and your options. Your health benefits will tell you what your specific share of the costs is. If you're not sure, you can call Member Service at the number on the front of your member ID card.

# **Questions?**

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

This health plan option includes a tiered network feature called Hospital Choice Cost Sharing. As a member in this plan, you'll pay different levels of cost share\* (such as copayments and/ or co-insurance) for certain services depending on the network\* general hospital you choose to furnish those covered services. For most network general hospitals, you'll pay the lowest cost sharing level. However, if you receive certain covered services from some network general hospitals, you pay the highest cost-sharing level. A network general hospital's cost-sharing level may change from time to time. Overall changes to add another network general hospital to the highest cost-sharing level will happen no more than once each calendar year. For help in finding a network general hospital for which you pay the lowest cost-sharing level, check the most current provider directory for your health plan option or visit the online provider search tool at myplans.bluecrossma.com/medical-insurance/hospital-choice-cost-sharing. Then click the Planning Guide link on the left of the screen to download a printable network hospital list, or to access the provider search page.

### **FOLLOW THESE THREE SIMPLE STEPS**



# Step 1: Make a List of the Hospitals Where You Receive Care

In the table below, list all the hospitals and clinics where you and your family go for care. Be sure to check which hospitals your doctors are affiliated with whenyou make your list.



# Step 2: Find Out What You'd Pay at the Hospitals Where You Receive Care

Finding out whether your hospitals have a Lower or Higher Cost Share is easy:

- Visit the Hospital Choice Cost Sharing website at myplans.bluecrossma.com/medical-insurance/ hospital-choice-cost-sharing.
- Review the hospital list included with this document to check your hospitals.
- Call to 1-888-636-4808. Our specially trained Member Service associates are ready to help you review your current hospitals.



# Step 3: Choose Hospitals with a Lower Cost Share

If you go to Higher Cost Share hospitals, you might consider switching to Lower Cost Share hospitals. This will allow you to pay less every time you get care.

We can help you quickly and easily pick Lower Cost Share hospitals near where you live or work. Call Member Service at 1-888-636-4808. You can also use our hospital search at the Hospital Choice Cost Sharing website: myplans.bluecrossma.com/medical-insurance/hospital-choice-cost-sharing.

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

# **HOSPITAL LIST**

Hospital Name	City	State	Member Cost Share
Addison Gilbert Hospital	Gloucester	MA	Lower
Anna Jaques Hospital	Newburyport	MA	Lower
Athol Memorial Hospital	Athol	MA	Lower
Baystate Franklin Medical Center	Greenfield	MA	Lower
Baystate Medical Center	Springfield	MA	Higher
Berkshire Medical Center	Pittsfield	MA	Lower
Beth Israel Deaconess Hospital—Milton	Milton	MA	Lower
Beth Israel Deaconess Hospital—Needham Campus	Needham	MA	Lower
Beth Israel Deaconess Hospital—Plymouth	Plymouth	MA	Lower
Beth Israel Deaconess Medical Center	Boston	MA	Lower
Beverly Hospital	Beverly	MA	Lower
Boston Children's Hospital	Boston	MA	Higher
Boston Children's at Lexington	Lexington	MA	Lower
Boston Children's at Peabody	Peabody	MA	Lower
Boston Children's at Waltham	Waltham	MA	Lower

Hospital Name	City	State	Member Cost Share
Boston Medical Center	Boston	MA	Lower
Brigham and Women's Hospital	Boston	MA	Higher
Brigham and Women's/Mass General Health Care Center at Patriot Place	Foxborough	MA	Lower
Cambridge Health Alliance—Cambridge Campus	Cambridge	MA	Lower
Cambridge Health Alliance—Somerville Campus	Somerville	MA	Lower
Cambridge Health Alliance—Whidden Campus	Everett	MA	Lower
Cape Cod Hospital	Hyannis	MA	Higher
Carney Hospital	Dorchester	MA	Lower
Clinton Hospital	Clinton	MA	Lower
Cooley Dickinson Hospital	Northampton	MA	Lower
Dana-Farber Cancer Institute	Boston	MA	Higher
Emerson Hospital	Concord	MA	Lower
Fairview Hospital	Great Barrington	MA	Higher
Falmouth Hospital	Falmouth	MA	Lower
Faulkner Hospital	Jamaica Plain	MA	Lower
Good Samaritan Medical Center	Brockton	MA	Lower
Harrington Memorial Hospital	Southbridge	MA	Lower
HealthAlliance Hospitals—Burbank Campus	Fitchburg	MA	Lower
HealthAlliance Hospitals—Leominster Campus	Leominster	MA	Lower
Heywood Hospital	Gardner	MA	Lower
Holy Family Hospital	Methuen	MA	Lower
Holy Family Hospital at Merrimack Valley	Haverhill	MA	Lower
Holyoke Medical Center	Holyoke	MA	Lower
Lahey Clinic	Burlington	MA	Lower
Lawrence General Hospital	Lawrence	MA	Lower
Lawrence Memorial Hospital	Medford	MA	Lower
Lowell General Hospital (includes the campus formerly known as Saints Medical Center)	Lowell	MA	Lower
Marlborough Hospital	Marlborough	MA	Lower
Martha's Vineyard Hospital	Oak Bluffs	MA	Lower
Massachusetts Eye and Ear®' Infirmary	Boston	MA	Lower
Massachusetts General Hospital	Boston	MA	Higher
Mass General/North Shore Center for Outpatient Care	Danvers	MA	Lower
Melrose-Wakefield Hospital	Melrose	MA	Lower
Mercy Medical Center	Springfield	MA	Lower
MetroWest Medical Center—Framingham Union	Framingham	MA	Lower
MetroWest Medical Center—Leonard Morse	Natick	MA	Lower
Milford Regional Medical Center	Milford	MA	Lower
Morton Hospital and Medical Center	Taunton	MA	Lower

Hospital Name	City	State	Member Cost Share
Mount Auburn Hospital	Cambridge	MA	Lower
Nantucket Cottage Hospital	Nantucket	MA	Lower
Nashoba Valley Medical Center	Ayer	MA	Lower
New England Baptist® Hospital	Boston	MA	Lower
Newton-Wellesley Hospital	Newton	MA	Lower
Noble Hospital	Westfield	MA	Lower
North Shore Medical Center—Salem Campus	Salem	MA	Lower
North Shore Medical Center—Union Campus	Lynn	MA	Lower
Norwood Hospital	Norwood	MA	Lower
Saint Vincent Hospital	Worcester	MA	Lower
Shriners Hospitals for Children—Boston	Boston	MA	Lower
Shriners Hospitals for Children—Springfield	Springfield	MA	Lower
Signature Healthcare Brockton Hospital	Brockton	MA	Lower
South Shore Hospital	South Weymouth	MA	Lower
Southcoast Hospitals Group—Charlton Memorial Hospital	Fall River	МА	Lower
Southcoast Hospitals Group—St. Luke's Hospital	New Bedford	MA	Lower
Southcoast Hospitals Group—Tobey Hospital	Wareham	MA	Lower
Southwestern Vermont Medical Center	Bennington	VT	Lower
St. Anne's Hospital	Fall River	MA	Lower
St. Elizabeth's Medical Center	Brighton	MA	Lower
Sturdy Memorial Hospital	Attleboro	MA	Lower
The Vernon Cancer Center at Newton-Wellesley	Newton	MA	Lower
Tufts Medical Center	Boston	MA	Lower
UMass Memorial Medical Center—Memorial Campus	Worcester	MA	Higher
UMass Memorial Medical Center— University Campus	Worcester	МА	Higher
Winchester Hospital	Winchester	MA	Lower
Wing Memorial Hospital	Palmer	MA	Lower



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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.<sup>1</sup>



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.<sup>2</sup>

## Sign In

Download the MyBlue App from the App Store  $^{\otimes}$  or Google Play  $^{\text{TM}}$ , or go to **bluecrossma.org**.

<sup>1.</sup> 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.

<sup>2.</sup> 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
- 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 members<sup>3</sup>

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,<sup>4</sup> 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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# LEARN ABOUT TIERS

# BLUE CROSS BLUE SHIELD OF MASSACHUSETTS FORMULARY

The following information explains our tiered pharmacy plans with the Blue Cross Blue Shield of Massachusetts formulary (list of covered medications), and how those tiers determine the cost of your medications.

Our formulary includes a range of generic and brand-name medications, which are placed into tiers. Your out-of-pocket costs will depend on your plan benefits and the tier of your medication.

# HOW TIERS DETERMINE WHAT YOU PAY FOR MEDICATIONS

Our list of covered medications is based on a tiered cost structure. When you fill a prescription, the amount you pay the pharmacy is determined by your medication's tier and your benefits. The amount you pay may also include your copayment, co-insurance, and deductibles. The pharmacist will tell you what you owe at checkout. To find your out-of-pocket costs in advance, download the MyBlue app, or create an account at **bluecrossma.org**. Once signed in, click **Price a Medication** under **My Medications**.

# HOW COVERED MEDICATIONS ARE PLACED INTO TIERS

Medications are placed into tiers according to a variety of factors, including what they're used for, their cost, and whether equivalent or alternative medications are available. Lower-tier medications typically cost less than higher-tier medications. For example, in a 3-tier structure, you'll likely pay the least for Tier 1 medications and the most for Tier 3 medications.

Pharmacy plans can use one of the five different tier structures outlined in this document. Check your plan materials to see which tier structure your plan uses, and to learn more about how medications are covered.<sup>1</sup>

## Learn more about your coverage

For more information about your pharmacy benefits, sign in to MyBlue at bluecrossma.org.

# **OUR TIER STRUCTURES**

2-TIER	
Tier 1: Generics	Generic medications are effective, low-cost alternatives to brand-name medications. They're expected to work the same as brand-name medications, and meet the same Food & Drug Administration (FDA) requirements.
Tier 2: Brands	Brand-name medications cost more than generic medications, so you'll <b>pay more</b> if you use them.

3-TIER	
Tier 1: Generics	Generic medications are effective, low-cost alternatives to brand-name medications. They're expected to work the same as brand-name medications, and meet the same FDA requirements.
Tier 2: Preferred brands	These are preferred brand-name medications because they're safe, effective alternatives to more expensive brands.
Tier 3: Non-preferred brands	Non-preferred brand-name medications cost more than preferred brands, so you'll <b>pay more</b> if you use them instead of any generics or preferred brands.

4-TIER		
Tier 1: Preferred generics	These medications are preferred because they cost less than other generic medications.	
Tier 2: Non-preferred generics	Non-preferred generic medications cost more than preferred generics, so you'll <b>pay more</b> if you use them instead of preferred generics.	
Tier 3: Preferred brands	These are preferred brand-name medications because they're safe, effective alternatives to more expensive brands.	
Tier 4: Non-preferred brands	Non-preferred brand-name medications cost more than preferred brands, so you'll <b>pay more</b> if you use them instead of any generics or preferred brands.	

5-TIER	
Tier 1: Generics	Generic medications are effective, low-cost alternatives to brand-name medications. They're expected to work the same as brand-name medications, and meet the same FDA requirements.
Tier 2: Preferred brands	These are preferred brand-name medications because they're safe, effective alternatives to more expensive brands.
Tier 3: Non-preferred brands	Non-preferred brand-name medications cost more than preferred brands, so you'll <b>pay more</b> if you use them instead of any generics or preferred brands.
Tier 4: Preferred brand specialty	These specialty medications are preferred because they're safe, effective alternatives to more expensive, brand-name specialty medications.
Tier 5: Non-preferred brand specialty	Non-preferred brand-name specialty medications cost more than preferred brands, so you'll <b>pay more</b> if you use them instead of any generics or preferred brand-name specialty medications.

6-TIER	
Tier 1: Preferred generics	These medications are preferred because they cost less than other generic medications.
Tier 2: Non-preferred generics	Non-preferred generic medications cost more than preferred generics, so you'll <b>pay more</b> if you use them instead of preferred generics.
Tier 3: Preferred brands	These are preferred brand-name medications because they're safe, effective alternatives to more expensive brands.
Tier 4: Non-preferred brands	Non-preferred brand-name medications cost more than preferred brands, so you'll <b>pay more</b> if you use them instead of any generics or preferred brands.
Tier 5: Preferred brand specialty	These specialty medications are preferred because they're safe, effective alternatives to more expensive, brand-name specialty medications.
Tier 6: Non-preferred brand specialty	Non-preferred brand-name specialty medications cost more than preferred brands, so you'll <b>pay more</b> if you use them instead of any generics or preferred brand-name specialty medications.



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# 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**.





# SAVE TIME AND MONEY WITH MAINTENANCE CHOICE VOLUNTARY

Maintenance Choice Voluntary saves you 33% on the cost of your maintenance medications, also known as long-term medications, when you switch to a 90-day supply and fill your prescriptions at a retail pharmacy that participates in the Maintenance Choice Voluntary program, or through the mail service pharmacy.<sup>2</sup>



#### **SWITCHING BRINGS BENEFITS**



Pay 33% less for 90-day supplies of most maintenance medications.



Enjoy the convenience of filling medications at any of the 9,000+ retail pharmacies that participate in the Maintenance Choice Voluntary program.



Pay \$0 for standard delivery through the mail service pharmacy.



Make fewer trips to the pharmacy, or none at all.

#### **EXAMPLE OF HOW YOU CAN SAVE<sup>3</sup>**

Type of prescription	Medication copay		
Type of prescription	Tier 1	Tier 2	Tier 3
30-day supply, retail pharmacy	\$15	\$30	\$50
90-day supply, participating retail pharmacy or mail service pharmacy	\$30	\$60	\$150

 $<sup>1. \ \</sup> In \ most \ cases \ for \ eligible \ maintenance \ medications. \ Check \ plan \ materials \ for \ more \ details.$ 

<sup>2.</sup> Maintenance Choice Voluntary isn't available in Oklahoma and West Virginia. If you're a resident of these states, you can still save money on your medications when you fill them in 90-day supplies at an in-network pharmacy that is able to dispense medications in 90-day supplies.

<sup>3.</sup> For illustrative purposes only, using a 3-tier plan.

#### **HOW TO SWITCH TO 90-DAY FILLS**



#### Participating retail pharmacy

Talk to your health care provider about switching to a 90-day prescription, or show the pharmacist one of the emails you receive about switching to 90-day fills.

To find a participating pharmacy:

- 1 Download the MyBlue app or create an account at bluecrossma.org.
- 2 Once signed in, click **Find a Pharmacy** under **My Medications**, then look for a pharmacy that offers 90-day supplies.



#### Mail service pharmacy

- Download the MyBlue app or create an account at bluecrossma.org.
- 2 Once signed in, click 90-Day Mail Service Pharmacy under My Medications.



To make sure you receive emails about the Maintenance Choice Voluntary program, update your communication preferences in MyBlue:

- 1 Download the MyBlue app or create an account at bluecrossma.org.
- 2 Once signed in, click Pharmacy Benefit Manager under My Medications.
- 3 Go to Profile.
- 4 Select Communication preferences and enter your email address.

#### **Questions?**

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

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# NO-COST GENERIC MEDICATIONS

## **MEDICATION LIST**

#### For plans that use the:

Blue Cross Blue Shield of Massachusetts Formulary

#### GET A PERSONALIZED VIEW OF YOUR HEALTH PLAN WITH MYBLUE

MyBlue is your personalized online member account that makes understanding and using your health plan simple. You can use MyBlue to:



Find, understand, and use your benefits



Review your claims details



Get personalized care options that fit your unique needs



Look up medications

Sign in or create your MyBlue account at bluecrossma.org.

# GENERIC MEDICATIONS THAT ARE COVERED AT NO COST

The following list includes medications that are covered at no cost for eligible members who have one or more of the following conditions: depression, high cholesterol, diabetes, heart disease, and high blood pressure. The copay and deductible will be waived for these medications when purchased at an in-network retail pharmacy, or through the mail service pharmacy. You should talk with your doctor first to ensure that these medications are right for you.

This isn't a complete list of covered medications, and inclusion on this list doesn't guarantee coverage.¹ You must have a valid prescription from a licensed health provider to receive coverage for these medications. Some medications may also be subject to pharmacy management programs, such as step therapy, prior authorization, or quality care dosing, or have other coverage requirements.

NOTE: Some medications on this list may be considered non-covered, including new medications under review by Blue Cross. Your doctor may request an exception for a non-covered medication when medically necessary.<sup>2</sup>

#### Learn more about your coverage

For more information about coverage for these medications, sign in to MyBlue at **bluecrossma.org** then go to **Medication Lookup Tool** under **My Medications**.

If you're not a member, you can get more information by visiting bluecrossma.org/medication.

<sup>1.</sup> Not all medications listed are covered by all prescription plans. Check your benefit materials for details

Medication class	Medication name		
Antidepressants	FLUOXETINE 10 MG CAP		
	FLUOXETINE 20 MG CAP		
Antidiabetics	METFORMIN HYDROCHLORIDE 500 MG TABS		
	METFORMIN HYDROCHLORIDE 850 MG TABS		
	METFORMIN HYDROCHLORIDE 1000 MG TABS		
Antihyperlipidemics	ATORVASTATIN CALCIUM 10 MG TAB		
	ATORVASTATIN CALCIUM 20 MG TAB		
	ATORVASTATIN CALCIUM 40 MG TAB		
	ATORVASTATIN CALCIUM 80 MG TAB		
	SIMVASTATIN 5 MG TAB		
	SIMVASTATIN 10 MG TAB		
	SIMVASTATIN 20 MG TAB		
	SIMVASTATIN 40 MG TAB		
	SIMVASTATIN 80 MG TAB		
Antihypertensives	LISINOPRIL 2.5 MG TAB		
	LISINOPRIL 5 MG TAB		
	LISINOPRIL 10 MG TAB		
	LISINOPRIL 20 MG TAB		
	LISINOPRIL 30 MG TAB		
	LISINOPRIL 40 MG TAB		
	LOSARTAN POTASSIUM 25 MG TAB		
	LOSARTAN POTASSIUM 50 MG TAB		
	LOSARTAN POTASSIUM 100 MG TAB		
Beta blockers	ATENOLOL 25 MG TAB		
	ATENOLOL 50 MG TAB		
	ATENOLOL 100 MG TAB		
	METOPROLOL SUCCINATE ER 25 MG 24HR TAB		
	METOPROLOL SUCCINATE ER 50 MG 24HR TAB		
	METOPROLOL SUCCINATE ER 100 MG 24HR TAB		
	METOPROLOL SUCCINATE ER 200 MG 24HR TAB		

Medication class	Medication name
Calcium channel blockers	AMLODIPINE BESYLATE 2.5 MG TAB
	AMLODIPINE BESYLATE 5 MG TAB
	AMLODIPINE BESYLATE 10 MG TAB
Diuretics	FUROSEMIDE 20 MG TAB
	FUROSEMIDE 40 MG TAB
	FUROSEMIDE 80 MG TAB
	HYDROCHLOROTHIAZIDE 12.5 MG CAP
	HYDROCHLOROTHIAZIDE 12.5 MG TAB
	HYDROCHLOROTHIAZIDE 25 MG TAB
	HYDROCHLOROTHIAZIDE 50 MG TAB



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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.<sup>1</sup>



#### 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 SAVE<sup>2</sup>**

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

<sup>1.</sup> In most cases for eligible maintenance medications. Check plan materials for more details.

<sup>2.</sup> 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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	Mail this form to:	
Member ID # (if not shown or if different from above)	Ilili IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	เเ <sup>น</sup> ่นเป็นเป็นเป็นเป็นเป็นเป็น TX 78265-9541
Prescription Plan Sponsor or Company Name		
Instructions: Please use blue or black ink and print in capital le	etters. Fill in both sides o	of this form.
New Prescriptions - Mail your new prescriptions with Refills - Order by Web, phone, or write in Rx numbers TO RECEIVE YOUR ORDER SOONER request refigo to 90-Day Mail Service under My Medications.	th this form.  (s) below.  Number  Ils or new prescriptions o	per of <b>New</b> prescriptions:
A Shipping Address. To ship to an address differen	t from the one printed abo	ove, enter the changes here.
Last Name	First Name	MI Suffix (JR, SR)
Street Address	Apt./Suite #	Use shipping address for this order only.
City	State	ZIP Code
Daytime Phone #:	Evening Phone #:	
B Refills. To order mail service refills, enter your pro	escription number(s) here	).
1)2)	3)	4)

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.

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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.  Last Name	Spanish forms and labels  First Name  MI  Suffix (JR,SR)
Nickname	Date of birth:
E-mail address:	Dete new messwintien witten.
Doctor's last name Doctor's f	first name Doctor's phone #
Tell us about new health information for 1st pe	· · · · · · · · · · · · · · · · · · ·
Medical conditions: Arthritis Asthma D High blood pressure High cholesterol Other:	Migraine Osteoporosis Prostate issues Thyroid
Second person with a refill or new prescription.	○ Spanish forms and label
Last Name Nickname	Date of birth:
E-mail address:	Date new prescription written:
Doctor's last name Doctor's f	first name Doctor's phone #
Other:	orin Codeine Erythromycin Peanuts Penicillia iabetes Acid reflux Glaucoma Heart problem Migraine Osteoporosis Prostate issues Thyroid
Special instructions:	
low would you like to pay tar this arder?)/lt//	
	our copay is \$0, you do not need to provide payment information. nt. (You must first register online or call Customer Care.)
	nt. (You must first register online or call Customer Care.)
<ul> <li>Electronic check. Pay from your bank account</li> <li>Credit or debit card. (VISA®, MasterCard®, D</li> <li>Use your card on file.</li> <li>Use a new card or update your card's expirate</li> </ul>	nt. (You must first register online or call Customer Care.)  Discover®, or American Express®)  ation date.
Credit or debit card. (VISA®, MasterCard®, D Use your card on file. Use a new card or update your card's expira	nt. (You must first register online or call Customer Care.)  Discover®, or American Express®)  ation date.  Date
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Credit or debit card. (VISA®, MasterCard®, D Use your card on file. Use a new card or update your card's expiration Exp. MN Check or money order. Amount: \$  Make check or money order payable to CVS C Write your prescription benefit ID number on your check or money order.	Action date.  Date MYY  Credit card holder signature/Date  Regular delivery is free and takes up to 5 days after your order is processed.  If you want faster delivery, choose:  2nd business day (\$17)  Next business day (\$17)  Next business day (\$23)  Expected processing time from receipt of this form to a poly so you provide  Refills: 1-2 days  New/renewed prescriptions: Within 5 days unless additional information is needed from your doctor (Charges subject to change)



# 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 Nama	Network Coverage			
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.

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 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

<sup>\*</sup>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 total health solution for members with qualifying medical conditions that may require increased oral care. 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	~	~		
CORONARY ARTERY DISEASE	~	~		
STROKE	~	~		
PREGNANCY <sup>2</sup>	~	<b>✓</b>		
ORAL CANCER	~		~	~
SJÖGREN'S SYNDROME	~		<b>~</b>	~
INTELLECTUAL AND/ OR DEVELOPMENTAL DISABILITIES <sup>2,3</sup>	~		~	~
MENTAL HEALTH CONDITIONS <sup>2,3</sup>	~		~	~

<sup>1.</sup> 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.

Note: Certain dental plans cover preventive dental services and Enhanced Dental Benefits at different frequency intervals. Check your plan benefits to confirm your coverage before scheduling dental services.

<sup>2.</sup> Self-enrollment is required for this condition. You can download the Enhanced Dental Benefits Enrollment Form at bluecrossma.org/myblue/fast-forms

<sup>3.</sup> Intellectual and/or Developmental Disabilities and Mental Health Conditions are being added to benefits on renewal starting October 1, 2023.

## **USING THESE BENEFITS**

#### There's No Additional Cost to Receive These Extra Services4

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 have to pay co-insurance.

#### **Accessing Enhanced Dental Benefits**

You may be automatically enrolled for these extra services if you have medical coverage through Blue Cross and have been identified to have a qualifying medical condition. However, there are some instances where you'll need to self-enroll using the Enhanced Dental Benefits Enrollment Form.

- · You don't have Blue Cross medical coverage
- For the following conditions, even if you have Blue Cross medical coverage:
  - Intellectual and/or developmental disability
  - · Mental health condition
  - Pregnancy

4. Qualifying members only

#### **Ouestions?**

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

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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 (TTÝ: 711).



## ENHANCED DENTAL BENEFITS ENROLLMENT FORM

This is a self-enrollment form to receive Enhanced Dental Benefits from Blue Cross Blue Shield of Massachusetts. Enhanced Dental Benefits provide coverage for additional preventive services for members diagnosed with one or more of the qualifying medical conditions listed below. Please complete this form with your doctor and mail it back to the address provided below to receive these benefits.

(Your dental coverage policy must include Enhanced Dental Benefits in order to be eligible for coverage.)

Please check qualifying medical conditions:					
□ Diabetes □ Coronary artery disease □ Stroke □ Pregnancy (expected date of birth/) □ Oral cancer □ Sjögren's syndrome □ Intellectual and/or developmental disabilities* □ Mental health conditions*					
Subsc	riber/Mem	ber Information			
Subscriber Name	Member I	Name		Date of Birth//	
Member Address		City	State	ZIP Code	
Member Telephone # (Home) Member Telephone # (Other)					
Blue Cross Blue Shield of Massachusetts Dental ID #	#				
To Be	Completed	By Your Doctor			
I hereby confirm that my patient has been diagnose	ed with the	conditions listed above.		Date	
Doctor's Signature				/	
Doctor's Name (please print, circle MD or DO)  MD/DO  License #				State	
Doctor's Address		Doctor's Telephone #			

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



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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® FREEDOM

With the ability to see any dentist in our Dental Blue® and Dental Blue® PPO networks, as well as out-of-network dentists, Dental Blue Freedom gives you the most choices for dental care. You'll save the most when you get care from an in-network dentist.

#### **PLAN HIGHLIGHTS**



#### **Freedom of Choice**

With the largest selection of network dentists, plus the ability to see out-of-network dentists, you'll have the most choices for dental care.



#### No "Balance Billing"

When using our Dental Blue and Dental Blue PPO networks, you won't be billed for the difference between what the dentist charges and the allowed amount.



#### The Best Rates for In-Network Service

The dentist's charge for services will be lowest when you use the Dental Blue PPO network, while the charge for services from dentists in the Dental Blue network will be slightly higher.



#### **No-Cost Preventive Care**

You won't have to pay any out-of-pocket costs for preventive care, such as regular checkups, when you use in-network dentists.

#### **OUR NETWORKS**

#### **Dental Blue**

Our traditional network offers you access to more than 93 percent of dentists in Massachusetts, as well as a large number of national dentists. Rates for services are slightly higher than those in our PPO network.

#### **Dental Blue PPO**

When you visit dentists in our PPO network, you'll get the lowest rates, and pay the least out-of-pocket costs for dental services.

#### **OUT-OF-NETWORK COVERAGE**

You have the flexibility to visit out-of-network dentists, but will pay the highest out-of-pocket costs for services.

#### **HOW TO FIND IN-NETWORK DENTISTS**



Sign in, or create an account at bluecrossma.com/myblue.



Go to the Find a Doctor tool.



Fill in all fields and enter Dental Blue or Dental Blue PPO\* for your network.



Click Search.

\*Choosing Dental Blue PPO will give you the most coverage

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# Blue MedicareRx<sup>SM</sup> (PDP) 2 Tier Select 2025 Formulary

(List of Covered Drugs or "Drug List")

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

This formulary was updated on 09/20/2024. 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 the Document Portal (rxmedicareplans.memberdoc.com).

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Customer Care for more information.

Important Message About What You Pay for Insulin - You won't pay more than \$35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

**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. If you are unsure about which drugs may or may not be covered, please call Customer Care to verify drug coverage.

When this Drug List (Formulary) refers to "we," "us," or "our," it means Blue MedicareRx<sup>SM</sup> (PDP). When it refers to "plan" or "our plan," it means Blue MedicareRx.

This document includes a Drug List (Formulary) for our plan which is current as of January 1, 2025. For an updated Drug List (Formulary), please contact us. Our contact information, along with the date we last updated the Drug List (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, 2026, and from time to time during the year.

#### What is the Blue MedicareRx Formulary?

In this document, we use the terms Drug List and formulary to mean the same thing. 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 change?

Most changes in drug coverage happen on January 1, but Blue MedicareRx may add or remove drugs on the formulary during the year, move them to different cost sharing tiers, or add new restrictions. We must follow the Medicare rules in making these changes. Updates to the formulary are posted monthly to our Document Portal here: rxmedicareplans.memberdoc.com.

Changes that can affect you this year: In the below cases, you will be affected by coverage changes during the year:

Immediate substitutions of certain new versions of brand name drugs and original biological products. We may immediately remove a drug on our formulary if we are replacing it with a certain new version of that drug that will appear on the same or lower cost sharing tier and with the same or fewer restrictions. When we add a new version of a drug to our formulary, we may decide to keep the brand name drug or original biological product on our formulary, but immediately move it to a different cost sharing tier or add new restrictions.

We can make these immediate changes only if we are adding a new generic version of a brand name drug, or adding certain new biosimilar versions of an original biological product, that was already on the formulary (for example, adding an interchangeable biosimilar that can be substituted for an original biological product by a pharmacy without a new prescription).

If you are currently taking the brand name drug or original biological product, we may not tell you in advance before we make an immediate change, but we will later provide you with information about the specific change(s) we have made.

If we make such a change, you or your prescriber can ask us to make an exception and continue to cover for you the drug that is being changed. For more information, see the section below titled "How do I request an exception to the Blue MedicareRx Formulary?"

Some of these drug types may be new to you. For more information, see the section below titled "What are original biological products and how are they related to biosimilars?"

Drugs removed from the market. If a drug is withdrawn from sale by the manufacturer or the Food and Drug Administration (FDA) determines it be withdrawn for safety or effectiveness reasons, we may immediately remove the drug from our formulary and later provide notice to members who take the drug.

09/20/2024 I

Other changes. We may make other changes that affect members currently taking a drug. For instance, we may remove a brand name drug from the formulary when adding a generic equivalent or remove an original biological product when adding a biosimilar. We may also apply new restrictions to the brand name drug or original biological product, or move it to a different cost sharing tier, or both. 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. Alternatively, when a member requests a refill of the drug, they may receive a 30-day supply of the drug and notice of the change.

If we make these other changes, you or your prescriber can ask us to make an exception for you and continue to cover the brand name drug you have been taking. 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 titled "How do I request an exception to the Blue MedicareRx Formulary?"

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2025 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2025 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 formulary for the new benefit year for any changes to drugs.

The enclosed formulary is current as of September 20, 2024. 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. 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 Document Portal (rxmedicareplans.memberdoc.com) to get information showing changes, additions, and/or deletions of medications contained in our formulary.

09/20/2024

#### 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 work just as well and usually cost less than brand name drugs. There are generic drug substitutes available for many brand name drugs. Generic drugs usually can be substituted for the brand name drug at the pharmacy without needing a new prescription, depending on state laws.

#### What are original biological products and how are they related to biosimilars?

On the formulary, when we refer to drugs, this could mean a drug or a biological product. Biological products are drugs that are more complex than typical drugs. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, biosimilars work just as well as the original biological product and may cost less. There are biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state laws, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

For discussion of drug types, please see the *Evidence of Coverage*, Chapter 3, Section 3.1, "The 'Drug List' tells which Part D drugs are covered."

09/20/2024 III

#### 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 prescriber 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.

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 ATROVENT 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 V 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 them 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.

09/20/2024 IV

## 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 waive coverage restrictions including prior authorization, step therapy, or a quantity limit on your drug. For example, for certain drugs, Blue MedicareRx limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

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.

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 the restriction would not be as effective for you and/or would cause you to have adverse effects.

You or your prescriber should contact us to ask for a tiering or formulary exception, including an exception to a coverage restriction. When you request an exception, your prescriber will need to explain the medical reasons why you need this exception. Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can ask for an expedited (fast) decision if you believe, and we agree, that your health could be seriously harmed by waiting up to 72 hours for a decision. If we agree, or if your prescriber asks for a fast decision, we must give you a decision no later than 24 hours after we get your prescriber's supporting statement.

## What can I do if my drug is not on the formulary or has a restriction?

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 has a coverage restriction, such as prior authorization. You should talk to your prescriber about requesting a coverage decision to show that you meet the criteria for approval, switching to an alternative drug that we cover, or requesting a formulary exception so that we will cover the drug you take. While you talk to your prescriber 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 has a coverage restriction, we will cover a temporary 30-day supply (unless you have a prescription written for fewer days) when you go to a network pharmacy. If coverage is not approved, 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.

09/20/2024 V

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.

## 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 HFA) 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.

09/20/2024 VI

Drug Name	Drug Tier	Requirements/ Limits	Drug Name Dr Ti		Requirements/ Limits
ANALGESICS GOUT			naproxen TABS 250mg, 375mg	Tier 1	
allopurinol TABS 100mg, 300mg	Tier 1	I	naproxen (generic of NAPROSYN) TABS 500mg	Tier 1	
colchicine (generic of MITIGARE) CAPS .6mg	Tier 2	QL	sulindac TABS 150mg, 200mg	Tier 1	
QL (60 caps / 30 days	5)		OPIOID ANALGESICS, I	LONG	-ACTING
colchicine TABS .6mg QL (120 tabs / 30 days)	Tier 1	QL	fentanyl PT72 12mcg/hr, 25mcg/hr, 37.5mcg/hr, 50mcg/hr, 62.5mcg/hr,	Tier 2	QL PA
colchicine w/ probenecid tal 0.5-500 mg	b Tier 2	2	75mcg/hr, 87.5mcg/hr, 100mcg/hr		
MITIGARE CAPS .6mg QL (60 caps / 30 days	Tier 2	QL	QL (10 patches / 30 days)		
probenecid TABS 500mg	Tier 2	2	hydrocodone bitartrate	Tier 2	QL PA
MISCELLANEOUS	•	<del>,</del>	T24A 20mg, 30mg, 40mg,		
lidocaine hcl (local anesth.)	Tier 2	2 B/D	60mg, 80mg		
(generic of XYLOCAINE-			QL (30 tabs / 30 days)		
MPF) SOLN .5%, 1%, 1.5%	<b>6</b>		hydrocodone bitartrate	Tier 1	QL PA
lidocaine hcl (local anesth.)		2 B/D	T24A 100mg, 120mg		
(generic of XYLOCAINE)			QL (30 tabs / 30 days)		01.54
SOLN .5%, 1%, 2%			methadone hcl TABS 5mg,	Her 2	QL PA
NSAIDS			10mg		
celecoxib (generic of	Tier 2	QL	QL (90 tabs / 30 days) morphine sulfate (generic of		QL PA
CELEBREX) CAPS 50mg,			MS CONTIN) TBCR 15mg,		. QLIA
100mg, 200mg			30mg, 60mg, 100mg,		
QL (60 caps / 30 days	•		200mg		
celecoxib (generic of	Tier 2	2 QL	QL (90 tabs / 30 days)	)	
CELEBREX) CAPS 400mg			OPIOID ANALGESICS,	•	T-ACTING
QL (30 caps / 30 days			acetaminophen w/ codeine		
diclofenac potassium TABS 50mg	o Her	I QL	soln 120-12 mg/5ml		
QL (120 tabs / 30			QL (2700 mL / 30		
days)			days)		
diclofenac sodium TB24	Tier 2	<u> </u>	acetaminophen w/ codeine	Tier 1	QL
100mg	1101 2	-	tab 300-15 mg		
diclofenac sodium TBEC	Tier 1	<u> </u>	QL (400 tabs / 30		
25mg, 50mg, 75mg		•	days)	- <u>-</u>	
flurbiprofen TABS 100mg	Tier 2	2	acetaminophen w/ codeine	Tier 1	QL
ibu TABS 400mg, 600mg,	Tier 1	<u> </u>	tab 300-30 mg		
800mg		-	QL (360 tabs / 30		
ibuprofen SUSP 100mg/5n	nl Tier 2	2	days)	Tion 1	01
ibuprofen TABS 400mg,	Tier 1	-	acetaminophen w/ codeine tab 300-60 mg	rieri	QL
600mg, 800mg			QL (180 tabs / 30		
meloxicam TABS 7.5mg, 15mg	Tier 1	<u> </u>	days)		
nabumetone TABS 500mg	Tier 1	<u> </u>			
750mg		•			

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
endocet tab 2.5-325mg (generic of PERCOCET) QL (360 tabs / 30 days)	Tier 2	2 QL	hydromorphone hcl (generic of DILAUDID) TABS 2mg, 4mg, 8mg QL (180 tabs / 30		
endocet tab 5-325mg (generic of PERCOCET) QL (360 tabs / 30	Tier 2	2 QL	days) morphine sulfate SOLN 4mg/ml, 8mg/ml, 10mg/ml	Tier 2	
days) endocet tab 7.5-325mg (generic of PERCOCET)	Tier 2	QL	morphine sulfate SOLN 10mg/5ml, 20mg/5ml QL (900 mL / 30 days)	Tier 2	2 QL
QL (240 tabs / 30 days)	T' C		morphine sulfate SOLN 100mg/5ml	Tier 2	QL
endocet tab 10-325mg (generic of PERCOCET) QL (180 tabs / 30 days)	Tier 2		QL (180 mL / 30 days) morphine sulfate TABS 15mg, 30mg QL (180 tabs / 30	Tier 2	2 QL
fentanyl citrate LPOP 200mcg QL (120 lozenges / 30	Tier 2	2 QL PA	days) nalbuphine hcl SOLN 10mg/ml, 20mg/ml	Tier 2	2
days) fentanyl citrate LPOP 400mcg, 600mcg, 800mcg,	Tier 1	QL PA	oxycodone hcl SOLN 5mg/5ml QL (900 mL / 30 days)	Tier 2	2 QL
1200mcg, 1600mcg QL (120 lozenges / 30 days)			oxycodone hcl TABS 5mg, 10mg, 20mg QL (180 tabs / 30		2 QL
hydrocodone- acetaminophen soln 7.5-32 mg/15ml QL (2700 mL / 30 days)	Tier 2 5	2 QL	days) oxycodone hcl (generic of ROXICODONE) TABS 15mg, 30mg QL (180 tabs / 30	Tier 2	QL
hydrocodone- acetaminophen tab 5-325 mg QL (240 tabs / 30 days)	Tier 2	QL	days) oxycodone w/ acetaminophen tab 2.5-325 mg (generic of PERCOCET) QL (360 tabs / 30	Tier 2	2 QL
hydrocodone- acetaminophen tab 7.5-325 mg QL (180 tabs / 30 days)	Tier 2	2 QL	days)  oxycodone w/ acetaminophen tab 5-325 mg (generic of PERCOCET) QL (360 tabs / 30	Tier 2	2 QL
hydrocodone- acetaminophen tab 10-325 mg QL (180 tabs / 30 days)	Tier 2		days) oxycodone w/ acetaminophen tab 7.5-325 mg (generic of PERCOCET) QL (240 tabs / 30	Tier 2	QL
hydrocodone-ibuprofen tab 7.5-200 mg QL (150 tabs / 30 days)	Tier 2	QL	days)		

Drug Name	Drug Tier	Requirements/ Limits	Drug Name		Requirements/ Limits
oxycodone w/ acetaminophen tab 10-325	Tier 2		gentamicin in saline inj 2 mg/ml	Tier Tier 2	•
mg (generic of PERCOCET QL (180 tabs / 30	)		gentamicin sulfate SOLN 10mg/ml, 40mg/ml	Tier 2	
days) tramadol hcl TABS 50mg	Tier 1	QL	imipenem-cilastatin intravenous for soln 250 mg	Tier 2	
QL (240 tabs / 30 days)			imipenem-cilastatin intravenous for soln 500 mg	Tier 2	2
ANTI-INFECTIVES  ANTI-INFECTIVES - MIS	CFLI	ANFOUS	(generic of PRIMAXIN IV) IMPAVIDO CAPS 50mg	Tier 2	PA
albendazole TABS 200mg QL (672 tabs / year)			ivermectin (generic of STROMECTOL) TABS 3mg	Tier 2	
<i>amikacin sulfat</i> e SOLN 1gm/4ml, 500mg/2ml	Tier 2		QL (12 tabs / 90 days)  linezolid (generic of ZYVOX)	Tier 2	<u> </u>
ARIKAYCE SUSP 590mg/8.4ml	Tier 2	NM PA	SOLN 600mg/300ml linezolid (generic of ZYVOX)	Tier 1	QL
atovaquone (generic of MEPRON) SUSP 750mg/5ml	Tier 2	QL PA	SUSR 100mg/5ml QL (1800 mL / 30 days)	1101	Q2
QL (300 mL / 30 days)			linezolid (generic of ZYVOX) TABS 600mg	Tier 2	QL
aztreonam (generic of AZACTAM) SOLR 1gm, 2gm	Tier 2		QL (60 tabs / 30 days) LINEZOLID INJ 2MG/ML	Tier 2	)
CAYSTON SOLR 75mg	Tier 2	NM PA	meropenem SOLR 1gm,	Tier 2	
clindamycin hcl (generic of CLEOCIN) CAPS 75mg,	Tier 1		500mg methenamine hippurate	Tier 2	
150mg, 300mg  clindamycin phosphate	Tier 2		(generic of HIPREX) TABS	1101 2	•
(generic of CLEOCIN PHOSPHATE) SOLN 900mg/6ml, 9000mg/60ml			metronidazole (generic of METRONIDAZOLE) SOLN 500mg/100ml	Tier 2	2
colistimethate sodium (generic of COLY-MYCIN	Tier 2		<i>metronidazole</i> TABS 250mg, 500mg	Tier 1	
M) SOLR 150mg dapsone TABS 25mg,	Tier 2		neomycin sulfate TABS 500mg	Tier 1	
100mg			nitazoxanide TABS 500mg	Tier 1	QL
DAPTOMYCIN SOLR 350mg	Tier 2		QL (6 tabs / 30 days) nitrofurantoin macrocrystal	Tier 2	<u>.</u>
daptomycin (generic of DAPTOMYCIN) SOLR 350mg	Tier 1		(generic of MACRODANTIN) CAPS 50mg, 100mg		
daptomycin SOLR 500mg	Tier 1	<del></del>	nitrofurantoin monohyd	Tier 2	)
EMVERM CHEW 100mg QL (12 tabs / year)	Tier 1	QL	macro (generic of MACROBID) CAPS 100mg		
ertapenem sodium SOLR 1gm	Tier 2		pentamidine isethionate inh (generic of NEBUPENT)	Tier 2	B/D
gentamicin in saline inj 0.8 mg/ml	Tier 2	<u></u>	SOLR 300mg		

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
pentamidine isethionate inj (generic of PENTAM 300) SOLR 300mg	Tier 2		vancomycin hcl SOLR 1gm, 1.5gm, 5gm, 10gm, 500mg, 750mg	Tier 2	
praziquantel (generic of	Tier 2		VANCOMYCIN INJ 1 GM	Tier 2	2
BILTRICIDE) TABS 600mg			VANCOMYCIN INJ 500MG	Tier 2	
pyrimethamine (generic of	Tier 1	QL PA	VANCOMYCIN INJ 750MG	Tier 2	2
DARAPRIM) TABS 25mg			ANTIFUNGALS		
QL (90 tabs / 30 days)		<del>.</del>	ABELCET SUSP 5mg/ml	Tier 2	B/D
streptomycin sulfate SOLR	Her 2		amphotericin b SOLR 50mg	Tier 2	B/D
1gm sulfadiazine TABS 500mg	Tier 1		amphotericin b liposome	Tier 1	B/D
sulfamethoxazole-	Tier 2		(generic of AMBISOME)		
trimethoprim iv soln 400-80	Her 2		SUSR 50mg		<u>.</u>
mg/5ml			caspofungin acetate	Tier 2	2
sulfamethoxazole-	Tier 2	<del>,                                     </del>	(generic of CANCIDAS)		
trimethoprim susp 200-40	1101 2	•	SOLR 50mg, 70mg		
mg/5ml			fluconazole SUSR	Tier 2	
sulfamethoxazole-	Tier 1		10mg/ml; TABS 50mg	T: C	
trimethoprim tab 400-80 mg			fluconazole (generic of	Tier 2	_
(generic of BACTRIM)			DIFLUCAN) SUSR		
sulfamethoxazole-	Tier 1		40mg/ml fluconazole (generic of	Tier 1	<del> </del>
trimethoprim tab 800-160			DIFLUCAN) TABS 100mg,	i i <del>c</del> i i	
mg (generic of BACTRIM			150mg, 200mg		
DS)			fluconazole in nacl 0.9% inj	Tier 2	<u> </u>
tinidazole TABS 250mg,	Tier 2		200 mg/100ml		
TOBI PODHALER CAPS	Tier 2	NM PA	fluconazole in nacl 0.9% inj 400 mg/200ml	Tier 2	2
28mg	T: a # 4	NM PA	flucytosine (generic of	Tier 1	PA
tobramycin (generic of KITABIS PAK) NEBU	Tier 1	NIVI PA	ANCOBON) CAPS 250mg,		
300mg/5ml			500mg		
tobramycin sulfate SOLN	Tier 2	)	griseofulvin microsize	Tier 2	) -
1.2gm/30ml, 10mg/ml,		•	SUSP 125mg/5ml; TABS		
40mg/ml, 80mg/2ml			500mg	T: 0	
trimethoprim TABS 100mg	Tier 2		griseofulvin ultramicrosize TABS 125mg, 250mg	Tier 2	-
vancomycin hcl (generic of	Tier 2	. QL	itraconazole (generic of	Tier 2	PA
VANCOCIN) CAPS 125mg			SPORANOX) CAPS 100mg		. гд
QL (80 caps / 180			ketoconazole TABS 200mg	_	PA
days)			micafungin sodium (generic		
vancomycin hcl (generic of		. QL	of MYCAMINE) SOLR		•
VANCOCIN) CAPS 250mg			50mg, 100mg		
QL (160 caps / 180			nystatin TABS 500000unit	Tier 2	)
days)	T: 0	<u></u>	posaconazole (generic of	Tier 1	QL PA
vancomycin hcl (generic of	Her 2	-	NOXAFIL) SUSP 40mg/ml		
VANCOMYCIN HYDROCHLORIDE) SOLR	1		QL (630 mL / 30 days)		
1.25gm	<u>.</u>		posaconazole (generic of	Tier 1	QL PA
			NOXAFIL) TBEC 100mg		
			QL (93 tabs / 30 days)		

Drug Name	Drug Tier	Requirements/ Limits
terbinafine hcl TABS 250mg	Tier 1	QL PA
QL (30 tabs / 30 days)		
PA applies after a 90 day		
supply in a calendar year	T: 0	D.4
voriconazole (generic of VFEND IV) SOLR 200mg	Tier 2	
voriconazole (generic of VFEND) SUSR 40mg/ml QL (600 mL / 28 days)	Tier 1	QL PA
voriconazole (generic of VFEND) TABS 50mg QL (480 tabs / 30 days)	Tier 2	QL
voriconazole (generic of VFEND) TABS 200mg QL (120 tabs / 30 days)	Tier 2	QL
ANTIMALARIALS	•	,
atovaquone-proguanil hcl tab 62.5-25 mg (generic of MALARONE)	Tier 2	
atovaquone-proguanil hcl tab 250-100 mg (generic of MALARONE)	Tier 2	
chloroquine phosphate TABS 250mg, 500mg	Tier 2	
COARTEM TAB 20-120MG	Tier 2	
mefloquine hcl TABS 250mg	Tier 2	
PRIMAQUINE PHOSPHATE TABS 26.3mg	Tier 2	
primaquine phosphate (generic of PRIMAQUINE PHOSPHATE) TABS 26.3mg	Tier 2	
quinine sulfate (generic of QUALAQUIN) CAPS 324mg	Tier 2	PA
ANTIRETROVIRAL AGE	NTS	
abacavir sulfate (generic of ZIAGEN) SOLN 20mg/ml	Tier 2	NM
abacavir sulfate TABS 300mg	Tier 2	NM
APTIVUS CAPS 250mg	Tier 2	NM
atazanavir sulfate CAPS 150mg	Tier 2	NM

Drug Name	Drug Tier	Requirements/ Limits
atazanavir sulfate (generic	Tier 2	. NM
of REYATAZ) CAPS		
200mg, 300mg	_	
darunavir (generic of	Tier 1	QL NM
PREZISTA) TABS 600mg		
QL (60 tabs / 30 days)		
darunavir (generic of	Tier 1	QL NM
PREZISTA) TABS 800mg		
QL (30 tabs / 30 days)		
EDURANT TABS 25mg	Tier 2	
<i>efavirenz</i> (generic of	Tier 2	. NM
SUSTIVA) TABS 600mg		
emtricitabine (generic of	Tier 2	. NM
EMTRIVA) CAPS 200mg		
EMTRIVA SOLN 10mg/ml	Tier 2	
etravirine (generic of	Tier 1	NM
INTELENCE) TABS		
100mg, 200mg	-	
fosamprenavir calcium	Tier 1	NM
(generic of LEXIVA) TABS		
700mg	-	
FUZEON SOLR 90mg	Tier 2	
INTELENCE TABS 25mg	Tier 2	
SENTRESS CHEW 25mg	Tier 2	
SENTRESS CHEW	Tier 2	. NM
100mg; PACK 100mg;		
TABS 400mg		
ISENTRESS HD TABS	Tier 2	. NM
600mg		
lamivudine (generic of	Tier 2	. NM
EPIVIR) SOLN 10mg/ml;		
TABS 150mg, 300mg	<b>—</b> .	
maraviroc (generic of	Tier 1	NM
SELZENTRY) TABS		
150mg, 300mg	T'. ^	NIS 4
nevirapine SUSP	Tier 2	. NM
50mg/5ml; TB24 400mg	T: 4	NIN 4
nevirapine TABS 200mg	Tier 1	
NORVIR PACK 100mg	Tier 2	
PIFELTRO TABS 100mg	Tier 2	
PREZISTA SUSP	Tier 2	QL NM
100mg/ml		
QL (400 mL / 30 days)	<b>T</b> : ^	01 112
PREZISTA TABS 75mg	Tier 2	QL NM
QL (480 tabs / 30		
days)		

PREZISTA TABS 150mg	Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
days)  REYATAZ PACK 50mg Tier 2 NM  ritonavir (generic of Tier 2 NM  NORVIR) TABS 100mg  RUKOBIA TB12 600mg Tier 2 NM  SELZENTRY SOLN Tier 2 NM  SELZENTRY TABS 25mg Tier 2 NM  SUNLENCA TBPK 300mg Tier 2 NM  TIVICAY TABS 10mg Tier 2 NM  TIVICAY TABS 10mg Tier 2 NM  TIVICAY TABS 10mg Tier 2 NM  TIVICAY TABS 15mg Tier 2 NM  SUNLENCA TBPK 300mg Tier 2 NM  TIVICAY TABS 15mg Tier 2 NM  SUNLENCA TBPK 300mg Tier 2 NM  TIVICAY TABS 10mg Tier 2 NM  SUNLENCA TBPK 300mg Tier 2 NM  TIVICAY TABS 10mg Tier 2 NM  SUNLENCA TBPK 300mg Tier 2 NM  TIVICAY TABS 10mg Tier 2 NM  TIVICAY TABS 10mg Tier 2 NM  SUNLENCA TBPK 300mg Tier 2 NM  TIVICAY TABS 150mg Tier 2 NM  TIVICAY TABS 25mg, Tier 2 NM  SUNLENCA TBPK 300mg Tier 2 NM  TIVICAY TABS 25mg Tier 2 NM  TIVICAY TABS 25mg Tier 2 NM  TIVICAY TABS 25mg Tier 2 NM  TYPOST TABS 150mg Tier 2 NM  C25mg  VIREAD POWD 40mg/gm; Tier 2 NM  RETROVIR) CAPS 100mg;  SYRP 50mg/5ml  ANTIRETROVIRAL COMBINATION  AGENTS  ABAGAVIX sulfate-lamivudine Tier 2 NM  MG  CIMDUO TAB 300-300 Tier 2 NM  MG  CIMDUO TAB 300-300 Tier 2 NM  DELSTRIGO TAB Tier 2 NM  DESCOVY TAB 200-15MG Tier 2 NM  QL (30 tabs / 30 days)  DESCOVY TAB 200/25MG Tier 2 QL NM  QL (30 tabs / 30 days)  DESCOVY TAB 200/25MG Tier 2 NM  QL (30 tabs / 30 days)  DESCOVY TAB 200/25MG Tier 2 NM  QL (30 tabs / 30 days)  DESCOVY TAB 200/25MG Tier 2 NM  QL (30 tabs / 30 days)  DESCOVY TAB 200/25MG Tier 2 NM  QL (30 tabs / 30 days)  DESCOVY TAB 200/25MG Tier 2 NM  QL (30 tabs / 30 days)  DESCOVY TAB 200/25MG Tier 2 NM  Glabs 600-300 MG Tier 2 NM  GLABS 700-300 MG Tier 2 N	PREZISTA TABS 150mg	Tier 2	QL NM	efavirenz-lamivudine-	Tier 1	I NM
REYATAZ PACK 50mg Tier 2 NM ritonavir (generic of Tier 2 NM NORVIR) TABS 100mg Tier 2 NM SUNLENCA TBPK 300mg Tier 2 NM (generic of VIREAD) TABS 300mg Tier 2 NM (generic of VIREAD) TABS 300mg Tier 2 NM (generic of VIREAD) TABS 25mg Tier 2 NM (generic of VIREAD) TABS 300mg Tier 2 NM (generic of VIREAD) TABS 150mg Tier 2 NM VIRACEPT TABS 25mg, Tier 2 NM VIRACEPT TABS 250mg, Tier 2 NM VIRACEPT TABS 300mg Tier 2 NM ASS 150mg, 200mg, 250mg  Zidovudine (generic of Tier 2 NM AGENTS)  ANTIRETROVIR) CAPS 100mg; Tier 2 NM AGENTS  Abacavir sulfate-lamivudine Tier 2 NM AGENTS  Abacavir sulfate-lamivudine Tier 2 NM MG BIKTARVY TAB 30-120-15 Tier 2 NM MG BIKTARVY TAB 30-120-15 Tier 2 NM DELSTRIGO TAB Tier 2 NM DELSTRIGO TAB Tier 2 NM OL (30 tabs / 30 days)  DESCOVY TAB 120-15MG Tier 2 QL NM QL (30 tabs / 30 days)  DESCOVY TAB 120-15MG Tier 2 NM OL (30 tabs / 30 days)  DESCOVY TAB 120-15MG Tier 2 NM OL (30 tabs / 30 days)  DESCOVY TAB 120-15MG Tier 2 NM OL (30 tabs / 30 days)  DESCOVY TAB 120-15MG Tier 2 NM OL (30 tabs / 30 days)  DESCOVY TAB 120-15MG Tier 2 NM OL (30 tabs / 30 days)  DESCOVY TAB 120-15MG Tier 2 NM OL (30 tabs / 30 days)  DESCOVY TAB 120-15MG Tier 2 NM OL (30 tabs / 30 days)  DESCOVY TAB 120-15MG Tier 2 NM OL (30 tabs / 30 days)  DESCOVY TAB 120-15MG Tier 2 NM OL (30 tabs / 30 days)  DESCOVY TAB 120-15MG Tier 2 NM OL (30 tabs / 30 days)  DESCOVY TAB 120-15MG Tier 2 NM OL (30 tabs / 30 days)  DESCOVY TAB 120-15MG Tier 2 NM OL (30 tabs / 30 days)  DESCOVY TAB 120-15MG Tier 2 NM OL (30 tabs / 30 days)  DESCOVY TAB 120-15MG Tier 2 NM OL (30 tabs / 30 days)  DESCOVY TAB 120-15MG Tier 2 NM OL (30 tabs / 30 days)  DESCOVY TAB 120-15MG Tier 2 NM OL (30 tabs / 30 days)  DESCOVY TAB 120-15MG Tier 2 NM OL (30 tabs / 30 days	QL (240 tabs / 30				)	
ritonavir (generic of NORVIR) TABS 100mg RUKOBIA TB12 600mg RUKOBIA TB12 6 NM RUKOBIA TB12 600mg RUKOBIA TB12 6 NM RUKOBIA TB13 100-300 Nd Inter 2 NM RUKOBIA TB13 100-300 Nd Inter 2 NM RUKOBIA TB13 100-300 Nd Inter 2 NM RUKOBIA TB12 6 NM RUKOBIA TB13 100-300 Nd Inter 2 NM RUKOBIA	days)			mg (generic of SYMFI LO)		
NORVIR)   TABS 100mg	REYATAZ PACK 50mg	Tier 2	2 NM	efavirenz-lamivudine-	Tier 1	l NM
RUKOBIA TB12 600mg   Tier 2   NM   SELZENTRY SOLN   Tier 2   NM   SELZENTRY SOLN   Tier 2   NM   SELZENTRY SOLN   Tier 2   NM   SELZENTRY TABS 25mg   Tier 2   NM   SUNLENCA TBPK 300mg   Tier 2   NM   (generic of VIREAD) TABS   300mg   Tivror 2   NM   (generic of VIREAD) TABS   300mg   Tivror 2   NM   TIVICAY TABS 25mg   Tier 2   NM   TIVICAY TABS 150mg   Tier 2   NM   TIVICAY TABS 150mg   Tier 2   NM   TIVICAY TABS 25mg   Tier 2   NM   TYBOST TABS 150mg   Tier 2   NM   VIRACEPT TABS 250mg   Tier 2   NM   RETROVIR) CAPS 100mg; SYRP 50mg/5ml   2idovudine Tabs 300mg   Tier 2   NM   ANTIRETROVIRAL COMBINATION   AGENTS   abacavir sulfate-lamivudine   Tier 2   NM   MG   CIMDUO TAB 300-300   Tier 2   NM   CIMDUO TAB 300-300   Tier 2   NM   DELSTRIGO TAB   Tier 2   NM   CIMDUO TAB 300-300   Tier 2   NM   OL (30 tabs / 30 days)   DESCOVY TAB 200/25MG   Tier 2   QL NM   CIMDUO TAB 50-300MG   Tier 2   NM   OL (30 tabs / 30 days)   DESCOVY TAB 200/25MG   Tier 2   QL NM   CIMDUO TAB 50-300MG   Tier 2   NM   OL (30 tabs / 30 days)   DESCOVY TAB 200/25MG   Tier 2   NM   CIMDUO TAB 50-300MG   Tier 2   NM   CIMDUO	ritonavir (generic of	Tier 2	2 NM	tenofovir df tab 600-300-300	)	
SELZENTRY SOLN	NORVIR) TABS 100mg			mg (generic of SYMFI)		
20mg/ml; TABS 25mg   Tier 2   NM   SUNLENCA TBPK 300mg   Tier 2   NM   QL (30 tabs / 30 days)	RUKOBIA TB12 600mg	Tier 2	2 NM	emtricitabine-tenofovir	Tier 1	I QL NM
SELZENTRY TABS 25mg Tier 2 NM SUNLENCA TBPK 300mg Tier 2 NM (generic of VIREAD) TABS 300mg TIVICAY TABS 10mg Tier 2 NM TIVICAY TABS 10mg Tier 2 NM TIVICAY TABS 25mg, Tier 2 NM 50mg TIVICAY TABS 25mg, Tier 2 NM 50mg TIVICAY TABS 150mg Tier 2 NM 50mg TIVICAY TABS 150mg Tier 2 NM 50mg TIVICAY TABS 150mg Tier 2 NM 50mg TIVICAY TABS 25mg, Tier 2 NM 50mg TIVICAY TABS 25mg, Tier 2 NM 70mg TIVICAY TABS 30mg, Tier 2 NM 70mg TIVICAY TABS 30mg, Tier 2 NM 70mg TIVICAY TABS 30mg		Tier 2	2 NM	•	-	
SUNLENCA TBPK 300mg Tier 2 NM tenofovir disoproxil furnarate Tier 2 NM (generic of VIREAD) TABS 300mg TIVICAY TABS 10mg Tier 2 NM TIVICAY TABS 25mg, Tier 2 NM TVBOST TABS 150mg Tier 2 NM VIRACEPT TABS 250mg, Tier 2 NM VIRACEPT TABS 250mg, Tier 2 NM VIRACEPT TABS 150mg Tier 2 NM VIRACEPT TABS 150mg, Tier 2 NM Z55mg VIREAD POWD 40mg/gm; Tier 2 NM Z55mg VIREAD POWD 40mg/gm; Tier 2 NM RETROVIR) CAPS 100mg; SYRP 50mg/5ml Zidovudine TABS 300mg Tier 2 NM ANTIRETROVIRAL COMBINATION AGENTS Abacavir sulfate-lamivudine Tier 2 NM GIMDUO TAB 30-120-15 Tier 2 NM GIMDUO TAB 300-300 Tier 2 NM COMPLERA TAB Tier 2 NM DELSTRIGO TAB Tier 2 NM DESCOVY TAB 120-15MG Tier 2 QL NM QL (30 tabs / 30 days)  DOVATO TAB 50-300MG Tier 2 QL NM QL (30 tabs / 30 days)  DOVATO TAB 50-300MG Tier 2 NM Cafarrinz-centricitabine- Ire 1 NM Introduction of the book 200-300  ANTIPER COLOR OF THE CARN	20mg/ml; TABS 75mg			5 .5		
tenofovir disoproxil fumarate Tier 2 NM (generic of ViREAD) TABS 300mg TiviCAY TABS 10mg Tier 2 NM TIVICAY TABS 15mg Tier 2 NM TIVICAY TABS 25mg, Tier 2 NM TYBOST TABS 150mg Tier 2 NM VIRACEPT TABS 250mg, Tier 2 NM VIRACEPT TABS 300mg, Tier 3 NM VIRACEPT TABS 300mg, Tier 3 NM VIRACEPT TABS 300mg, Tier 4 VIRACEPT TABS 300mg, Tier 5 NM VIRACEPT TABS Tier 2 NM VIRACEPT TABS 300mg, Tier 1 VIRACEPT TABS Tier 2 NM VIRACEPT TABS Tier 3 NM VIRACEPT TABS Tier 3 NM VIRACEPT TABS Tier 3 NM VIRACEPT TABS Tier 4 NM VIRACEPT TABS Tier 4 NM VIRACEPT TABS Tier 5 NM VIR	SELZENTRY TABS 25mg	Tier 2	NM	· · · · · · · · · · · · · · · · · · ·		
Generic of VIREAD  TABS   Tier 2   NM	SUNLENCA TBPK 300mg	Tier 2	2 NM		•	
300mg TIVICAY TABS 10mg Tier 2 NM TIVICAY TABS 25mg, Tier 2 NM S0mg TIVICAY PD TBSO 5mg Tier 2 NM VIRACEPT TABS 250mg, Tier 2 NM VIRACEPT TABS 250mg, Tier 2 NM ARETROVIR) CAPS 100mg; SYRP 50mg SYRP 50mg/5ml Zidovudine (generic of Tier 2 NM ANTIRETROVIRAL COMBINATION AGENTS  abacavir sulfate-lamivudine Tier 2 NM BIKTARVY TAB 30-120-15 Tier 2 NM GCIMDUO TAB 300-300 Tier 2 NM COMPLERA TAB Tier 2 NM DELSTRIGO TAB Tier 2 NM DESCOVY TAB 120-15MG Tier 2 QL NM QL (30 tabs / 30 days)  DOVATO TAB 50-300MG Tier 2 NM QL (30 tabs / 30 days)  Tier 2 NM DESCOVY TAB 20-015MG Tier 2 QL NM QL (30 tabs / 30 days)  Tier 2 NM DESCOVY TAB 20-025MG Tier 2 QL NM QL (30 tabs / 30 days)  Tier 2 NM DESCOVY TAB 20-015MG Tier 2 QL NM QL (30 tabs / 30 days)  Tier 2 NM DESCOVY TAB 20-025MG Tier 2 QL NM QL (30 tabs / 30 days)  DOVATO TAB 50-300MG Tier 2 NM Gelavieroz-emtricitabine- Tier 1 NM TRIUVADA)  Tier 2 NM TRUVADA)  QL (30 tabs / 30 days)  Tier 2 NM JOL (30 tabs / 30 days)  Tier 2 NM JOL (30 tabs / 30 days)  Tier 2 NM JOL (30 tabs / 30 days)  Tier 2 NM JOL (30 tabs / 30 days)  Tier 2 NM JOL (30 tabs / 30 days)  Tier 2 NM JOL (30 tabs / 30 days)  Tier 2 NM TRUVADA)  QL (30 tabs / 30 days)  Tier 2 NM JOL (30 tabs /	tenofovir disoproxil fumarate	Tier 2	2 NM			I QL NM
TIVICAY TABS 10mg   Tier 2   NM   OL (30 tabs / 30 days)	(generic of VIREAD) TABS			•	-	
TIVICAY TABS 25mg, Tier 2 NM 50mg TIVICAY PD TBSO 5mg Tier 2 NM TYBOST TABS 150mg Tier 2 NM VIRACEPT TABS 250mg, Tier 2 NM 625mg VIREAD POWD 40mg/gm; Tier 2 NM TABS 150mg, 200mg, 250mg Zidovudine (generic of Tier 2 NM RETROVIR) CAPS 100mg; SYRP 50mg/5ml Zidovudine TABS 300mg Tier 2 NM ANTIRETROVIRAL COMBINATION AGENTS ABACAVIr SUlfate-lamivudine Tier 2 NM BIKTARVY TAB 30-120-15 Tier 2 NM MG BIKTARVY TAB 30-120-15 Tier 2 NM MG BIKTARVY TAB 300-300 Tier 2 NM COMPLERA TAB Tier 2 NM DELSTRIGO TAB Tier 2 NM DELSTRIGO TAB Tier 2 NM QL (30 tabs / 30 days)  DESCOVY TAB 200/25MG Tier 2 QL NM QL (30 tabs / 30 days)  DESCOVY TAB 200/25MG Tier 2 QL NM QL (30 tabs / 30 days)  DOVATO TAB 50-300MG Tier 2 NM efavirenz-emtricitabine- tier 1 NM totopic virial tab 600-200-300  EVALUATION (So tabs / 30 days)  DOVATO TAB 50-300MG Tier 2 NM efavirenz-emtricitabine- tier 1 NM totopic virial tab 600-200-300  EVALUATION (So tabs / 30 days)  DOVATO TAB 50-300MG Tier 2 NM efavirenz-emtricitabine- tier 1 NM tensological file of the following tab tier 2 nm tricitabine-tenofovir Tier 1 nm disoproxil fumarate tab 167- 250 mg (generic of TRUVADA) QL (30 tabs / 30 days)  EWITICIABINO (Tier 2 NM TIER 1 QL NM disoproxil fumarate tab 167- 250 mg (generic of TRUVADA) QL (30 tabs / 30 days)  EWOTAZ TAB 300 days)  EVOTAZ TAB 300 days)  EVOTAZ TAB 300-150 Tier 2 NM Initiation-tenofovir Tier 2 NM Initiation-tenof	300mg					
### control of the co	TIVICAY TABS 10mg	Tier 2	2 NM	,		
TIVICAY PD TBSO 5mg Tier 2 NM TYBOST TABS 150mg Tier 2 NM VIRACEPT TABS 250mg, Tier 2 NM VIRACEPT TABS 250mg, Tier 2 NM 625mg VIREAD POWD 40mg/gm; Tier 2 NM TABS 150mg, 200mg, 250mg Zidovudine (generic of Tier 2 NM ETROVIR) CAPS 100mg; SYRP 50mg/5ml Zidovudine TABS 300mg Tier 2 NM ANTIRETROVIRAL COMBINATION AGENTS  abacavir sulfate-lamivudine Tier 2 NM MG BIKTARVY TAB 30-120-15 Tier 2 NM BIKTARVY TAB 30-120-15 Tier 2 NM COMPLERA TAB Tier 2 NM COMPLERA TAB Tier 2 NM DELSTRIGO TAB Tier 2 NM DELSTRIGO TAB Tier 2 NM QL (30 tabs / 30 days)  DESCOVY TAB 200/25MG Tier 2 QL NM QL (30 tabs / 30 days)  DOVATO TAB 50-300MG Tier 2 NM efavirenz-emtricitabine- tenofovir df tab 600-200-300  disoproxil fumarate tab 167- 250 mg (generic of TRUVADA) QL (30 tabs / 30 days)  emtricitabine-tenofovir Tier 2 QL NM GENVOYA TAB 300-150 Tier 2 NM JULUCA TAB 50-05MG Tier 2 NM lamivudine-zidovudine tab Tier 2 NM lopinavir-ritonavir soln 400- Tier 2 NM lopinavir-ritonavir tab 100-25Tier 2 NM Indicate tab 167- 250 mg (generic of TRUVADA) QL (30 tabs / 30 days)  EVOTAZ TAB 30 days)  EVOTAZ TAB 300-150 Tier 2 NM JULUCA TAB 50-25MG Tier 2 NM lamivudine-zidovudine tab Tier 2 NM lopinavir-ritonavir soln 400- Tier 2 NM lopinavir-ritonavir tab 100-25Tier 2 NM g(generic of KALETRA) lopinavir-ritonavir tab 200-50Tier 2 NM STRIBILD TAB Tier 2 NM STRIBILD TAB Tier 2 NM TRIUMEQ TAB Tier 2 NM TRIUMEQ TAB Tier 2 NM ANTITUBERCULAR AGENTS cycloserine CAPS 250mg Tier 1 ethambutol hol TABS Tier 2	TIVICAY TABS 25mg,	Tier 2	2 NM			
TYBOST TABS 150mg Tier 2 NM VIRACEPT TABS 250mg, Tier 2 NM 625mg VIREAD POWD 40mg/gm; Tier 2 NM TABS 150mg, 200mg, 250mg  zidovudine (generic of Tier 2 NM RETROVIR) CAPS 100mg; SYRP 50mg/5ml  zidovudine TABS 300mg Tier 2 NM ANTIRETROVIRAL COMBINATION AGENTS  abacavir sulfate-lamivudine Tier 2 NM BIKTARVY TAB 30-120-15 Tier 2 NM G BIKTARVY TAB 50-200-25 Tier 2 NM COMPLERA TAB Tier 2 NM DESCOVY TAB 120-15MG Tier 2 NM DESCOVY TAB 200/25MG Tier 2 QL NM QL (30 tabs / 30 days)  DESCOVY TAB 200/25MG Tier 2 QL NM QL (30 tabs / 30 days)  Tier 2 NM TRUVADA) QL (30 tabs / 30 days)  EVOTAZ TAB 300-150 Tier 2 NM JULUCA TAB 50-25MG Tier 2 NM Iamivudine-zidovudine tab Tier 2 NM Iamivu	_50mg					I QL NM
VIRACEPT TABS 250mg, 625mg         Tier 2 NM         NM         QL (30 tabs / 30 days)           625mg         VIREAD POWD 40mg/gm; Tier 2 NM         NM         QL (30 tabs / 30 days)           7ABS 150mg, 200mg, 250mg         Tier 2 NM         NM         emtricitabine-tenofovir Tier 2 QL NM           750mg         Tier 2 NM         NM         QL (30 tabs / 30 days)         EVOTAZ TAB 300-150 Tier 2 NM           8APR 50mg/5ml         SYRP 50mg/5ml         SEVOTAZ TAB 300-150 Tier 2 NM         Tier 2 NM           ANTIRETROVIRAL COMBINATION AGENTS         ABACAVIR SUlfate-lamivudine Tier 2 NM         JULUCA TAB 50-25MG Tier 2 NM           ABCAVIY TAB 30-120-15 Tier 2 NM MG         Interest of KALETRA)         Interest of KALETRA)           BIKTARVY TAB 50-200-25 Tier 2 NM         NM         Interest of KALETRA)           DELSTRIGO TAB Tier 2 NM         NM         ODEFSEY TAB Tier 2 NM           DESCOVY TAB 120-15MG Tier 2 NM         NM         STRIBILD TAB Tier 2 NM           QL (30 tabs / 30 days)         STRIBILD TAB Tier 2 NM           DESCOVY TAB 50-300MG Tier 2 NM         STRIBUMEQ PD TAB Tier 2 NM           QL (30 tabs / 30 days)         Tier 2 NM           DESCOVY TAB 50-300MG Tier 2 NM         STRIBUMEQ PD TAB Tier 2 NM           QL (30 tabs / 30 days)         Tier 2 NM           DOVATO TAB 50-300MG Tier 2 NM	TIVICAY PD TBSO 5mg	Tier 2	2 NM	•	-	
VIRACEPT TABS 250ffg, Tier 2 NM VIREAD POWD 40mg/gm; Tier 2 NM TABS 150mg, 200mg, 250mg 25	TYBOST TABS 150mg	Tier 2	2 NM			
VIREAD POWD 40mg/gm; Tier 2 NM TABS 150mg, 200mg, 250mg  zidovudine (generic of Tier 2 NM RETROVIR) CAPS 100mg; SYRP 50mg/5ml  zidovudine TABS 300mg Tier 2 NM ANTIRETROVIRAL COMBINATION AGENTS  abacavir sulfate-lamivudine Tier 2 NM BIKTARVY TAB 30-120-15 Tier 2 NM BIKTARVY TAB 50-200-25 Tier 2 NM BIKTARVY TAB 300-300 Tier 2 NM COMPLERA TAB Tier 2 NM DESCOVY TAB 120-15MG Tier 2 QL NM QL (30 tabs / 30 days)  DESCOVY TAB 200/25MG Tier 2 QL NM QL (30 tabs / 30 days)  DOVATO TAB 50-300MG Tier 2 NM efavirenz-emtricitabine- Tier 1 NM efavirenz-emtricitabine- Tier 1 NM to Complement of tier 2 NM efavirenz-emtricitabine- Tier 1 NM efavirenz-emtricitabine- tier 2 NM TRUVADA) QL (30 tabs / 30 days)  emtricitabine-tenofovir disporaci Tier 2 QL NM disporaci funarate tab 200-300 Tier 2 NM QL (30 tabs / 30 days)  EVOTAZ TAB 300-150 Tier 2 NM GENVOYA TAB Tier 2 NM JULUCA TAB 50-25MG Tier 2 NM lamivudine-zidovudine tab Tier 2 NM lamivudine-zidovudine tab Tier 2 NM lopinavir-ritonavir soln 400- Tier 2 NM lopinavir-ritonavir tab 100-25Tier 2 NM mg (generic of KALETRA) lopinavir-ritonavir tab 100-25Tier 2 NM mg (generic of KALETRA) lopinavir-ritonavir tab 100-25Tier 2 NM mg (generic of KALETRA)  ODEFSEY TAB Tier 2 NM STRIBILD TAB Tier 2 NM TRIUMEQ PD TAB Tier 2 NM TRIUMEQ PD TAB Tier 2 NM TRIUMEQ TAB Tier 2 NM ANTITUBERCULAR AGENTS cycloserine CAPS 250mg Tier 1 ethambutol hcl TABS Tier 2	VIRACEPT TABS 250mg,	Tier 2	2 NM	,		
TABS 150mg, 200mg, 250mg  zidovudine (generic of Tier 2 NM RETROVIR) CAPS 100mg; SYRP 50mg/5ml  zidovudine TABS 300mg Tier 2 NM ANTITUBERCULAR AGENTS  abacavir sulfate-lamivudine Tier 2 NM BIKTARVY TAB 30-120-15 Tier 2 NM BIKTARVY TAB 30-200-25 Tier 2 NM DELSTRIGO TAB Tier 2 NM DELSTRIGO TAB Tier 2 NM DESCOVY TAB 120-15MG Tier 2 NM DESCOVY TAB 200/25MG Tier 2 QL NM QL (30 tabs / 30 days)  DOVATO TAB 50-300MG Tier 2 NM efavirenz-emtricitabine- Tier 1 tms 200 ndm (generic of tab of 300 mg) (generic of tab of 300 days)  disoproxil fumarate tab 200-300 mg (generic of TRUVADA)  LOU and (generic of Tier 2 NM SEVOTAZ TAB 30-150 Tier 2 NM Individual Tier 2 NM	625mg				-	OL NIM
300 mg (generic of TRUVADA)   QL (30 tabs / 30 days)	VIREAD POWD 40mg/gm;	Tier 2	2 NM			2 QL NM
TRUVADA   QL (30 tabs / 30 days)	TABS 150mg, 200mg,			•	-	
RETROVIR) CAPS 100mg;   SYRP 50mg/5ml   Zidovudine TABS 300mg   Tier 2   NM	_250mg			5 .5		
EVOTAZ TAB 300-150 Tier 2 NM  Zidovudine TABS 300mg Tier 2 NM  ANTIRETROVIRAL COMBINATION AGENTS  abacavir sulfate-lamivudine Tier 2 NM tab 600-300 mg (generic of EPZICOM)  BIKTARVY TAB 30-120-15 Tier 2 NM MG  BIKTARVY TAB 50-200-25 Tier 2 NM MG  CIMDUO TAB 300-300 Tier 2 NM DELSTRIGO TAB Tier 2 NM DELSTRIGO TAB Tier 2 NM DESCOVY TAB 120-15MG Tier 2 QL NM QL (30 tabs / 30 days)  DOVATO TAB 50-300MG Tier 2 NM efavirenz-emtricitabine-tier 1 NM efavirenz-emtricitabine-tier 1 NM efavirenz-emtricitabine-tier 1 NM efavirenz-emtricitabine-tier 1 NM  EVOTAZ TAB 300-150 Tier 2 NM GENVOYA TAB 300-150 Tier 2 NM JULUCA TAB 50-25MG Tier 2 NM lamivudine-zidovudine tab Tier 2 NM lopinavir-ritonavir soln 400- Tier 2 NM lopinavir-ritonavir tab 100-25Tier 2 NM mg (generic of KALETRA) lopinavir-ritonavir tab 100-25Tier 2 NM mg (generic of KALETRA)  ODEFSEY TAB Tier 2 NM STRIBILD TAB Tier 2 NM TRIUMEQ PD TAB Tier 2 NM TRIUMEQ PD TAB Tier 2 NM TRIUMEQ TAB Tier 2 NM ANTITUBERCULAR AGENTS cycloserine CAPS 250mg Tier 1 ethambutol hcl TABS Tier 2	zidovudine (generic of	Tier 2	2 NM	· · · · · · · · · · · · · · · · · · ·		
Zidovudine TABS 300mg   Tier 2   NM	RETROVIR) CAPS 100mg				•	) NIM
ANTIRETROVIRAL COMBINATION AGENTS  abacavir sulfate-lamivudine Tier 2 NM tab 600-300 mg (generic of EPZICOM)  BIKTARVY TAB 30-120-15 Tier 2 NM MG BIKTARVY TAB 50-200-25 Tier 2 NM CIMDUO TAB 300-300 Tier 2 NM COMPLERA TAB Tier 2 NM DELSTRIGO TAB Tier 2 NM DESCOVY TAB 120-15MG Tier 2 QL NM QL (30 tabs / 30 days)  DESCOVY TAB 50-300MG Tier 2 NM QL (30 tabs / 30 days)  DOVATO TAB 50-300MG Tier 2 NM efavirenz-emtricitabine-tenofovir df tab 600-200-300  JULUCA TAB 50-25MG Tier 2 NM lamivudine-zidovudine tab Tier 2 NM lopinavir-ritonavir soln 400- Tier 2 NM lopinavir-ritonavir tab 100-25Tier 2 NM lopinavir-ritonavir tab 100-25Tier 2 NM lopinavir-ritonavir tab 200-50Tier 2 NM Mg (generic of KALETRA)  ODEFSEY TAB Tier 2 NM STRIBILD TAB Tier 2 NM SYMTUZA TAB Tier 2 NM TRIUMEQ PD TAB Tier 2 NM TRIUMEQ TAB Tier 2 NM ANTITUBERCULAR AGENTS cycloserine CAPS 250mg Tier 1 etambutol hcl TABS Tier 2						
ARTIRE TROVIRAL COMBINATION  AGENTS  abacavir sulfate-lamivudine Tier 2 NM  tab 600-300 mg (generic of EPZICOM)  BIKTARVY TAB 30-120-15 Tier 2 NM  MG  BIKTARVY TAB 50-200-25 Tier 2 NM  CIMDUO TAB 300-300 Tier 2 NM  COMPLERA TAB Tier 2 NM  DELSTRIGO TAB Tier 2 NM  DESCOVY TAB 120-15MG Tier 2 QL NM  QL (30 tabs / 30 days)  DOVATO TAB 50-300MG Tier 2 NM  efavirenz-emtricitabine- tier 1 tenofovir df tab 600-200-300  lamivudine-zidovudine tab Tier 2 NM  150-300 mg  lopinavir-ritonavir soln 400- Tier 2 NM  lopinavir-ritonavir tab 100-25Tier 2 NM  lopinavir-ritonavir tab 200-50Tier 2 NM  MG  ODEFSEY TAB Tier 2 NM  STRIBILD TAB Tier 2 NM  SYMTUZA TAB Tier 2 NM  TRIUMEQ PD TAB Tier 2 NM  TRIUMEQ TAB Tier 2 NM  ANTITUBERCULAR AGENTS  cycloserine CAPS 250mg Tier 1  ethance 400cms	zidovudine TABS 300mg	Tier 2	2 NM			
AGENTS  abacavir sulfate-lamivudine Tier 2 NM tab 600-300 mg (generic of EPZICOM)  BIKTARVY TAB 30-120-15 Tier 2 NM MG  BIKTARVY TAB 50-200-25 Tier 2 NM MG  CIMDUO TAB 300-300 Tier 2 NM COMPLERA TAB Tier 2 NM DELSTRIGO TAB Tier 2 NM DESCOVY TAB 120-15MG Tier 2 QL NM QL (30 tabs / 30 days)  DOVATO TAB 50-300MG Tier 2 NM Efavirenz-emtricitabine- tenofovir df tab 600-200-300  150-300 mg lopinavir-ritonavir soln 400- Tier 2 NM lopinavir-ritonavir tab 100-25Tier 2 NM lopinavir-ritonavir tab 200-50Tier 2 NM Mg (generic of KALETRA)  lopinavir-ritonavir tab 200-50Tier 2 NM PREZCOBIX TAB 800-150 Tier 2 NM STRIBILD TAB Tier 2 NM TRIUMEQ PD TAB Tier 2 NM TRIUMEQ TAB Tier 2 NM ANTITUBERCULAR AGENTS cycloserine CAPS 250mg Tier 1 ethambutol hcl TABS Tier 2	ANTIRETROVIRAL CON	1BINA	TION		•	
International Process of the Computation of the C	<b>AGENTS</b>				1161 2	2 INIVI
tab 600-300 mg (generic of EPZICOM)           BIKTARVY TAB 30-120-15 Tier 2 MG         NM (generic of KALETRA)           BIKTARVY TAB 50-200-25 Tier 2 MG         NM (generic of KALETRA)           CIMDUO TAB 300-300 Tier 2 NM         NM (generic of KALETRA)           COMPLERA TAB Tier 2 NM         DELSTRIGO TAB Tier 2 NM           DESCOVY TAB 120-15MG Tier 2 QL NM         NM (generic of KALETRA)           DESCOVY TAB 120-15MG Tier 2 QL NM         NM (generic of KALETRA)           DESCOVY TAB 120-15MG Tier 2 NM         NM (generic of KALETRA)           DESCOVY TAB 120-15MG Tier 2 NM         NM (generic of KALETRA)           STRIBILD TAB Tier 2 NM         NM (generic of KALETRA)           STRIBILD TAB Tier 2 NM         NM (generic of KALETRA)           STRIBILD TAB Tier 2 NM         NM (generic of KALETRA)           STRIBILD TAB Tier 2 NM         NM (generic of KALETRA)           STRIBILD TAB Tier 2 NM         NM (generic of KALETRA)           STRIBILD TAB Tier 2 NM         NM (generic of KALETRA)           SYMTUZA TAB Tier 2 NM         NM (generic of KALETRA)           SYMTUZA TAB Tier 2 NM         NM (generic of KALETRA)           SYMTUZA TAB Tier 2 NM         NM (generic of KALETRA)           TRIUMEQ PD TAB Tier 2 NM         NM (generic of KALETRA)           TRIUMEQ TAB Tier 2 NM         NM (generic of KALETRA) <td>abacavir sulfate-lamivudine</td> <td>Tier 2</td> <td>2 NM</td> <td></td> <td>Tior 3</td> <td>) NIM</td>	abacavir sulfate-lamivudine	Tier 2	2 NM		Tior 3	) NIM
EPZICOM) BIKTARVY TAB 30-120-15 Tier 2 NM MG BIKTARVY TAB 50-200-25 Tier 2 NM MG CIMDUO TAB 300-300 Tier 2 NM COMPLERA TAB Tier 2 NM DELSTRIGO TAB Tier 2 NM QL (30 tabs / 30 days)  DESCOVY TAB 200/25MG Tier 2 QL NM QL (30 tabs / 30 days)  DOVATO TAB 50-300MG Tier 2 NM efavirenz-emtricitabine- Tier 1 tenofovir df tab 600-200-300    Generic of KALETRA   Iopinavir-ritonavir tab 200-50Tier 2 NM   Mg (generic of KALETRA)     Iopinavir-ritonavir tab 200-50Tier 2 NM     Mg (generic of KALETRA)     Iopinavir-ritonavir tab 200-50Tier 2 NM     Mg (generic of KALETRA)     Iopinavir-ritonavir tab 200-50Tier 2 NM     Mg (generic of KALETRA)     Iopinavir-ritonavir tab 200-50Tier 2 NM     Mg (generic of KALETRA)     Iopinavir-ritonavir tab 200-50Tier 2 NM     Mg (generic of KALETRA)     Iopinavir-ritonavir tab 200-50Tier 2 NM     Mg (generic of KALETRA)     Iopinavir-ritonavir tab 200-50Tier 2 NM     Mg (generic of KALETRA)     Iopinavir-ritonavir tab 200-50 Tier 2 NM     Mg (generic of KALETRA)     Iopinavir-ritonavir tab 200-50 Tier 2 NM     Mg (generic of KALETRA)     Iopinavir-ritonavir tab 200-50 Tier 2 NM     Mg (generic of KALETRA)     Iopinavir-ritonavir tab 200-50 Tier 2 NM     Mg (generic of KALETRA)     Iopinavir-ritonavir tab 200-50 Tier 2 NM     STRIBILD TAB Tier 2 NM     SYMTUZA TAB Tier 2 NM     TRIUMEQ PD TAB Tier 2 NM     TRIUMEQ TAB Tier 2 NM     ANTITUBERCULAR AGENTS     Cycloserine CAPS 250mg Tier 1     Iopinavir-ritonavir tab 100-25 Tier 2 NM     Mg (generic of KALETRA)     Iopinavir-ritonavir tab 200-50 Tier 2 NM     Mg (generic of KALETRA)     Iopinavir-ritonavir tab 200-50 Tier 2 NM     STRIBILD TAB Tier 2 NM     TRIUMEQ PD TAB Tier 2 NM     TRIUMEQ TAB Tier 1     Comparison of KALETRA     Iopinavir-ritonavir tab 200-50 Tier 2 NM     STRIBILD TAB Tier 2 NM     STRIBILD TAB Tier 2 NM     STRIBULD TAB Tier 2 NM     ST	tab 600-300 mg (generic of			•	1161 2	L INIVI
BIKTARVY TAB 30-120-15 Tier 2 NM MG  BIKTARVY TAB 50-200-25 Tier 2 NM MG  CIMDUO TAB 300-300 Tier 2 NM COMPLERA TAB Tier 2 NM DELSTRIGO TAB Tier 2 NM DESCOVY TAB 120-15MG Tier 2 QL NM QL (30 tabs / 30 days)  DESCOVY TAB 200/25MG Tier 2 QL NM QL (30 tabs / 30 days)  DOVATO TAB 50-300MG Tier 2 NM efavirenz-emtricitabine- Tier 1 NM tenofovir df tab 600-200-300  Iter 2 NM Iopinavir-ritonavir tab 100-25Tier 2 NM Iopinavir-ritonavir tab 200-50Tier 2 NM DESCOV-50Tier 2 NM PREZCOBIX TAB 800-150 Tier 2 NM STRIBILD TAB Tier 2 NM SYMTUZA TAB Tier 2 NM TRIUMEQ PD TAB Tier 2 NM ANTITUBERCULAR AGENTS cycloserine CAPS 250mg Tier 1 ethambutol hcl TABS Tier 2	EPZICOM)					
BIKTARVY TAB 50-200-25 Tier 2 NM MG CIMDUO TAB 300-300 Tier 2 NM COMPLERA TAB Tier 2 NM DELSTRIGO TAB Tier 2 NM DESCOVY TAB 120-15MG Tier 2 QL NM QL (30 tabs / 30 days)  DESCOVY TAB 200/25MG Tier 2 QL NM QL (30 tabs / 30 days)  DOVATO TAB 50-300MG Tier 2 NM efavirenz-emtricitabine- Tier 1 NM tenofovir of tab 600-200-300  mg (generic of KALETRA) lopinavir-ritonavir tab 200-50Tier 2 NM DEFSEY TAB Tier 2 NM PREZCOBIX TAB 800-150 Tier 2 NM STRIBILD TAB Tier 2 NM SYMTUZA TAB Tier 2 NM TRIUMEQ PD TAB Tier 2 NM ANTITUBERCULAR AGENTS cycloserine CAPS 250mg Tier 1 ethambutol hcl TABS Tier 2	BIKTARVY TAB 30-120-15	Tier 2	2 NM		5Tier 2	) NIM
BIKTARVY TAB 50-200-25 Tier 2 NM MG CIMDUO TAB 300-300 Tier 2 NM COMPLERA TAB Tier 2 NM DELSTRIGO TAB Tier 2 NM DESCOVY TAB 120-15MG Tier 2 QL NM QL (30 tabs / 30 days) DESCOVY TAB 200/25MG Tier 2 QL NM QL (30 tabs / 30 days) DOVATO TAB 50-300MG Tier 2 NM efavirenz-emtricitabine- Tier 1 NM tenofovir df tab 600-200-300    Double Table 1	MG			•	5 1 101 2	_ 14171
CIMDUO TAB 300-300 Tier 2 NM  COMPLERA TAB Tier 2 NM  DELSTRIGO TAB Tier 2 NM  DESCOVY TAB 120-15MG Tier 2 QL NM QL (30 tabs / 30 days)  DESCOVY TAB 200/25MG Tier 2 QL NM QL (30 tabs / 30 days)  DOVATO TAB 50-300MG Tier 2 NM  efavirenz-emtricitabine- Tier 1 NM  tenofovir df tab 600-200-300  Tier 2 NM  ODEFSEY TAB Tier 2 NM  PREZCOBIX TAB 800-150 Tier 2 NM  STRIBILD TAB Tier 2 NM  SYMTUZA TAB Tier 2 NM  TRIUMEQ PD TAB Tier 2 NM  ANTITUBERCULAR AGENTS  cycloserine CAPS 250mg Tier 1  ethambutol hcl TABS Tier 2	BIKTARVY TAB 50-200-25	Tier 2	2 NM		OTier 2	> NM
CIMDUO TAB 300-300 Tier 2 NM  COMPLERA TAB Tier 2 NM  DELSTRIGO TAB Tier 2 NM  DESCOVY TAB 120-15MG Tier 2 QL NM QL (30 tabs / 30 days)  DESCOVY TAB 200/25MG Tier 2 QL NM QL (30 tabs / 30 days)  DOVATO TAB 50-300MG Tier 2 NM  efavirenz-emtricitabine- Tier 1 NM  tenofovir df tab 600-200-300  Tier 2 NM  ODEFSEY TAB Tier 2 NM  PREZCOBIX TAB 800-150 Tier 2 NM  STRIBILD TAB Tier 2 NM  TRIUMEQ PD TAB Tier 2 NM  ANTITUBERCULAR AGENTS  cycloserine CAPS 250mg Tier 1  ethambutol hcl TABS Tier 2	MG			•	0 1 101 2	- 14141
COMPLERA TAB Tier 2 NM  DELSTRIGO TAB Tier 2 NM  DESCOVY TAB 120-15MG Tier 2 QL NM QL (30 tabs / 30 days)  DESCOVY TAB 200/25MG Tier 2 QL NM QL (30 tabs / 30 days)  DOVATO TAB 50-300MG Tier 2 NM  efavirenz-emtricitabine- Tier 1 NM  tenofovir df tab 600-200-300  Tier 2 NM  PREZCOBIX TAB 800-150 Tier 2 NM  STRIBILD TAB Tier 2 NM  TRIUMEQ PD TAB Tier 2 NM  ANTITUBERCULAR AGENTS  cycloserine CAPS 250mg Tier 1  ethambutol hcl TABS Tier 2	CIMDUO TAB 300-300	Tier 2	NM NM		Tier 2	> NM
DELSTRIGO TAB Tier 2 NM DESCOVY TAB 120-15MG Tier 2 QL NM QL (30 tabs / 30 days)  DESCOVY TAB 200/25MG Tier 2 QL NM QL (30 tabs / 30 days)  DOVATO TAB 50-300MG Tier 2 NM efavirenz-emtricitabine- Tier 1 NM tenofovir df tab 600-200-300  STRIBILD TAB Tier 2 NM SYMTUZA TAB Tier 2 NM TRIUMEQ PD TAB Tier 2 NM ANTITUBERCULAR AGENTS cycloserine CAPS 250mg Tier 1 ethambutol hcl TABS Tier 2	COMPLERA TAB	Tier 2	2 NM			
DESCOVY TAB 120-15MG Tier 2 QL NM QL (30 tabs / 30 days)  DESCOVY TAB 200/25MG Tier 2 QL NM QL (30 tabs / 30 days)  DOVATO TAB 50-300MG Tier 2 NM efavirenz-emtricitabine- Tier 1 NM tenofovir df tab 600-200-300  SYMTUZA TAB Tier 2 NM TRIUMEQ PD TAB Tier 2 NM ANTITUBERCULAR AGENTS cycloserine CAPS 250mg Tier 1 ethambutol hcl TABS Tier 2	DELSTRIGO TAB	Tier 2	2 NM		_	
DESCOVY TAB 200/25MG Tier 2 QL NM QL (30 tabs / 30 days)  DOVATO TAB 50-300MG Tier 2 NM efavirenz-emtricitabine- Tier 1 NM tenofovir df tab 600-200-300  TRIUMEQ PD TAB Tier 2 NM ANTITUBERCULAR AGENTS cycloserine CAPS 250mg Tier 1 ethambutol hcl TABS Tier 2	DESCOVY TAB 120-15MG	Tier 2	QL NM			-
DESCOVY TAB 200/25MG Tier 2 QL NM QL (30 tabs / 30 days)  DOVATO TAB 50-300MG Tier 2 NM efavirenz-emtricitabine- Tier 1 NM tenofovir df tab 600-200-300  TRIUMEQ TAB Tier 2 NM ANTITUBERCULAR AGENTS cycloserine CAPS 250mg Tier 1 ethambutol hcl TABS Tier 2	QL (30 tabs / 30 days)	)				
DOVATO TAB 50-300MG Tier 2 NM  efavirenz-emtricitabine- Tier 1 NM tenofovir df tab 600-200-300  ANTITUBERCULAR AGENTS cycloserine CAPS 250mg Tier 1 ethambutol hcl TABS Tier 2	DESCOVY TAB 200/25MG	Tier 2	QL NM			
efavirenz-emtricitabine- Tier 1 NM tenofovir df tab 600-200-300  Tier 2 NM cycloserine CAPS 250mg Tier 1 ethambutol hcl TABS Tier 2	QL (30 tabs / 30 days)	•			•	
tenofovir df tab 600-200-300  tenofovir df tab 600-200-300  tenofovir df tab 600-200-300  tenofovir df tab 600-200-300	DOVATO TAB 50-300MG	Tier 2	2 NM		_	
100mg 400mg	efavirenz-emtricitabine-	Tier 1	I NM			
mg (generic of ATRIPLA) 100mg, 400mg		)			i ier 2	<u> </u>
	mg (generic of ATRIPLA)			100mg, 400mg		

Drug Name	Drug Tier	Requirements/ Limits
isoniazid TABS 100mg, 300mg	Tier 1	
PRIFTIN TABS 150mg	Tier 2	
pyrazinamide TABS 500mg	Tier 2	•
rifabutin (generic of MYCOBUTIN) CAPS 150mg	Tier 2	
rifampin CAPS 150mg, 300mg	Tier 2	
rifampin (generic of RIFADIN) SOLR 600mg	Tier 2	
SIRTURO TABS 20mg, 100mg	Tier 2	NM PA
TRECATOR TABS 250mg	Tier 2	
ANTIVIRALS		
acyclovir CAPS 200mg; TABS 400mg, 800mg	Tier 1	
acyclovir sodium SOLN 50mg/ml	Tier 2	B/D
adefovir dipivoxil TABS 10mg	Tier 2	NM
BARACLUDE SOLN .05mg/ml	Tier 2	NM ST
entecavir (generic of BARACLUDE) TABS .5mg, 1mg	Tier 2	NM
EPCLUSA PAK 150-37.5	Tier 2	NM PA
EPCLUSA PAK 200-50MG	Tier 2	NM PA
EPCLUSA TAB 200-50MG	Tier 2	NM PA
EPCLUSA TAB 400-100	Tier 2	NM PA
ganciclovir sodium SOLR 500mg	Tier 2	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	NM PA
HARVONI TAB 90-400MG	Tier 2	NM PA
lamivudine (hbv) TABS 100mg	Tier 2	
LIVTENCITY TABS 200mg QL (336 tabs / 28 days)	Tier 2	QL NM PA
MAVYRET PAK 50-20MG	Tier 2	NM PA
MAVYRET TAB 100-40MG	Tier 2	NM PA

Drug Name	Drug Tier	Requirements/ Limits
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
PAXLOVID TAB 150-100 QL (40 tabs / 90 days)	Tier 2	QL
PAXLOVID TAB 300-100 QL (60 tabs / 90 days)	Tier 2	QL
PEGASYS SOLN 180mcg/ml; SOSY 180mcg/0.5ml	Tier 2	NM PA
PREVYMIS TABS 240mg, 480mg QL (28 tabs / 28 days)	Tier 2	QL PA
RELENZA DISKHALER AEPB 5mg/blister QL (6 inhalers / year)	Tier 2	QL
ribavirin (hepatitis c) CAPS 200mg; TABS 200mg	Tier 2	NM
rimantadine hydrochloride TABS 100mg	Tier 2	
valacyclovir hcl (generic of VALTREX) TABS 1gm, 500mg		
valganciclovir hcl (generic of VALCYTE) SOLR 50mg/ml	Tier 1	
valganciclovir hcl (generic of VALCYTE) TABS 450mg	Tier 2	
VOSEVI TAB CEPHALOSPORINS	Tier 2	NM PA
cefaclor CAPS 250mg, 500mg	Tier 2	
cefadroxil CAPS 500mg CEFAZOLIN SOLR 2gm,	Tier 1	
3gm CEFAZOLIN INJ 1GM/50ML	Tier 2	
cefazolin sodium SOLR 1gm, 2gm, 3gm, 10gm, 500mg	Tier 2	

Drug Name	Drug Requirements/ Tier Limits	Drug Name		Requirements/ Limits
CEFAZOLIN SOLN	Tier 2	ery-tab TBEC 250mg,	Tier 2	2
2GM/100ML-4%		333mg, 500mg ERYTHROCIN	Tier 2	<u> </u>
cefdinir CAPS 300mg		LACTOBIONATE SOLR	i iei z	2
cefdinir SUSR 125mg/5ml,	Tier 2	500mg		
250mg/5ml	Tier 2	erythromycin base CPEP	Tier 2	)
cefepime hcl SOLR 1gm,	Her Z	250mg; TABS 250mg,	1101 2	-
2gm cefixime CAPS 400mg	Tier 2	500mg; TBEC 250mg,		
cefoxitin sodium SOLR	Tier 2	333mg, 500mg		
1gm, 2gm, 10gm	Her Z	erythromycin lactobionate	Tier 2	2
cefpodoxime proxetil TABS	Tier 2	(generic of ERYTHROCIN		
100mg, 200mg	Her Z	LACTOBIONATE) SOLR		
cefprozil TABS 250mg,	Tier 2	500mg		
500mg	1101 2	FLUOROQUINOLONES		
ceftazidime SOLR 1gm,	Tier 2	ciprofloxacin 200 mg/100ml	Tier 2	2
2gm, 6gm		in d5w		
ceftriaxone sodium SOLR	Tier 2	ciprofloxacin 400 mg/200ml	Tier 2	2
1gm, 2gm, 10gm, 250mg,		in d5w	•	
500mg		ciprofloxacin hcl (generic of	Tier 1	
cefuroxime axetil TABS	Tier 1	CIPRO) TABS 250mg,		
250mg, 500mg		500mg	<del></del>	
cefuroxime sodium SOLR	Tier 2	ciprofloxacin hcl TABS	Tier 1	
1.5gm, 750mg		750mg levofloxacin SOLN 25mg/m	I Tior 1	<u> </u>
cephalexin CAPS 250mg,	Tier 1			
500mg	T: 0	levofloxacin TABS 250mg, 500mg, 750mg	Hei	
cephalexin SUSR	Tier 2	levofloxacin in d5w iv soln	Tier 2	)
125mg/5ml, 250mg/5ml tazicef SOLR 1gm, 2gm,	Tier 2	250 mg/50ml	1101 2	-
6gm	Her Z	levofloxacin in d5w iv soln	Tier 2	)
TEFLARO SOLR 400mg,	Tier 2	500 mg/100ml		_
600mg		levofloxacin in d5w iv soln	Tier 2	2
ERYTHROMYCINS/MAC	ROLIDES	750 mg/150ml		
azithromycin PACK 1gm	Tier 2	moxifloxacin hcl TABS	Tier 2	2
azithromycin (generic of	Tier 2	400mg		<del></del>
ZITHROMAX) SOLR	1101 2	moxifloxacin hcl 400	Tier 2	2
500mg; SUSR 100mg/5ml,		mg/250ml in sodium		
200mg/5ml		chloride 0.8% inj		<del> </del>
azithromycin (generic of	Tier 1	PENICILLINS		
ZITHROMAX) TABS		amoxicillin CAPS 250mg,	Tier 1	
250mg, 500mg		500mg; CHEW 125mg,		
azithromycin TABS 600mg	Tier 1	250mg; SUSR 125mg/5ml, 200mg/5ml, 250mg/5ml;		
clarithromycin SUSR	Tier 2	TABS 500mg, 875mg		
125mg/5ml, 250mg/5ml	- <u>-</u>	amoxicillin (generic of	Tier 1	 
clarithromycin TABS	Tier 2	AMOXICILLIN) SUSR	1101	•
250mg, 500mg	T' 0	400mg/5ml		
DIFICID SUSR 40mg/ml;	Tier 2	amoxicillin & k clavulanate	Tier 2	2
TABS 200mg		chew tab 400-57 mg		

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Drug Name	Drug Tier	Requirements/ Limits
penicillin g potassium SOLR 5000000unit, 20000000unit	Tier 2	2
penicillin g sodium SOLR 5000000unit	Tier 2	2
penicillin v potassium SOLR 125mg/5ml, 250mg/5ml; TABS 250mg, 500mg	Tier 1	
pfizerpen SOLR 5000000unit, 2000000unit	Tier 2	2
piperacillin sod-tazobactam na for inj 3.375 gm (3-0.375 gm)	Tier 2	2
piperacillin sod-tazobactam sod for inj 2.25 gm (2-0.25 gm)	Tier 2	2
piperacillin sod-tazobactam sod for inj 4.5 gm (4-0.5 gm)		2
piperacillin sod-tazobactam sod for inj 13.5 gm (12-1.5 gm)	Tier 2	2
piperacillin sod-tazobactam sod for inj 40.5 gm (36-4.5 gm)	Tier 2	)
TETRACYCLINES		
doxy 100 SOLR 100mg	Tier 2	2
doxycycline (monohydrate) CAPS 50mg, 100mg	Tier 1	
	Tier 2	)
	Tier 2	2
doxycycline hyclate (generic of VIBRAMYCIN) CAPS 100mg	Tier 2	2
doxycycline hyclate SOLR 100mg	Tier 2	2
minocycline hcl CAPS 50mg, 75mg, 100mg	Tier 2	2
tetracycline hcl CAPS 250mg, 500mg	Tier 2	2
tigecycline (generic of TYGACIL) SOLR 50mg	Tier 1	

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
ANTINEOPLASTIC AGE ALKYLATING AGENTS	NTS		ERLEADA TABS 240mg QL (30 tabs / 30 days)	Tier 2	
cyclophosphamide CAPS	Tier 2	B/D	EULEXIN CAPS 125mg	Tier 1	
25mg, 50mg CYCLOPHOSPHAMIDE	Tier 2	B/D	exemestane (generic of AROMASIN) TABS 25mg	Tier 2	
TABS 25mg, 50mg			FIRMAGON SOLR 80mg	Tier 2	NM PA
GLEOSTINE CAPS 10mg, 40mg	Tier 2	. NM	FIRMAGON SOLR 120mg/vial	Tier 2	NM PA
GLEOSTINE CAPS 100mg	Tier 2	NM	letrozole (generic of	Tier 1	•
ANTIMETABOLITES			FEMARA) TABS 2.5mg		
INQOVI TAB 35-100MG QL (5 tabs / 28 days)	Tier 2	QL NM PA	leuprolide acetate KIT 1mg/0.2ml	Tier 2	
LONSURF TAB 15-6.14 QL (100 tabs / 28	Tier 2	QL NM PA	LUPRON DEPOT (1- MONTH) KIT 3.75mg	Tier 2	NM PA
days) LONSURF TAB 20-8.19	Tier 2	QL NM PA	LUPRON DEPOT (3- MONTH) KIT 11.25mg	Tier 2	NM PA
QL (80 tabs / 28 days)			LYSODREN TABS 500mg	Tier 2	
<i>mercaptopurine</i> TABS 50mg	Tier 2		megestrol acetate TABS 20mg, 40mg	Tier 2	
methotrexate sodium SOLN 1gm/40ml, 50mg/2ml, 250mg/10ml; SOLR 1gm	Tier 1	B/D	nilutamide (generic of NILANDRON) TABS 150mg	Tier 1	
ONUREG TABS 200mg, 300mg QL (14 tabs / 28 days)	Tier 2	QL NM PA	NUBEQA TABS 300mg QL (120 tabs / 30 days)	Tier 2	QL NM PA
PURIXAN SUSP	Tier 2	. NM	ORGOVYX TABS 120mg	Tier 2	NM PA
2000mg/100ml		<del> </del>	ORSERDU TABS 86mg	Tier 2	QL NM PA
HORMONAL ANTINEOP			QL (90 tabs / 30 days)		01.111.51
abiraterone acetate (generic of ZYTIGA) TABS 250mg	: Tier 1	QL NM PA	ORSERDU TABS 345mg QL (30 tabs / 30 days)		QL NM PA
QL (120 tabs / 30 days)			SOLTAMOX SOLN 10mg/5ml	Tier 2	
abiraterone acetate (generic of ZYTIGA) TABS 500mg	: Tier 1	QL NM PA	tamoxifen citrate TABS 10mg, 20mg	Tier 1	
QL (60 tabs / 30 days)			toremifene citrate (generic	Tier 2	PA
AKEEGA TAB 50/500MG		QL NM PA	of FARESTON) TABS		
QL (60 tabs / 30 days)	•	OL NIM DA	60mg	Tior 2	QL NM PA
AKEEGA TAB 100/500 QL (60 tabs / 30 days)		QL NM PA	XTANDI CAPS 40mg QL (120 caps / 30	Hei Z	. QLINIVIPA
anastrozole (generic of	Tier 1		days) XTANDI_TABS_40mg	Tior 2	QL NM PA
ARIMIDEX) TABS 1mg bicalutamide (generic of CASODEX) TABS 50mg	Tier 1	<del>,</del>	QL (120 tabs / 30 days)	1161 2	. QENWIFA
ELIGARD KIT 7.5mg, 22.5mg, 30mg, 45mg	Tier 2	NM PA	XTANDI TABS 80mg QL (60 tabs / 30 days)		QL NM PA
ERLEADA TABS 60mg QL (120 tabs / 30 days)	Tier 2	QL NM PA			

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug   Tier	Requirements/ Limits
IMMUNOMODULATORS	3		ALUNBRIG PAK	Tier 2	QL NM PA
lenalidomide CAPS 2.5mg,	Tier 1	QL NM PA	QL (30 tabs / 30 days	s)	
5mg, 10mg, 15mg			AUGTYRO CAPS 40mg		QL NM PA
QL (28 caps / 28 days	3)		QL (240 caps / 30		
lenalidomide CAPS 20mg,		QL NM PA	days)		
25mg			AYVAKIT TABS 25mg,	Tier 2	QL NM PA
QL (21 caps / 28 days	3)		50mg, 100mg, 200mg,		
POMALYST CAPS 1mg,	Tier 2	QL NM PA	300mg		
2mg, 3mg, 4mg			QL (30 tabs / 30 days		
QL (21 caps / 28 days	s)		BALVERSA TABS 3mg	Tier 2	QL NM PA
THALOMID CAPS 50mg	Tier 2	QL NM PA	QL (84 tabs / 28 days	<del> </del>	
QL (84 caps / 28 days	s)		BALVERSA TABS 4mg	Tier 2	QL NM PA
THALOMID CAPS 100mg	Tier 2	QL NM PA	QL (56 tabs / 28 days		_
QL (112 caps / 28			BALVERSA TABS 5mg	_	QL NM PA
days)		<del></del>	QL (28 tabs / 28 days	<i>'</i>	
THALOMID CAPS 150mg,	Tier 2	QL NM PA	BOSULIF CAPS 50mg	Tier 2	QL NM PA
200mg			QL (360 caps / 30		
QL (56 caps / 28 days	s)	<u>.</u>	days)	· · · · · · · · · · · · · · · · · · ·	
MISCELLANEOUS			BOSULIF CAPS 100mg	Tier 2	QL NM PA
BESREMI SOSY	Tier 2	QL NM PA	QL (150 caps / 25		
500mcg/ml			days)		
QL (2 syringes / 28			BOSULIF TABS 100mg	Tier 2	QL NM PA
days)		<del></del>	QL (180 tabs / 30		
bexarotene (generic of	Tier 1	I QL NM PA	days)		
TARGRETIN) CAPS 75mg			BOSULIF TABS 400mg,	Lier 2	QL NM PA
QL (300 caps / 30			500mg	,	
days)			QL (30 tabs / 30 days		01.111.00
hydroxyurea (generic of	Tier 1		BRAFTOVI CAPS 75mg	Her 2	QL NM PA
HYDREA) CAPS 500mg			QL (180 caps / 30		
IWILFIN TABS 192mg	Tier 2	QL NM PA	days)	T: 0	OL NIM DA
QL (240 tabs / 30			BRUKINSA CAPS 80mg	Her 2	QL NM PA
days)			QL (120 caps / 30		
MATULANE CAPS 50mg	Tier 2	•	days)	Tion 2	
tretinoin (chemotherapy)	Tier 1		CABOMETYX TABS 20mg 40mg, 60mg	j, Hei Z	QL NIVI PA
CAPS 10mg	<b>T</b> : 6	01.1114.54	QL (30 tabs / 30 days	1	
WELIREG TABS 40mg		QL NM PA	CALQUENCE CAPS		QL NM PA
QL (90 tabs / 30 days		<del></del>	100mg	Hel Z	QL NIVI PA
MOLECULAR TARGET	_,	•	QL (60 caps / 30 days	2)	
ALECENSA CAPS 150mg	Tier 2	2 QL NM PA	CALQUENCE TABS		QL NM PA
QL (240 caps / 30			100mg	1161 2	QL MINI FA
days)	<u> </u>		QL (60 tabs / 30 days		
ALUNBRIG TABS 30mg	Lier 2	QL NM PA	CAPRELSA TABS 100mg		QL NM PA
QL (120 tabs / 30			QL (60 tabs / 30 days		QL INIVI I A
days)	<del>_</del>		CAPRELSA TABS 300mg		QL NM PA
ALUNBRIG TABS 90mg,	Lier 2	QL NM PA	QL (30 tabs / 30 days		SE MINITA
180mg			<u> </u>	7	
QL (30 tabs / 30 days	)				

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
COMETRIQ (60MG DOSE) KIT 20mg	Tier 2	QL NM PA	FRUZAQLA CAPS 5mg QL (21 caps / 28 days)		QL NM PA
QL (84 caps / 28 days	s)		GAVRETO CAPS 100mg		QL NM PA
COMETRIQ KIT 100MG		QL NM PA	QL (120 caps / 30		
QL (56 caps / 28 days			days)		
COMETRIQ KIT 140MG	Tier 2	QL NM PA	gefitinib (generic of	Tier 1	QL NM PA
QL (112 caps / 28			IRESSA) TABS 250mg		
days) COPIKTRA CAPS 15mg,	Tior 2	QL NM PA	QL (60 tabs / 30 days) GILOTRIF TABS 20mg,		QL NM PA
25mg	1161 2	QL MINI FA	30mg, 40mg	1161 2	. QLINNIFA
QL (56 caps / 28 days	3)		QL (30 tabs / 30 days)		
COTELLIC TABS 20mg		QL NM PA	IBRANCE CAPS 75mg,		QL NM PA
QL (63 tabs / 28 days			100mg, 125mg		
DAURISMO TABS 25mg		QL NM PA	QL (21 caps / 28 days)	)	
QL (60 tabs / 30 days	()		IBRANCE TABS 75mg,	Tier 2	QL NM PA
DAURISMO TABS 100mg		QL NM PA	100mg, 125mg		
QL (30 tabs / 30 days			QL (21 tabs / 28 days)		
ERIVEDGE CAPS 150mg		QL NM PA	ICLUSIG TABS 10mg,	Tier 2	QL NM PA
QL (30 caps / 30 days	· .	01.111.51	15mg, 30mg, 45mg		
erlotinib hcl TABS 25mg		QL NM PA	QL (30 tabs / 30 days)		
QL (90 tabs / 30 days	•	OL NIM DA	IDHIFA TABS 50mg, 100mg	ner z	QL NM PA
erlotinib hcl (generic of TARCEVA) TABS 100mg,	Tier 1	QL NM PA	QL (30 tabs / 30 days)		
150mg			imatinib mesylate (generic		OL NM PA
QL (30 tabs / 30 days	()		of GLEEVEC) TABS 100mg		α=
everolimus (generic of	•	QL NM PA	QL (90 tabs / 30 days)	•	
AFINITOR) TABS 2.5mg,			imatinib mesylate (generic	Tier 1	QL NM PA
5mg, 7.5mg, 10mg			of GLEEVEC) TABS 400mg	•	
QL (30 tabs / 30 days	•		QL (60 tabs / 30 days)		
everolimus (generic of	Tier 1	QL NM PA	IMBRUVICA CAPS 70mg		QL NM PA
AFINITOR DISPERZ)			QL (30 caps / 30 days)		
TBSO 2mg			IMBRUVICA CAPS 140mg	Lier 2	QL NM PA
QL (150 tabs / 30			QL (120 caps / 30		
days) everolimus (generic of	Tior 1	QL NM PA	days) IMBRUVICA SUSP	Tior 2	QL NM PA
AFINITOR DISPERZ)	1161 1	QL MINI FA	70mg/ml	1161 2	. QLINNIFA
TBSO 3mg			QL (216 mL / 27 days)		
QL (90 tabs / 30 days	)		IMBRUVICA TABS 140mg,	•	QL NM PA
everolimus (generic of		QL NM PA	280mg, 420mg		-
AFINITOR DISPERZ)			QL (30 tabs / 30 days)		
TBSO 5mg			INLYTA TABS 1mg	•	QL NM PA
QL (60 tabs / 30 days			QL (180 tabs / 30		
FOTIVDA CAPS .89mg,	Tier 2	QL NM PA	days)		
1.34mg	_\		INLYTA TABS 5mg	Tier 2	QL NM PA
QL (21 caps / 28 days		OL NIM DA	QL (120 tabs / 30		
FRUZAQLA CAPS 1mg		QL NM PA	days)		
QL (84 caps / 28 days	<u>)</u>				

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
INREBIC CAPS 100mg	Tier 2	QL NM PA	LENVIMA 12MG DAILY	Tier 2	QL NM PA
QL (120 caps / 30			DOSE CPPK 4mg		
days)			QL (90 caps / 30 days	s)	
JAKAFI TABS 5mg, 10mg,	Tier 2	QL NM PA	LENVIMA 20 MG DAILY		QL NM PA
15mg, 20mg, 25mg			DOSE CPPK 10mg		
QL (60 tabs / 30 days)	)		QL (60 caps / 30 days	s)	
JAYPIRCA TABS 50mg		QL NM PA	LENVIMA CAP 14 MG		QL NM PA
QL (30 tabs / 30 days)			QL (60 caps / 30 days		
		QL NM PA	LENVIMA CAP 18 MG		QL NM PA
QL (60 tabs / 30 days	)		QL (90 caps / 30 days	s)	
KISQALI 200 DOSE TBPK		QL NM PA	LENVIMA CAP 24 MG		QL NM PA
200mg			QL (90 caps / 30 days		
QL (21 tabs / 28 days)	)		LORBRENA TABS 25mg		QL NM PA
KISQALI 200 PAK FEMARA		QL NM PA	QL (90 tabs / 30 days		
QL (49 tabs / 28 days	)		LORBRENA TABS 100mg		QL NM PA
KISQALI 400 DOSE TBPK		QL NM PA	QL (30 tabs / 30 days		
200mg			LUMAKRAS TABS 120mg		QL NM PA
QL (42 tabs / 28 days	)		QL (240 tabs / 30		
KISQALI 400 PAK FEMARA		QL NM PA	days)		
QL (70 tabs / 28 days			LUMAKRAS TABS 320mg	Tier 2	QL NM PA
KISQALI 600 DOSE TBPK		QL NM PA	QL (90 tabs / 30 days		
200mg			LYNPARZA TABS 100mg,		QL NM PA
QL (63 tabs / 28 days	)		150mg		<u>~</u>
KISQALI 600 PAK FEMARA		QL NM PA	QL (120 tabs / 30		
QL (91 tabs / 28 days	)		days)		
KOSELUGO CAPS 10mg		QL NM PA	LYTGOBI (12 MG DAILY	Tier 2	QL NM PA
QL (240 caps / 30			DOSE) TBPK 4mg		
days)			QL (84 tabs / 28 days	)	
KOSELUGO CAPS 25mg	Tier 2	QL NM PA	LYTGOBI (16 MG DAILY		QL NM PA
QL (120 caps / 30			DOSE) TBPK 4mg		
days)			QL (112 tabs / 28		
KRAZATI TABS 200mg	Tier 2	QL NM PA	days)		
QL (180 tabs / 30			LYTGOBI (20 MG DAILY	Tier 2	QL NM PA
days)			DOSE) TBPK 4mg		
lapatinib ditosylate (generic	Tier 1	QL NM PA	QL (140 tabs / 28		
of TYKERB) TABS 250mg			days)		
QL (180 tabs / 30			MEKINIST SOLR .05mg/m	I Tier 2	QL NM PA
days)			QL (1260 mL / 30		
LENVIMA 4 MG DAILY	Tier 2	QL NM PA	days)		
DOSE CPPK 4mg			MEKINIST TABS 2mg	Tier 2	QL NM PA
QL (30 caps / 30 days	)		QL (30 tabs / 30 days	)	
LENVIMA 8 MG DAILY		QL NM PA	MEKINIST TABS .5mg		QL NM PA
DOSE CPPK 4mg			QL (90 tabs / 30 days		
QL (60 caps / 30 days	)		MEKTOVI TABS 15mg		QL NM PA
LENVIMA 10 MG DAILY		QL NM PA	QL (180 tabs / 30		
DOSE CPPK 10mg			days)		
QL (30 caps / 30 days	)				

Drug Name	Drug Requirements/ Tier Limits	Drug Name	Drug Requirements/ Tier Limits
NERLYNX TABS 40mg	Tier 2 QL NM PA	RETEVMO TABS 80mg,	Tier 2 QL NM PA
QL (180 tabs / 30		120mg, 160mg	
days)		QL (60 tabs / 30 days	
NINLARO CAPS 2.3mg,	Tier 2 QL NM PA	REZLIDHIA CAPS 150mg	
3mg, 4mg		QL (60 caps / 30 days	
QL (3 caps / 28 days)		ROZLYTREK CAPS 100m	g Tier 2 QL NM PA
ODOMZO CAPS 200mg	Tier 2 QL NM PA	QL (180 caps / 30	
QL (30 caps / 30 days	Tier 2 QL NM PA	days)	a Tior O. O. NIM DA
OGSIVEO TABS 50mg QL (180 tabs / 30	Her Z QL NIVI PA	ROZLYTREK CAPS 200m	
days)		QL (90 caps / 30 days ROZLYTREK PACK 50mg	
OGSIVEO TABS 100mg,	Tier 2 QL NM PA	QL (336 packets / 28	HEIZ QLINIVIFA
150mg	TICI Z QLIVIVITA	days)	
QL (56 tabs / 28 days)	)	RUBRACA TABS 200mg,	Tier 2 QL NM PA
OJEMDA SUSR 25mg/ml	Tier 2 QL NM PA	250mg, 300mg	
QL (96 mL / 28 days)		QL (120 tabs / 30	
OJEMDA TABS 100mg	Tier 2 QL NM PA	days)	
QL (24 tabs / 28 days)	)	RYDAPT CAPS 25mg	Tier 2 QL NM PA
OJJAARA TABS 100mg,	Tier 2 QL NM PA	QL (224 caps / 28	
150mg, 200mg		days)	
QL (30 tabs / 30 days)	)	SCEMBLIX TABS 20mg	Tier 2 QL NM PA
	Tier 1 QL NM PA	QL (60 tabs / 30 days	• • • • • • • • • • • • • • • • • • • •
VOTRIENT) TABS 200mg		SCEMBLIX TABS 40mg	Tier 2 QL NM PA
QL (120 tabs / 30		QL (300 tabs / 30	
days)		days)	
PEMAZYRE TABS 4.5mg,	Tier 2 QL NM PA	SCEMBLIX TABS 100mg	Tier 2 QL NM PA
9mg, 13.5mg	<b>\</b>	QL (120 tabs / 30	
QL (28 tabs / 28 days) PIQRAY 200MG DAILY	Tier 2 QL NM PA	days)	Tior 1 OL NIM DA
DOSE TBPK 200mg	Her Z QL NIVI PA	sorafenib tosylate (generic of NEXAVAR) TABS	HELL QLINNIPA
QL (28 tabs / 28 days)	)	200mg	
PIQRAY 250MG TAB DOSI		QL (120 tabs / 30	
QL (56 tabs / 28 days)		days)	
PIQRAY 300MG DAILY	Tier 2 QL NM PA	SPRYCEL TABS 20mg	Tier 2 QL NM PA
DOSE TBPK 150mg		QL (90 tabs / 30 days	)
QL (56 tabs / 28 days	)	SPRYCEL TABS 50mg,	Tier 2 QL NM PA
QINLOCK TABS 50mg	Tier 2 QL NM PA	70mg, 80mg, 100mg,	
QL (90 tabs / 30 days)	)	140mg	
RETEVMO CAPS 40mg	Tier 2 QL NM PA	QL (30 tabs / 30 days	
QL (180 caps / 30		STIVARGA TABS 40mg	Tier 2 QL NM PA
days)		QL (84 tabs / 28 days	·
RETEVMO CAPS 80mg	Tier 2 QL NM PA	sunitinib malate (generic of	Tier 1 QL NM PA
QL (120 caps / 30		SUTENT) CAPS 12.5mg,	
days)	Tion O. O. NIMADA	25mg, 37.5mg, 50mg	-1
RETEVMO TABS 40mg	Tier 2 QL NM PA	QL (30 caps / 30 days	
QL (90 tabs / 30 days)	)	TABRECTA TABS 150mg, 200mg	IICIZ QLINIVI PA
		QL (112 tabs / 28	
		days)	

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
TAFINLAR CAPS 50mg, 75mg QL (120 caps / 30	Tier 2	QL NM PA	VENCLEXTA TABS 50mg QL (112 tabs / 28 days)	Tier 2	QL NM PA
days) TAFINLAR TBSO 10mg QL (900 tabs / 30	Tier 2	2 QL NM PA	VENCLEXTA TABS 100mg QL (180 tabs / 30 days)	Tier 2	QL NM PA
days) TAGRISSO TABS 40mg, 80mg	Tier 2	QL NM PA	VENCLEXTA TAB START PK QL (42 tabs / 28 days)		QL NM PA
QL (30 tabs / 30 days) TALZENNA CAPS .1mg, .35mg, .5mg, .75mg, 1mg	•	2 QL NM PA	VERZENIO TABS 50mg, 100mg, 150mg, 200mg QL (56 tabs / 28 days)	Tier 2	QL NM PA
QL (30 caps / 30 days TALZENNA CAPS .25mg	Tier 2	2 QL NM PA	VITRAKVI CAPS 25mg QL (180 caps / 30		QL NM PA
QL (90 caps / 30 days TASIGNA CAPS 50mg QL (120 caps / 30		2 QL NM PA	days) VITRAKVI CAPS 100mg QL (60 caps / 30 days)	)	QL NM PA
days) TASIGNA CAPS 150mg,	Tier 2	QL NM PA	VITRAKVI SOLN 20mg/ml QL (300 mL / 30 days)		
200mg QL (112 caps / 28 days)			VIZIMPRO TABS 15mg, 30mg, 45mg QL (30 tabs / 30 days)		QL NM PA
TAZVERIK TABS 200mg QL (240 tabs / 30 days)	Tier 2	2 QL NM PA	VONJO CAPS 100mg QL (120 caps / 30 days)	Tier 2	QL NM PA
TEPMETKO TABS 225mg QL (60 tabs / 30 days) TIBSOVO TABS 250mg		QL NM PA	XALKORI CAPS 200mg, 250mg; CPSP 50mg QL (120 caps / 30	Tier 2	QL NM PA
QL (60 tabs / 30 days) torpenz (generic of		QL NM PA	days)  XALKORI CPSP 20mg	Tier 2	QL NM PA
AFINITOR) TABS 2.5mg, 5mg, 7.5mg, 10mg		QENWITA	QL (240 caps / 30 days)		
QL (30 tabs / 30 days) TRUQAP TABS 160mg, 200mg		2 QL NM PA	XALKORI CPSP 150mg QL (180 caps / 30 days)	Tier 2	QL NM PA
QL (64 tabs / 28 days) TUKYSA TABS 50mg,		2 QL NM PA	XOSPATA TABS 40mg QL (90 tabs / 30 days)		QL NM PA
150mg QL (120 tabs / 30 days)			XPOVIO PAK (40 MG ONCE WEEKLY) TBPK 40mg		QL NM PA
TURALIO CAPS 125mg QL (120 caps / 30 days)	Tier 2	QL NM PA	QL (4 tabs / 28 days) XPOVIO PAK (40 MG TWICE WEEKLY) TBPK	Tier 2	QL NM PA
VANFLYTA TABS 17.7mg, 26.5mg		2 QL NM PA	40mg QL (8 tabs / 28 days)	·	
QL (56 tabs / 28 days) VENCLEXTA TABS 10mg QL (112 tabs / 28 days)		2 QL NM PA	XPOVIO PAK (60 MG ONCE WEEKLY) TBPK 60mg QL (4 tabs / 28 days)	Tier 2	QL NM PA

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
XPOVIO PAK (60 MG TWICE WEEKLY) TBPK 20mg	Tier 2	QL NM PA	amlodipine besylate- benazepril hcl cap 5-40 mg QL (30 caps / 30 days)	Tier 1	I QL
QL (24 tabs / 28 days) XPOVIO PAK (80 MG ONCE WEEKLY) TBPK 40mg		QL NM PA	amlodipine besylate- benazepril hcl cap 10-20 mg (generic of LOTREL) QL (30 caps / 30 days)	)	
QL (8 tabs / 28 days) XPOVIO PAK (80 MG TWICE WEEKLY) TBPK 20mg		QL NM PA	amlodipine besylate- benazepril hcl cap 10-40 mg (generic of LOTREL) QL (30 caps / 30 days)	)	
QL (32 tabs / 28 days) XPOVIO PAK (100 MG ONCE WEEKLY) TBPK		QL NM PA	benazepril & hydrochlorothiazide tab 5- 6.25mg	Tier 2	
50mg QL (8 tabs / 28 days) ZEJULA TABS 100mg, 200mg, 300mg	Tier 2	QL NM PA	benazepril & hydrochlorothiazide tab 10- 12.5 mg (generic of LOTENSIN HCT)	Tier 2	2
QL (30 tabs / 30 days) ZELBORAF TABS 240mg QL (240 tabs / 30 days)		QL NM PA	benazepril & hydrochlorothiazide tab 20- 12.5 mg (generic of LOTENSIN HCT)	Tier 2	2
ZOLINZA CAPS 100mg QL (120 caps / 30 days) ZYDELIG TABS 100mg,		QL NM PA	benazepril & hydrochlorothiazide tab 20- 25 mg (generic of LOTENSIN HCT)	Tier 2	2
150mg QL (60 tabs / 30 days) ZYKADIA TABS 150mg	)	QL NM PA	enalapril maleate & hydrochlorothiazide tab 5- 12.5 mg	Tier 1	ľ
QL (84 tabs / 28 days)  PROTECTIVE AGENTS  leucovorin calcium TABS			enalapril maleate & hydrochlorothiazide tab 10-25 mg (generic of	Tier 1	
5mg, 10mg, 15mg, 25mg MESNEX TABS 400mg CARDIOVASCULAR	Tier 2	NC.	VASERETIC) fosinopril sodium & hydrochlorothiazide tab 10- 12.5 mg	Tier 2	2
amlodipine besylate- benazepril hcl cap 2.5-10 mg	Tier 1	QL	fosinopril sodium & hydrochlorothiazide tab 20-12.5 mg	Tier 2	
QL (30 caps / 30 days amlodipine besylate- benazepril hcl cap 5-10 mg (generic of LOTREL)	) Tier 1	QL	lisinopril & hydrochlorothiazide tab 10- 12.5 mg (generic of ZESTORETIC) lisinopril &	Tier 1	
QL (30 caps / 30 days amlodipine besylate- benazepril hcl cap 5-20 mg (generic of LOTREL) QL (30 caps / 30 days	Tier 1	QL	hydrochlorothiazide tab 20- 12.5 mg (generic of ZESTORETIC)	1101	

Drug Name	Drug Tier	Requirements/ Limits
lisinopril &	Tier 1	
hydrochlorothiazide tab 20-		
25 mg (generic of		
ZESTORETIC)		
ACE INHIBITORS		
benazepril hcl TABS 5mg	Tier 1	
benazepril hcl (generic of	Tier 1	
LOTENSIN) TABS 10mg,		
20mg, 40mg		
enalapril maleate (generic of	f Tier 1	
VASOTEC) TABS 2.5mg,		
5mg, 10mg, 20mg		
fosinopril sodium TABS	Tier 1	
10mg, 20mg, 40mg	<del>-</del> . ,	
lisinopril (generic of	Tier 1	
ZESTRIL) TABS 2.5mg,		
5mg, 10mg, 20mg, 30mg,		
40mg	Tier 2	
moexipril hcl TABS 7.5mg, 15mg	1161 2	<u>-</u>
perindopril erbumine TABS	Tior 2	)
2mg, 4mg, 8mg	1161 2	-
quinapril hcl (generic of	Tier 1	<del>.</del>
ACCUPRIL) TABS 5mg,	1101 1	
10mg, 20mg, 40mg		
ramipril (generic of	Tier 1	
ALTACE) CAPS 1.25mg,		
2.5mg, 5mg, 10mg		
trandolapril TABS 1mg,	Tier 1	
2mg, 4mg		
ALDOSTERONE RECEP	TOR	-
<b>ANTAGONISTS</b>		
eplerenone (generic of	Tier 2	<u> </u>
INSPRA) TABS 25mg,		
50mg		
KERENDIA TABS 10mg,	Tier 2	QL
20mg		
QL (30 tabs / 30 days)		
spironolactone (generic of	Tier 1	
ALDACTONE) TABS 25mg	,	
50mg, 100mg	_	
ALPHA BLOCKERS		
doxazosin mesylate (generic	Tier 1	
of CARDURA) TABS 1mg,		
2mg, 4mg, 8mg		<del>.</del>
prazosin hcl CAPS 1mg,	Tier 2	2
2mg, 5mg		

Drug Name	Drug Tier	Requirements/ Limits
terazosin hcl CAPS 1mg,	Tier 1	<u> </u>
2mg, 5mg, 10mg		
ANGIOTENSIN II RECEP	PTOR	
ANTAGONIST COMBINA	4 <i>TION</i>	IS
amlodipine besylate-	Tier 2	QL
valsartan tab 5-160 mg		
(generic of EXFORGE)		
QL (30 tabs / 30 days)	)	
amlodipine besylate-	Tier 2	2 QL
valsartan tab 5-320 mg		
(generic of EXFORGE)		
QL (30 tabs / 30 days)		
amlodipine besylate-	Tier 2	2 QL
valsartan tab 10-160 mg		
(generic of EXFORGE)		
QL (30 tabs / 30 days)		
amlodipine besylate-	Tier 2	2 QL
valsartan tab 10-320 mg		
(generic of EXFORGE)		
QL (30 tabs / 30 days) ENTRESTO CAP 6-6MG		<u> </u>
	Tier 2	2 QL
QL (240 caps / 30		
days) ENTRESTO CAP 15-16MG	Tior 3	2 QL
QL (240 caps / 30	1161 2	QL QL
days)		
ENTRESTO TAB 24-26MG	Tier 2	2 QL
QL (60 tabs / 30 days)		. QL
ENTRESTO TAB 49-51MG	Tier 2	2 QL
QL (60 tabs / 30 days)		~_
ENTRESTO TAB 97-103MC	•	QL
QL (60 tabs / 30 days)	)	
irbesartan-	Tier 1	l QL
hydrochlorothiazide tab 150	)_	
12.5 mg (generic of		
AVALIDE)		
QL (60 tabs / 30 days)	)	
irbesartan-	Tier 1	l QL
hydrochlorothiazide tab 300	)_	
<i>12.5 mg</i> (generic of		
AVALIDE)		
QL (30 tabs / 30 days)		<del></del>
losartan potassium &	Tier 1	
hydrochlorothiazide tab 50-		
12.5 mg (generic of		
HYZAAR)		

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
losartan potassium & hydrochlorothiazide tab 100	Tier 1		ANGIOTENSIN II RECEP	TOR	
12.5 mg (generic of			candesartan cilexetil	Tier 2	QL
HYZAAR)	T: 4	<u> </u>	(generic of ATACAND)		
losartan potassium & hydrochlorothiazide tab 100	Tier 1		TABS 4mg, 8mg, 16mg		
25 mg (generic of HYZAAR)			QL (60 tabs / 30 days) candesartan cilexetil	Tier 2	2 QL
olmesartan medoxomil-	Tier 2	2 QL	(generic of ATACAND)	1161 2	. QL
hydrochlorothiazide tab 20-			TABS 32mg		
<i>12.5 mg</i> (generic of			QL (30 tabs / 30 days)		
BENICAR HCT)			irbesartan (generic of	Tier 1	QL
QL (30 tabs / 30 days)		<u> </u>	AVAPRO) TABS 75mg,		
olmesartan medoxomil- hydrochlorothiazide tab 40-	Tier 2	2 QL	150mg, 300mg		
12.5 mg (generic of			QL (30 tabs / 30 days)  losartan potassium (generic		_
BENICAR HCT)			of COZAAR) TABS 25mg,	HEI	
QL (30 tabs / 30 days)			50mg, 100mg		
olmesartan medoxomil-	Tier 2	QL	olmesartan medoxomil	Tier 1	QL
hydrochlorothiazide tab 40-			(generic of BENICAR)		
25 mg (generic of BENICAF			TABS 5mg		
HCT) QL (30 tabs / 30 days)			QL (60 tabs / 30 days)		
valsartan-	Tier 2		olmesartan medoxomil	Tier 1	QL
hydrochlorothiazide tab 80-	1101 2	. QL	(generic of BENICAR) TABS 20mg, 40mg		
12.5 mg (generic of			QL (30 tabs / 30 days)		
DIOVAN HCT)			telmisartan (generic of	Tier 2	2 QL
QL (30 tabs / 30 days)			MICARDIS) TABS 20mg,		
valsartan-	Tier 2	2 QL	40mg, 80mg		
hydrochlorothiazide tab 160 12.5 mg (generic of	-		QL (30 tabs / 30 days)		
DIOVAN HCT)			valsartan (generic of	Tier 2	2 QL
QL (30 tabs / 30 days)			DIOVAN) TABS 40mg, 80mg, 160mg		
valsartan-	Tier 2	2 QL	QL (60 tabs / 30 days)		
hydrochlorothiazide tab 160			valsartan (generic of	Tier 2	2 QL
25 mg (generic of DIOVAN			DIOVAN) TABS 320mg		
HCT)			QL (30 tabs / 30 days)		
QL (30 tabs / 30 days)	Tier 2	QL	ANTIARRHYTHMICS		
hydrochlorothiazide tab 320		. QL	amiodarone hcl SOLN	Tier 2	) -
12.5 mg (generic of			50mg/ml, 900mg/18ml;		
DIOVAN HCT)			TABS 100mg, 400mg amiodarone hcl TABS	Tier 1	_
QL (30 tabs / 30 days)			200mg	Hell	
valsartan-	Tier 2	2 QL	disopyramide phosphate	Tier 2	<u> </u>
hydrochlorothiazide tab 320	-		(generic of NORPACE)		
25 mg (generic of DIOVAN			CAPS 100mg, 150mg		
HCT) QL (30 tabs / 30 days)			dofetilide (generic of	Tier 2	2 NM
<u> </u>			TIKOSYN) CAPS 125mcg,		
			250mcg, 500mcg		

Drug Name	Drug Re Tier	quirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
flecainide acetate TABS	Tier 2		simvastatin TABS 5mg,	Tier 1	
50mg, 100mg, 150mg			80mg		
MULTAQ TABS 400mg	Tier 2	QL	QL (30 tabs / 30 days)		
QL (60 tabs / 30 days)			simvastatin (generic of	Tier 1	QL
pacerone TABS 100mg,	Tier 2		ZOCOR) TABS 10mg,		
400mg			20mg, 40mg		
pacerone TABS 200mg	Tier 1		QL (30 tabs / 30 days)		
propafenone hcl CP12	Tier 2		ANTILIPEMICS, MISCEL	•	
225mg, 325mg, 425mg			cholestyramine (generic of	Tier 2	
propafenone hcl TABS	Tier 2		QUESTRAN) PACK 4gm;		
150mg, 225mg, 300mg			POWD 4gm/dose		
quinidine sulfate TABS	Tier 2		cholestyramine light PACK	Tier 2	
200mg, 300mg			4gm		
sotalol hcl (generic of	Tier 1		cholestyramine light	Tier 2	
BETAPACE) TABS 80mg,			(generic of QUESTRAN		
120mg, 160mg			LIGHT) POWD 4gm/dose		
sotalol hcl TABS 240mg	Tier 1		colestipol hcl (generic of	Tier 2	
sotalol hcl (afib/afl) (generic	Tier 2		COLESTID) GRAN 5gm		
of BETAPACE AF) TABS			colestipol hcl PACK 5gm	Tier 2	
80mg, 120mg, 160mg			colestipol hcl (generic of	Tier 2	
ANTILIPEMICS, FIBRAT	ES		COLESTID) TABS 1gm		_
fenofibrate (generic of	Tier 2		ezetimibe (generic of	Tier 2	
TRICOR) TABS 48mg,			ZETIA) TABS 10mg		
_145mg			NEXLETOL TABS 180mg	Tier 2	QL
fenofibrate TABS 54mg,	Tier 2		QL (30 tabs / 30 days)		
160mg			NEXLIZET TAB 180/10MG	Tier 2	QL
fenofibrate micronized	Tier 2		QL (30 tabs / 30 days)		
CAPS 67mg, 134mg,			niacin (antihyperlipidemic)	Tier 2	QL
200mg			TBCR 500mg, 750mg,		
gemfibrozil (generic of	Tier 1		1000mg		
LOPID) TABS 600mg			QL (60 tabs / 30 days)	·-· -	
ANTILIPEMICS, HMG-Co	oA REDU	JCTASE	omega-3-acid ethyl esters	Tier 2	PA
INHIBITORS			cap 1 gm (generic of		
atorvastatin calcium	Tier 1	QL	LOVAZA)	T: 0	
(generic of LIPITOR) TABS			prevalite PACK 4gm	Tier 2	
10mg, 20mg, 40mg, 80mg			prevalite (generic of	Tier 2	
QL (30 tabs / 30 days)			QUESTRAN LIGHT)		
lovastatin TABS 10mg,	Tier 1	QL	POWD 4gm/dose	T: ^	NINA DA
20mg, 40mg			REPATHA SOSY	Tier 2	NM PA
QL (60 tabs / 30 days)			140mg/ml	T: ^	NINA DA
pravastatin sodium TABS	Tier 1	QL	REPATHA PUSHTRONEX	Her 2	NM PA
10mg, 20mg, 40mg, 80mg			SYSTEM SOCT		
QL (30 tabs / 30 days)			420mg/3.5ml	Tie - O	NIM DA
rosuvastatin calcium	Tier 2	QL	REPATHA SURECLICK	Tier 2	NM PA
(generic of CRESTOR)			SOAJ 140mg/ml	Tio- 0	<u>.</u>
TABS 5mg, 10mg, 20mg,			VASCEPA CAPS .5gm,	Tier 2	
40mg			<u>1gm</u>		
QL (30 tabs / 30 days)					

BETA-BLOCKER/DIURETICpindolol TABS 5mg, 10mgTier 2COMBINATIONSpropranolol hcl (generic of atenolol & chlorthalidone tab Tier 1INDERAL LA) CP24 60mg, 80mg, 120mg, 160mg50-25 mg (generic of TENORETIC 50)propranolol hcl SOLN Tier 2atenolol & chlorthalidone tab Tier 120mg/5ml, 40mg/5ml100-25 mg (generic of TENORETIC 100)propranolol hcl TABS Tier 1bisoprolol & Tier 110mg, 20mg, 40mg, 60mg, 80mghydrochlorothiazide tab 2.5-timolol maleate TABS 5mg, Tier 2
atenolol & chlorthalidone tab Tier 1INDERAL LA) CP24 60mg, 80mg, 120mg, 160mg50-25 mg (generic of TENORETIC 50)80mg, 120mg, 160mgatenolol & chlorthalidone tab Tier 1 100-25 mg (generic of TENORETIC 100)20mg/5ml, 40mg/5mlbisoprolol &10mg, 20mg, 40mg, 60mg, 80mg
50-25 mg (generic of TENORETIC 50)       80mg, 120mg, 160mg         atenolol & chlorthalidone tab Tier 1       20mg/5ml, 40mg/5ml         100-25 mg (generic of TENORETIC 100)       propranolol hcl TABS Tier 1         bisoprolol & Tier 1       80mg
TENORETIC 50)  atenolol & chlorthalidone tab Tier 1  100-25 mg (generic of propranolol hcl TABS Tier 1  TENORETIC 100)  bisoprolol & Tier 1  propranolol hcl TABS Tier 1  10mg, 20mg, 40mg, 60mg, 80mg
atenolol & chlorthalidone tab Tier 1  100-25 mg (generic of propranolol hcl TABS Tier 1  TENORETIC 100)  bisoprolol & Tier 1  20mg/5ml, 40mg/5ml propranolol hcl TABS Tier 1  10mg, 20mg, 40mg, 60mg, 80mg
100-25 mg (generic of TENORETIC 100)       propranolol hcl TABS       Tier 1         bisoprolol & Tier 1       10mg, 20mg, 40mg, 60mg, 80mg
TENORETIC 100)         10mg, 20mg, 40mg, 60mg,           bisoprolol &         Tier 1           80mg
bisoprolol & Tier 1 80mg
<u> </u>
Trydrochlorothlazac tab 2.5- timolor maleate TABS 5mg, Tier 2
6.25 mg 10mg, 20mg
bisoprolol & Tier 1 CALCIUM CHANNEL BLOCKERS
hydrochlorothiazide tab 5- amlodipine besylate Tier 1
6.25 mg (generic of NORVASC)
bisoprolol & Tier 1 TABS 2.5mg, 5mg
hydrochlorothiazide tab 10- amlodipine besylate TABS Tier 1
<u>6.25 mg</u> 10mg
BETA-BLOCKERS cartia xt (generic of Tier 1
acebutolol hcl CAPS Tier 2 CARDIZEM CD) CP24
200mg, 400mg 120mg, 180mg, 240mg,
atenolol (generic of Tier 1 300mg
TENORMIN) TABS 25mg, dilt-xr CP24 120mg, Tier 1
50mg, 100mg 180mg, 240mg
bisoprolol fumarate TABS Tier 1 diltiazem hcl CP12 60mg, Tier 2
5mg, 10mg90mg, 120mgcarvedilol (generic of Tier 1diltiazem hcl SOLNTier 2
COREG) TABS 3.125mg, 25mg/5ml, 50mg/10ml,
6.25mg, 12.5mg, 25mg 125mg/25ml
labetalol hcl TABS 100mg, Tier 2 diltiazem hcl (generic of Tier 1
200mg, 300mg CARDIZEM) TABS 30mg,
metoprolol succinate Tier 1 60mg, 120mg
(generic of TOPROL XL) diltiazem hcl TABS 90mg Tier 1
TB24 25mg, 50mg, 100mg, diltiazem hcl coated beads Tier 1
200mg (generic of CARDIZEM CD)
metoprolol tartrate SOLN Tier 2 CP24 120mg, 180mg,
5mg/5ml 240mg, 300mg
metoprolol tartrate TABS Tier 1 diltiazem hcl coated beads Tier 2
25mg (generic of CARDIZEM CD)
metoprolol tartrate (generic Tier 1CP24 360mgof LOPRESSOR) TABSdiltiazem hol extendedTier 2
50mg, 100mg release beads (generic of nebivolol hcl (generic of Tier 2 QL TIAZAC) CP24 120mg,
BYSTOLIC) TABS 2.5mg, 180mg, 240mg, 300mg,
5mg, 10mg 360mg, 420mg
QL (30 tabs / 30 days) felodipine TB24 2.5mg, Tier 2
nebivolol hcl (generic of Tier 2 QL 5mg, 10mg
BYSTOLIC) TABS 20mg nifedipine TB24 30mg, Tier 2
QL (60 tabs / 30 days) 60mg, 90mg

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
nifedipine (generic of PROCARDIA XL) TB24 30mg, 60mg, 90mg	Tier	2	triamterene & hydrochlorothiazide cap 37.5-25 mg	Tier 1	
nimodipine CAPS 30mg tiadylt er (generic of TIAZAC) CP24 120mg,	Tier Tier		triamterene & hydrochlorothiazide tab 37.5-25 mg	Tier 1	
180mg, 240mg, 300mg, 360mg, 420mg	T:0#		triamterene & hydrochlorothiazide tab 75-50 mg	Tier 1	
verapamil hcl SOLN 2.5mg/ml	Tier		MISCELLANEOUS		
verapamil hcl TABS 40mg, 80mg, 120mg; TBCR 120mg, 180mg, 240mg	Tier	1	aliskiren fumarate (generic of TEKTURNA) TABS 150mg, 300mg	Tier 2	2
DIURETICS acetazolamide CP12 500mg; TABS 125mg,	Tier	2	clonidine (generic of CATAPRES-TTS-1) PTWK .1mg/24hr	Tier 2	2
250mg amiloride & hydrochlorothiazide tab 5-50	Tier	1	clonidine (generic of CATAPRES-TTS-2) PTWK .2mg/24hr	Tier 2	2
mg amiloride hcl TABS 5mg	Tier		clonidine (generic of CATAPRES-TTS-3) PTWK .3mg/24hr	Tier 2	
bumetanide SOLN .25mg/ml; TABS 1mg, 2mg	Tier		clonidine hcl TABS .1mg,	Tier 1	·
bumetanide (generic of BUMEX) TABS .5mg	Tier	2	.2mg, .3mg CORLANOR SOLN	Tier 2	2 QL
chlorthalidone TABS 25mg, 50mg	Tier	1	5mg/5ml QL (450 mL / 30 days)	•	
furosemide SOLN 10mg/ml 40mg/5ml	, Tier	1	digoxin SOLN .05mg/ml digoxin (generic of	Tier 2	
furosemide (generic of LASIX) TABS 20mg, 40mg, 80mg	Tier	1	LANOXIN) SOLN .25mg/ml digoxin (generic of LANOXIN) TABS 125mcg,	Tier 1	QL
furosemide inj SOLN 10mg/ml	Tier	2	250mcg QL (30 tabs / 30 days)		
hydrochlorothiazide CAPS 12.5mg; TABS 12.5mg, 25mg, 50mg	Tier	1	droxidopa (generic of NORTHERA) CAPS 100mg QL (90 caps / 30 days)		
indapamide TABS 1.25mg, 2.5mg			droxidopa (generic of NORTHERA) CAPS	Tier 1	QL NM PA
methazolamide TABS 25mg, 50mg	Tier		200mg, 300mg QL (180 caps / 30 days)		
metolazone TABS 2.5mg, 5mg, 10mg	Tier		epinephrine (anaphylaxis) SOLN 1mg/ml	Tier 2	2
spironolactone & hydrochlorothiazide tab 25-25 mg	Tier		guanfacine hcl TABS 1mg, 2mg		PA
torsemide TABS 5mg, 10mg, 20mg, 100mg	Tier	1 	PA applies if 70 years and older		

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug   Tier	Requirements/ Limits
hydralazine hcl SOLN 20mg/ml	Tier 2	2	sildenafil citrate (pulmonary hypertension) (generic of	Tier 2	QL NM PA
hydralazine hcl TABS 10mg, 25mg, 50mg, 100mg	Tier 1		REVATIO) TABS 20mg QL (360 tabs / 30		
ivabradine hcl (generic of CORLANOR) TABS 5mg,	Tier 2	QL	days) tadalafil (pulmonary	Tier 1	QL NM PA
7.5mg QL (60 tabs / 30 days	)		hypertension) (generic of ADCIRCA) TABS 20mg		
metyrosine (generic of DEMSER) CAPS 250mg	Tier 1	NM PA	QL (60 tabs / 30 days) CENTRAL NERVOUS SY	'STEM	
midodrine hcl TABS 2.5mg 5mg	, Tier 2	2	ANTIANXIETY alprazolam (generic of	Tier 1	QL
midodrine hcl TABS 10mg	Tier 2	2	XANAX) TABS .25mg,	1101 1	QL.
minoxidil TABS 2.5mg, 10mg	Tier 1		.5mg, 1mg, 2mg QL (150 tabs / 30		
ranolazine TB12 500mg, 1000mg	Tier 2		buspirone hcl TABS 5mg,	Tier 1	
VERQUVO TABS 2.5mg, 5mg, 10mg	Tier 2	2 QL PA	10mg, 15mg buspirone hcl TABS 7.5mg,	Tier 2	
QL (30 tabs / 30 days	)		30mg fluvoxamine maleate TABS	Tior 2	
NITRATES isosorbide dinitrate (generic	Tier	<u> </u>	25mg, 50mg, 100mg	1161 2	
of ISORDIL TITRADOSE) TABS 5mg	, 1101 2	-	lorazepam CONC 2mg/ml QL (150 mL / 30 days)	Tier 2	QL
isosorbide dinitrate TABS 10mg, 20mg, 30mg	Tier 2	2	lorazepam (generic of ATIVAN) SOLN 4mg/ml,	Tier 1	
isosorbide mononitrate TABS 10mg, 20mg; TB24 30mg, 60mg, 120mg	Tier 1		20mg/10ml lorazepam (generic of ATIVAN) TABS .5mg, 1mg,	Tier 1	QL
NITRO-BID OINT 2%	Tier 2		2mg QL (150 tabs / 30		
nitroglycerin PT24 .1mg/hr .2mg/hr, .4mg/hr, .6mg/hr	Her 2		days)	T: 0	01
nitroglycerin (generic of NITROSTAT) SUBL .3mg,	Tier 1		lorazepam intensol CONC 2mg/ml QL (150 mL / 30 days)		QL
4mg, .6mg PULMONARY ARTERIA	I HYE	PERTENSION	ANTIDEMENTIA		
alyq (generic of ADCIRCA) TABS 20mg QL (60 tabs / 30 days	Tier 1	QL NM PA	donepezil hydrochloride (generic of ARICEPT) TABS 5mg QL (30 tabs / 30 days)	Tier 1	QL
ambrisentan (generic of LETAIRIS) TABS 5mg, 10mg	Tier 1	QL NM PA	donepezil hydrochloride (generic of ARICEPT) TABS 10mg	Tier 1	
QL (30 tabs / 30 days bosentan (generic of TRACLEER) TABS 62.5mg, 125mg	Tier 1	QL NM PA	donepezil hydrochloride TBDP 5mg QL (30 tabs / 30 days)	Tier 1	QL
QL (60 tabs / 30 days	)		donepezil hydrochloride TBDP 10mg	Tier 1	

Drug Name	Drug Tier	Requirements/ Limits
galantamine hydrobromide CP24 8mg, 16mg, 24mg QL (30 caps / 30 days)	Tier 2	QL
galantamine hydrobromide SOLN 4mg/ml QL (200 mL / 30 days)	Tier 2	. QL
galantamine hydrobromide TABS 4mg, 8mg, 12mg QL (60 tabs / 30 days)		
memantine hcl CP24 7mg; SOLN 2mg/ml PA applies if 29 years and younger		PA
memantine hcl (generic of NAMENDA XR) CP24 14mg, 21mg, 28mg PA applies if 29 years and younger	Tier 2	PA
memantine hcl TABS 5mg, 10mg PA applies if 29 years and younger		PA
NAMZARIC CAP 7-10MG	Tier 2	
NAMZARIC CAP 14-10MG	Tier 2	
NAMZARIC CAP 21-10MG	Tier 2	<u> </u>
NAMZARIC CAP 28-10MG	Tier 2	
NAMZARIC CAP PACK	Tier 2	
rivastigmine (generic of EXELON) PT24 4.6mg/24hr, 9.5mg/24hr, 13.3mg/24hr QL (30 patches / 30 days)	Tier 2	. QL
rivastigmine tartrate CAPS 1.5mg, 3mg, 4.5mg, 6mg QL (60 caps / 30 days)		QL
ANTIDEPRESSANTS		
amitriptyline hcl TABS 10mg, 25mg, 50mg, 75mg, 100mg, 150mg	Tier 2	
amoxapine TABS 25mg,	Tier 2	
50mg, 100mg, 150mg AUVELITY TAB 45-105MG QL (60 tabs / 30 days)	Tier 2	QL PA
bupropion hcl TABS 75mg, 100mg	Tier 1	

Drug Name	Drug Tier	Requirements/ Limits
bupropion hcl (generic of WELLBUTRIN SR) TB12 100mg, 150mg, 200mg QL (60 tabs / 30 days)	Tier 1	QL
bupropion hcl (generic of WELLBUTRIN XL) TB24 150mg QL (60 tabs / 30 days)	Tier 1	QL
bupropion hcl (generic of WELLBUTRIN XL) TB24 300mg QL (30 tabs / 30 days)	Tier 1	QL
citalopram hydrobromide SOLN 10mg/5ml	Tier 2	
citalopram hydrobromide (generic of CELEXA) TABS 10mg, 20mg, 40mg	Tier 1	
clomipramine hcl (generic of ANAFRANIL) CAPS 25mg, 50mg, 75mg	Tier 2	PA
desipramine hcl (generic of NORPRAMIN) TABS 10mg 25mg		
desipramine hcl TABS 50mg, 75mg, 100mg, 150mg	Tier 2	
desvenlafaxine succinate (generic of PRISTIQ) TB24 25mg, 50mg, 100mg QL (30 tabs / 30 days)	Tier 2	QL
doxepin hcl CAPS 10mg, 25mg, 50mg, 75mg, 100mg, 150mg; CONC 10mg/ml	Tier 2	
DRIZALMA SPRINKLE CSDR 20mg, 30mg, 40mg, 60mg QL (60 caps / 30 days)	Tier 2	QL PA
duloxetine hcl (generic of CYMBALTA) CPEP 20mg, 30mg, 60mg QL (60 caps / 30 days)	Tier 2	QL
EMSAM PT24 6mg/24hr, 9mg/24hr, 12mg/24hr QL (30 patches / 30 days)	Tier 2	QL PA
escitalopram oxalate SOLN 5mg/5ml	Tier 2	

Drug Name	Drug Tier	Requirements/ Limits
escitalopram oxalate	Tier 1	
(generic of LEXAPRO)		
TABS 5mg, 10mg, 20mg	_	
FETZIMA CP24 20mg,	Tier 2	QL PA
40mg		
QL (60 caps / 30 days)		
FETZIMA CP24 80mg,	Tier 2	QL PA
120mg		
QL (30 caps / 30 days) FETZIMA CAP TITRATIO		OL DA
	Tier 2	QL PA
QL (2 packs / year)	Tier 1	
fluoxetine hcl (generic of	nen i	
PROZAC) CAPS 10mg, 20mg, 40mg		
fluoxetine hcl SOLN	Tier 2	
20mg/5ml	1161 2	
imipramine hcl TABS 10mg	Tier 1	
25mg, 50mg	, 1101 1	
MARPLAN TABS 10mg	Tier 2	QL
QL (180 tabs / 30	1101 2	<u> </u>
days)		
mirtazapine TABS 7.5mg	Tier 2	
mirtazapine (generic of	Tier 1	<u>.                                    </u>
REMERON) TABS 15mg,		
30mg		
mirtazapine TABS 45mg	Tier 1	
mirtazapine (generic of	Tier 2	
REMERON SOLTAB)		
TBDP 15mg, 30mg, 45mg		
nefazodone hcl TABS	Tier 2	
50mg, 100mg, 150mg,		
200mg, 250mg		
nortriptyline hcl (generic of	Tier 1	
PAMELOR) CAPS 10mg,		
25mg, 50mg, 75mg		
nortriptyline hcl SOLN	Tier 2	
10mg/5ml	<del></del>	01.04
paroxetine hcl (generic of	Tier 2	QL PA
PAXIL) SUSP 10mg/5ml		
QL (900 mL / 30 days)	T: 0 # 4	
paroxetine hcl (generic of	Tier 1	
PAXIL) TABS 10mg, 20mg, 30mg, 40mg		
phenelzine sulfate (generic	Tior 2	1
of NARDIL) TABS 15mg	i i <del>c</del> i Z	
protriptyline hcl TABS 5mg,	Tier 2	
10mg	1101 2	•

Drug Name	Drug Tier	Requirements/ Limits
sertraline hcl (generic of ZOLOFT) CONC 20mg/ml	Tier 2	
sertraline hcl (generic of ZOLOFT) TABS 25mg, 50mg, 100mg	Tier 1	
tranylcypromine sulfate (generic of PARNATE) TABS 10mg	Tier 2	
trazodone hcl TABS 50mg, 100mg, 150mg	Tier 1	
trimipramine maleate CAPS 25mg, 50mg QL (120 caps / 30 days)	Tier 2	QL
trimipramine maleate CAPS 100mg		QL
QL (60 caps / 30 days) TRINTELLIX TABS 5mg, 10mg, 20mg QL (30 tabs / 30 days)	Tier 2	QL PA
venlafaxine hcl (generic of EFFEXOR XR) CP24 37.5mg, 75mg, 150mg	Tier 1	
venlafaxine hcl TABS 25mg, 37.5mg, 50mg, 75mg, 100mg	Tier 2	
vilazodone hcl (generic of VIIBRYD) TABS 10mg, 20mg, 40mg QL (30 tabs / 30 days)	Tier 2	QL
ZURZUVAE CAPS 20mg, 25mg QL (28 caps / 14 days)		QL NM PA
ZURZUVAE CAPS 30mg QL (14 caps / 14 days)	Tier 2	
ANTIPARKINSONIAN AC		
amantadine hcl CAPS 100mg QL (120 caps / 30 days)	Tier 2	QL
amantadine hcl SOLN 50mg/5ml	Tier 2	
benztropine mesylate SOLN 1mg/ml	Tier 2	
benztropine mesylate TABS .5mg, 1mg, 2mg PA applies if 70 years and older		PA

Drug Name	Drug Tier	Requirements/ Limits
bromocriptine mesylate (generic of PARLODEL) TABS 2.5mg	Tier 2	
carb/levo orally disintegrating tab 10-100mg	Tier 2	
carb/levo orally disintegrating tab 25-100mg	Tier 2	
carb/levo orally disintegrating tab 25-250mg	Tier 2	
carbidopa & levodopa tab 10-100 mg (generic of SINEMET)	Tier 1	
carbidopa & levodopa tab 25-100 mg (generic of SINEMET)	Tier 1	
carbidopa & levodopa tab 25-250 mg	Tier 1	
carbidopa & levodopa tab er 25-100 mg	Tier 2	
carbidopa & levodopa tab er 50-200 mg	_	
carbidopa-levodopa- entacapone tabs 12.5-50- 200 mg	Tier 2	
carbidopa-levodopa- entacapone tabs 18.75-75- 200 mg	Tier 2	
carbidopa-levodopa- entacapone tabs 25-100- 200 mg	Tier 2	
carbidopa-levodopa- entacapone tabs 31.25-125- 200 mg	Tier 2	
carbidopa-levodopa- entacapone tabs 37.5-150- 200 mg	Tier 2	
carbidopa-levodopa- entacapone tabs 50-200- 200 mg	Tier 2	
entacapone TABS 200mg	Tier 2	
INBRIJA CAPS 42mg QL (300 caps / 30 days)	Tier 2	QL NM PA
pramipexole dihydrochloride TABS .125mg, .25mg, .5mg, .75mg, 1mg, 1.5mg		

Drug Name	Drug Tier	Requirements/ Limits
rasagiline mesylate (generic of AZILECT) TABS .5mg, 1mg	Tier 2	QL
QL (30 tabs / 30 days)		
ropinirole hydrochloride TABS .25mg, .5mg, 1mg, 2mg, 3mg, 4mg, 5mg	Tier 1	
selegiline hcl CAPS 5mg; TABS 5mg	Tier 2	
trihexyphenidyl hcl SOLN .4mg/ml PA applies if 70 years and	Tier 2	PA
older trihexyphenidyl hcl TABS 2mg, 5mg	Tier 1	PA
PA applies if 70 years and older		
ANTIPSYCHOTICS  aripiprazole SOLN 1mg/ml QL (900 mL / 30 days)	Tier 2	QL
aripiprazole (generic of ABILIFY) TABS 2mg, 5mg, 10mg, 15mg, 20mg, 30mg QL (30 tabs / 30 days)	Tier 2	. QL
aripiprazole TBDP 10mg, 15mg QL (60 tabs / 30 days)	Tier 2	QL ST
ARISTADA PRSY 441mg/1.6ml, 662mg/2.4ml, 882mg/3.2ml QL (1 syringe / 28 days)	Tier 2	. QL
ARISTADA PRSY 1064mg/3.9ml QL (1 syringe / 56 days)	Tier 2	QL
ARISTADA INITIO PRSY 675mg/2.4ml	Tier 2	!
asenapine maleate (generic of SAPHRIS) SUBL 2.5mg, 5mg, 10mg QL (60 tabs / 30 days)	Tier 2	. QL
CAPLYTA CAPS 10.5mg, 21mg, 42mg QL (30 caps / 30 days)		QL

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
chlorpromazine hcl CONC 30mg/ml, 100mg/ml; SOLN 25mg/ml, 50mg/2ml; TABS 10mg, 25mg, 50mg, 100mg			haloperidol decanoate (generic of HALDOL DECANOATE 100) SOLN 100mg/ml	Tier 2	
200mg clozapine (generic of	Tier 2	<u> </u>	haloperidol lactate CONC 2mg/ml; SOLN 5mg/ml	Tier 2	
CLOZARIL) TABS 25mg, 50mg	Tion 0	<u> </u>	INVEGA HAFYERA SUSY 1092mg/3.5ml, 1560mg/5ml		2 QL
clozapine (generic of CLOZARIL) TABS 100mg QL (270 tabs / 30 days)	Tier 2	. QL	QL (1 injection / 180 days) INVEGA SUSTENNA SUSY 39mg/0.25ml,	Tier 2	QL
clozapine (generic of CLOZARIL) TABS 200mg QL (120 tabs / 30 days)	Tier 2	QL	78mg/0.5ml, 117mg/0.75ml, 156mg/ml, 234mg/1.5ml QL (1 syringe / 28 days)		
clozapine TBDP 12.5mg, 25mg	Tier 2	PA	INVEGA TRINZA SUSY 273mg/0.88ml,	Tier 2	2 QL
clozapine TBDP 100mg QL (270 tabs / 30 days)	Tier 2	QL PA	410mg/1.32ml, 546mg/1.75ml, 819mg/2.63ml		
clozapine TBDP 150mg QL (180 tabs / 30 days)	Tier 2	. QL PA	QL (1 syringe / 90 days) loxapine succinate CAPS	Tier 2	<u> </u>
clozapine TBDP 200mg QL (120 tabs / 30 days)	Tier 2	QL PA	5mg, 10mg, 25mg, 50mg  Iurasidone hcl (generic of LATUDA) TABS 20mg,	Tier 2	
FANAPT TABS 1mg, 2mg, 4mg, 6mg, 8mg, 10mg,	Tier 2	QL PA	40mg, 60mg, 120mg QL (30 tabs / 30 days)	•	
12mg QL (60 tabs / 30 days)		01.04	lurasidone hcl (generic of LATUDA) TABS 80mg	Tier 2	2 QL
FANAPT PAK  QL (2 packs / year)  fluphenazine decanoate	Tier 2	<del>_</del>	QL (60 tabs / 30 days) molindone hcl TABS 5mg, 10mg, 25mg	Tier 2	<u>)</u>
SOLN 25mg/ml fluphenazine hcl CONC	Tier 2		NUPLAZID CAPS 34mg QL (30 caps / 30 days		QL NM PA
5mg/ml; ELIX 2.5mg/5ml; SOLN 2.5mg/ml; TABS	1101 2	•	NUPLAZID TABS 10mg QL (30 tabs / 30 days)	Tier 2	QL NM PA
1mg, 2.5mg, 5mg, 10mg haloperidol TABS .5mg, 1mg, 2mg, 5mg, 10mg,	Tier 2	<u> </u>	olanzapine (generic of ZYPREXA) SOLR 10mg QL (3 vials / 1 day)	Tier 2	2 QL
20mg haloperidol decanoate	Tier 2	1	olanzapine (generic of ZYPREXA) TABS 2.5mg,	Tier 2	2 QL
(generic of HALDOL DECANOATE 50) SOLN			5mg, 10mg QL (60 tabs / 30 days)	•	·
50mg/ml			olanzapine (generic of ZYPREXA) TABS 7.5mg, 15mg, 20mg QL (30 tabs / 30 days)	Tier 2	QL

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
olanzapine (generic of ZYPREXA ZYDIS) TBDP 5mg, 15mg, 20mg QL (30 tabs / 30 days)	Tier 2	QL ST	risperidone (generic of RISPERDAL) SOLN 1mg/ml QL (240 mL / 30 days)	Tier 2	QL
olanzapine (generic of ZYPREXA ZYDIS) TBDP 10mg	Tier 2	QL ST	risperidone (generic of RISPERDAL) TABS .5mg, 1mg, 2mg, 3mg, 4mg	Tier 1	
QL (60 tabs / 30 days)			risperidone TABS .25mg	Tier 1	
paliperidone TB24 1.5mg QL (30 tabs / 30 days)		· 	risperidone TBDP 1mg, 2mg, 3mg	Tier 2	2 QLST
paliperidone (generic of INVEGA) TB24 3mg, 9mg QL (30 tabs / 30 days	Tier 2	· 	QL (60 tabs / 30 days) risperidone TBDP 4mg QL (120 tabs / 30	Tier 2	QL ST
paliperidone (generic of INVEGA) TB24 6mg QL (60 tabs / 30 days)	Tier 2	2 QL	days)  risperidone TBDP .25mg, .5mg	Tier 2	2 QL ST
perphenazine TABS 2mg,	Tier 2	<u> </u>	QL (90 tabs / 30 days)	)	
4mg, 8mg, 16mg pimozide TABS 1mg, 2mg	Tier 2	<u> </u>	risperidone microspheres (generic of RISPERDAL	Tier 2	2 QL
quetiapine fumarate (generic of SEROQUEL) TABS 25mg QL (180 tabs / 30	Tier 2	<del>.</del>	CONSTA) SRER 12.5mg, 25mg, 37.5mg, 50mg QL (2 injections / 28 days)		
days) quetiapine fumarate (generic of SEROQUEL) TABS 50mg, 100mg, 200mg QL (90 tabs / 30 days)	_	2 QL	SECUADO PT24 3.8mg/24hr, 5.7mg/24hr, 7.6mg/24hr QL (30 patches / 30 days)	Tier 2	2 QL
quetiapine fumarate TABS 150mg		2 QL	thioridazine hcl TABS 10mg, 25mg, 50mg, 100mg	Tier 2	
QL (90 tabs / 30 days) quetiapine fumarate	) Tier 2	2 QL	thiothixene CAPS 1mg, 2mg, 5mg, 10mg	Tier 2	2
(generic of SEROQUEL) TABS 300mg, 400mg			trifluoperazine hcl TABS 1mg, 2mg, 5mg, 10mg	Tier 2	2
QL (60 tabs / 30 days) quetiapine fumarate (generic of SEROQUEL XR	Tier 2	2 QL PA	VERSACLOZ SUSP 50mg/ml QL (600 mL / 30 days)	Tier 2	2 QL PA
TB24 50mg, 300mg, 400mg QL (60 tabs / 30 days	•		VRAYLAR CAPS 1.5mg QL (60 caps / 30 days	Tier 2	QL
quetiapine fumarate (generic of SEROQUEL XR TB24 150mg, 200mg	Tier 2	2 QL PA	VRAYLAR CAPS 3mg, 4.5mg, 6mg QL (30 caps / 30 days	Tier 2	2 QL
QL (30 tabs / 30 days) REXULTI TABS 3mg, 4mg		2 QL	VRAYLAR CAP 1.5-3MG QL (2 packs / year)	Tier 2	2 QL
QL (30 tabs / 30 days REXULTI TABS .25mg, .5mg, 1mg, 2mg QL (60 tabs / 30 days	Tier 2		ziprasidone hcl (generic of GEODON) CAPS 20mg, 40mg, 60mg, 80mg QL (60 caps / 30 days	Tier 2	2 QL

Drug Name	Drug Tier	Requirements/ Limits
ziprasidone mesylate (generic of GEODON) SOLR 20mg QL (6 injections / 3	Tier 2	QL
days)		
ZYPREXA RELPREVV SUSR 210mg, 300mg QL (2 vials / 28 days)	Tier 2	QL NM PA
ZYPREXA RELPREVV SUSR 405mg	Tier 2	QL NM PA
QL (1 vial / 28 days)  ANTISEIZURE AGENTS		,
APTIOM TABS 200mg, 400mg	Tier 2	QL
QL (30 tabs / 30 days) APTIOM TABS 600mg,	Tier 2	QL
800mg QL (60 tabs / 30 days)		QL
BRIVIACT SOLN 10mg/ml QL (600 mL / 30 days)	Tier 2	QL PA
BRIVIACT TABS 10mg, 25mg, 50mg, 75mg, 100mg QL (60 tabs / 30 days)	Tier 2	QL PA
carbamazepine CHEW 100mg	Tier 2	
carbamazepine (generic of CARBATROL) CP12 100mg, 200mg, 300mg	Tier 2	
carbamazepine (generic of TEGRETOL) SUSP 100mg/5ml	Tier 2	
carbamazepine (generic of TEGRETOL) TABS 200mg	Tier 2	
carbamazepine (generic of TEGRETOL-XR) TB12 100mg, 200mg, 400mg	Tier 2	
clobazam (generic of ONFI) SUSP 2.5mg/ml QL (480 mL / 30 days)		QL PA
clobazam (generic of ONFI) TABS 10mg, 20mg QL (60 tabs / 30 days)		QL PA
clonazepam (generic of KLONOPIN) TABS 2mg QL (300 tabs / 30 days)	Tier 1	QL

	Drug Tier	Requirements/ Limits
KLONOPIN) TABS .5mg, 1mg	Tier 1	QL
QL (90 tabs / 30 days)		<u> </u>
clonazepam TBDP 2mg QL (300 tabs / 30 days)	Tier 2	. QL
clonazepam TBDP .125mg, .25mg, .5mg, 1mg QL (90 tabs / 30 days)	Tier 2	QL
clorazepate dipotassium TABS 3.75mg, 7.5mg, 15mg QL (180 tabs / 30 days) PA applies if 65 years and	Tier 2	QL PA
older		
DIACOMIT CAPS 250mg QL (360 caps / 30 days)	Tier 2	QL NM PA
DIACOMIT CAPS 500mg QL (180 caps / 30 days)	Tier 2	QL NM PA
	Tier 2	QL NM PA
	Tier 2	2 QL NM PA
diazepam SOLN 5mg/5ml QL (1200 mL / 30 days) PA applies if 65 years and older when greater than 5	Tier 2	QL PA
day supply diazepam (generic of VALIUM) TABS 2mg, 5mg,	Tier 1	QL PA
10mg QL (120 tabs / 30 days)		
PA applies if 65 years and older when greater than 5 day supply		
diazepam (anticonvulsant) GEL 2.5mg, 10mg, 20mg	Tier 2	
diazepam inj SOLN 5mg/ml	Tier 2	<u>'</u>

Drug Name	Drug Tier	Requirements/ Limits	Drug
diazepam intensol CONC 5mg/ml	Tier 2	QL PA	gaba NEU
QL (240 mL / 30 days PA applies if 65 years and older when greater than 5	d		400n
day supply			gaba
DILANTIN CAPS 30mg	Tier 2	_	NEU
divalproex sodium (generic of DEPAKOTE SPRINKLES) CSDR 125mg	Tier 2		250n
divalproex sodium (generic		<del></del>	gaba
of DEPAKOTE ER) TB24			ŇEU
250mg, 500mg			600n
divalproex sodium (generic	Tier 1		
of DEPAKOTE) TBEC			anha
125mg, 250mg, 500mg	T: 0	OL NIM DA	gaba NEU
EPIDIOLEX SOLN 100mg/ml	Tier 2	QL NM PA	800n
QL (600 mL / 30 days	)		00011
epitol (generic of	Tier 2	-	
TEGRETOL) TABS 200mg			lacos
EPRONTIA SOLN 25mg/m		QL PA	VIME
QL (480 mL / 30 days			200n
ethosuximide (generic of	Tier 2		lacos
ZARONTIN) CAPS 250mg;	;		VIMF
SOLN 250mg/5ml			
felbamate SUSP	Tier 2		lacos
600mg/5ml	T: 0		VIME
felbamate (generic of FELBATOL) TABS 400mg,	Tier 2		150n
600mg			
FINTEPLA SOLN 2.2mg/m	l Tier 2	QL NM PA	lacos
QL (360 mL / 30 days		Q211111171	VIME
FYCOMPA SUSP .5mg/ml		QL PA	
QL (720 mL / 30 days			
FYCOMPA TABS 2mg	Tier 2	QL PA	lamo
QL (60 tabs / 30 days)	)	<u> </u>	LAM DISF
FYCOMPA TABS 4mg,	Tier 2	QL PA	25mg
6mg, 8mg, 10mg, 12mg			lamo
QL (30 tabs / 30 days)		01	LAM
gabapentin (generic of NEURONTIN) CAPS	Tier 1	QL	100n
100mg, 300mg			levet
QL (360 caps / 30			KEP
days)			levet
			KEP

	Drug Name	Drug Tier	Requirements/ Limits
	gabapentin (generic of NEURONTIN) CAPS 400mg QL (270 caps / 30 days)	Tier 1	QL
_	gabapentin (generic of NEURONTIN) SOLN 250mg/5ml, 300mg/6ml QL (2160 mL / 30 days)	Tier 2	QL
_	gabapentin (generic of NEURONTIN) TABS 600mg QL (180 tabs / 30 days)	Tier 1	QL
=	gabapentin (generic of NEURONTIN) TABS 800mg QL (120 tabs / 30 days)	Tier 1	QL
	lacosamide (generic of VIMPAT) SOLN 200mg/20ml	Tier 2	
_	lacosamide (generic of VIMPAT) TABS 50mg QL (120 tabs / 30 days)	Tier 2	QL
_	lacosamide (generic of VIMPAT) TABS 100mg, 150mg, 200mg QL (60 tabs / 30 days)	Tier 2	QL
_	lacosamide oral (generic of VIMPAT) SOLN 10mg/ml QL (1200 mL / 30 days)	Tier 2	QL
_	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 levetiracetam (generic of KEPPRA) SOLN	Tier 2	
_	500mg/5ml		

Drug Name	Drug Requirement Tier Limits	nts/ Drug Name
levetiracetam (generic of KEPPRA) TABS 250mg, 500mg, 750mg, 1000mg levetiracetam in sodium	Tier 1	phenobarbital sodiu SOLN 65mg/ml, 130 PA applies if 70 y older
chloride iv soln 500 mg/100ml (generic of LEVETIRACETAM)		phenytek CAPS 20 300mg phenytoin (generic o
levetiracetam in sodium chloride iv soln 1000	Tier 2	DILANTIN INFATAE CHEW 50mg
mg/100ml (generic of LEVETIRACETAM) levetiracetam in sodium	Tier 2	phenytoin (generic o DILANTIN-125) SU 125mg/5ml
chloride iv soln 1500 mg/100ml (generic of LEVETIRACETAM)		phenytoin sodium \$ 50mg/ml phenytoin sodium e
LIBERVANT FILM 5mg, 7.5mg, 10mg, 12.5mg, 15mg	Tier 2 QL	(generic of DILANTI CAPS 100mg phenytoin sodium e
QL (10 buccal films / 30 days)		CAPS 200mg, 300n pregabalin (generic
methsuximide (generic of CELONTIN) CAPS 300mg	Tier 2	LYRICA) CAPS 250 50mg, 75mg, 100mg
NAYZILAM SOLN 5mg/0.1ml QL (10 nasal units per 30 days)	Tier 2 QL	150mg QL (120 caps days) pregabalin (generic
oxcarbazepine (generic of TRILEPTAL) SUSP 300mg/5ml	Tier 2	LYRICA) CAPS 200 QL (90 caps / pregabalin (generic
oxcarbazepine (generic of TRILEPTAL) TABS 150mg, 300mg, 600mg	Tier 2	LYRICA) CAPS 229 300mg QL (60 caps /
phenobarbital ELIX 20mg/5ml QL (1500 mL / 30 days) PA applies if 70 years and	Tier 2 QL PA	pregabalin (generic LYRICA) SOLN 201 QL (900 mL / 3 primidone (generic of MYSOLINE) TABS
older  phenobarbital TABS 15mg,	Tier 2 QL PA	250mg primidone TABS 12
16.2mg, 30mg, 32.4mg, 60mg, 64.8mg, 97.2mg, 100mg		roweepra (generic of KEPPRA) TABS 50
QL (120 tabs / 30 days) PA applies if 70 years and	ı	rufinamide (generic BANZEL) SUSP 40 QL (2400 mL /
older	•	days) 

Drug Name	Drug Tier	Requirements/ Limits
phenobarbital sodium SOLN 65mg/ml, 130mg/ml PA applies if 70 years and older	Tier 2	PA
phenytek CAPS 200mg, 300mg	Tier 2	
phenytoin (generic of DILANTIN INFATABS) CHEW 50mg	Tier 2	!
phenytoin (generic of DILANTIN-125) SUSP 125mg/5ml	Tier 2	
phenytoin sodium SOLN 50mg/ml	Tier 2	
phenytoin sodium extended (generic of DILANTIN) CAPS 100mg	Tier 2	
phenytoin sodium extended CAPS 200mg, 300mg	Tier 2	
pregabalin (generic of LYRICA) CAPS 25mg, 50mg, 75mg, 100mg, 150mg QL (120 caps / 30 days)	Tier 2	QL PA
pregabalin (generic of LYRICA) CAPS 200mg QL (90 caps / 30 days)	Tier 2	QL PA
pregabalin (generic of LYRICA) CAPS 225mg, 300mg QL (60 caps / 30 days)	Tier 2	QL PA
pregabalin (generic of LYRICA) SOLN 20mg/ml QL (900 mL / 30 days)	Tier 2	
primidone (generic of MYSOLINE) TABS 50mg, 250mg	Tier 1	
primidone TABS 125mg	Tier 1	
roweepra (generic of KEPPRA) TABS 500mg	Tier 1	
rufinamide (generic of BANZEL) SUSP 40mg/ml QL (2400 mL / 30 days)	Tier 2	QL PA

Drug Name	Drug I Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
rufinamide (generic of BANZEL) TABS 200mg QL (480 tabs / 30 days)	Tier 2	QL PA	VALTOCO 15 MG DOSE LQPK 7.5mg/0.1ml QL (10 blister packs per 30 days)	Tier 2	
rufinamide (generic of BANZEL) TABS 400mg QL (240 tabs / 30 days)	Tier 2	QL PA	VALTOCO 20 MG DOSE LQPK 10mg/0.1ml QL (10 blister packs per 30 days)	Tier 2	QL
SPRITAM TB3D 250mg QL (360 tabs / 30 days)	Tier 2	QL	vigabatrin (generic of SABRIL) PACK 500mg QL (180 packets / 30	Tier 1	QL NM PA
SPRITAM TB3D 500mg QL (180 tabs / 30 days) SPRITAM TB3D 750mg	Tier 2	QL QL	days) vigabatrin (generic of SABRIL) TABS 500mg QL (180 tabs / 30	Tier 1	QL NM PA
QL (120 tabs / 30 days) SPRITAM TB3D 1000mg QL (90 tabs / 30 days)	Tier 2	QL	days) vigadrone (generic of SABRIL) PACK 500mg QL (180 packets / 30	Tier 1	QL NM PA
subvenite (generic of LAMICTAL) TABS 25mg, 100mg, 150mg, 200mg SYMPAZAN FILM 5mg,	Tier 1	QL PA	days) vigadrone (generic of SABRIL) TABS 500mg QL (180 tabs / 30	Tier 1	QL NM PA
10mg, 20mg QL (60 films / 30 days tiagabine hcl TABS 2mg,			days) VIGAFYDE SOLN 100mg/ml QL (900 mL / 30 days)		2 QL NM PA
4mg, 12mg, 16mg topiramate (generic of TOPAMAX SPRINKLE) CPSP 15mg, 25mg	Tier 2		vigpoder (generic of SABRIL) PACK 500mg QL (180 packets / 30	Tier 1	QL NM PA
topiramate (generic of TOPAMAX) TABS 25mg, 50mg, 100mg, 200mg valproate sodium SOLN	Tier 1		days) XCOPRI TABS 25mg, 50mg, 100mg QL (30 tabs / 30 days)	Tier 2	. QL
100mg/ml valproate sodium SOLN 250mg/5ml	Tier 2		XCOPRI TABS 150mg, 200mg QL (60 tabs / 30 days)	Tier 2	. QL
valproic acid CAPS 250mg		01	XCOPRI PAK 12.5-25 QL (28 tabs / 28 days)	Tier 2	QL
VALTOCO 5 MG DOSE LIQD 5mg/0.1ml QL (10 blister packs	Tier 2	QL	XCOPRI PAK 50-100MG QL (28 tabs / 28 days)	Tier 2	
per 30 days) VALTOCO 10 MG DOSE	Tier 2	QL	XCOPRI PAK 100-150 QL (56 tabs / 28 days)	Tier 2	? QL
LIQD 10mg/0.1ml  QL (10 blister packs per 30 days)		~-	XCOPRI PAK 150-200MG (MAINTENANCE) QL (56 tabs / 28 days)	Tier 2	? QL
F3: 33 88)9)		_	XCOPRI PAK 150-200MG (TITRATION) QL (28 tabs / 28 days)	Tier 2	. QL

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
ZONISADE SUSP 100mg/5ml QL (900 mL / 30 days	Tier 2	QL PA	amphetamine- dextroamphetamine tab 7.5 mg (generic of ADDERALL)	Tier 2	
zonisamide (generic of ZONEGRAN) CAPS 25mg 100mg zonisamide CAPS 50mg	Tier 2	2	QL (60 tabs / 30 days)  amphetamine- dextroamphetamine tab 10 mg (generic of ADDERALL) QL (60 tabs / 30 days)	Tier 2	QL PA
ZTALMY SUSP 50mg/ml QL (1100 mL / 30 days) ATTENTION DEFICIT H DISORDER	YPER		amphetamine- dextroamphetamine tab 12.5 mg (generic of ADDERALL) QL (60 tabs / 30 days)	Tier 2	2 QL PA
amphetamine- dextroamphetamine cap er 24hr 5 mg (generic of ADDERALL XR) QL (30 caps / 30 days	Tier 2	2 QL PA	amphetamine- dextroamphetamine tab 15 mg (generic of ADDERALL) QL (60 tabs / 30 days)	Tier 2	
amphetamine- dextroamphetamine cap er 24hr 10 mg (generic of ADDERALL XR)	Tier 2	QL PA	amphetamine- dextroamphetamine tab 20 mg (generic of ADDERALL) QL (90 tabs / 30 days)	•	
QL (30 caps / 30 days amphetamine- dextroamphetamine cap er 24hr 15 mg (generic of	5) Tier 2	2 QL PA	amphetamine- dextroamphetamine tab 30 mg (generic of ADDERALL) QL (60 tabs / 30 days)		
ADDERALL XR) QL (30 caps / 30 days amphetamine- dextroamphetamine cap er	S)_ Tier 2	QL PA	atomoxetine hcl (generic of STRATTERA) CAPS 10mg 18mg, 25mg QL (120 caps / 30 days)		2 QL
24hr 20 mg (generic of ADDERALL XR) QL (30 caps / 30 days	s) Tier 2	2 QL PA	atomoxetine hcl (generic of STRATTERA) CAPS 40mg QL (60 caps / 30 days		QL
amphetamine- dextroamphetamine cap er 24hr 25 mg (generic of ADDERALL XR) QL (30 caps / 30 days		. QLFA	atomoxetine hcl (generic of STRATTERA) CAPS 60mg 80mg, 100mg QL (30 caps / 30 days	Tier 2	2 QL
amphetamine- dextroamphetamine cap er 24hr 30 mg (generic of ADDERALL XR) QL (30 caps / 30 days	Tier 2	QL PA	dexmethylphenidate hcl (generic of FOCALIN) TABS 2.5mg, 5mg QL (120 tabs / 30 days)	Tier 2	QL PA
amphetamine- dextroamphetamine tab 5 mg (generic of ADDERALL) QL (60 tabs / 30 days	Tier 2	QL PA	dexmethylphenidate hcl (generic of FOCALIN) TABS 10mg QL (60 tabs / 30 days)	Tier 2	QL PA

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
guanfacine hcl (adhd) (generic of INTUNIV) TB24 1mg, 2mg, 4mg QL (30 tabs / 30 days) PA applies if 70 years and older			temazepam (generic of RESTORIL) CAPS 7.5mg, 30mg QL (30 caps / 30 days) PA applies if 65 years and older	Tier 2	
guanfacine hcl (adhd) (generic of INTUNIV) TB24 3mg QL (60 tabs / 30 days) PA applies if 70 years and older		QL PA	temazepam (generic of RESTORIL) CAPS 15mg QL (60 caps / 30 days) PA applies if 65 years and older		
methylphenidate hcl (generic of METHYLIN) SOLN 5mg/5ml QL (1800 mL / 30 days)	Tier 2	QL PA	zolpidem tartrate (generic of 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	9	QL PA
methylphenidate hcl (generic of METHYLIN) SOLN 10mg/5ml QL (900 mL / 30 days)	Tier 2	QL PA	MIGRAINE	Tier 2	2 QL NM PA
methylphenidate hcl (generic of RITALIN) TABS 5mg, 10mg QL (180 tabs / 30 days)	Tier 2	QL PA	dihydroergotamine mesylate SOLN 1mg/ml dihydroergotamine mesylate (generic of MIGRANAL) SOLN 4mg/ml		
methylphenidate hcl (generic of RITALIN) TABS 20mg QL (90 tabs / 30 days)		QL PA	QL (8 mL / 30 days) EMGALITY SOAJ 120mg/ml	Tier 2	2 QL NM PA
methylphenidate hcl TBCR 10mg, 20mg QL (90 tabs / 30 days)	Tier 2	QL PA	QL (2 pens / 30 days) EMGALITY SOSY 100mg/ml QL (3 syringes / 30	Tier 2	2 QL NM PA
DAYVIGO TABS 5mg, 10mg QL (30 tabs / 30 days)		QL	days) EMGALITY SOSY 120mg/ml QL (2 syringes / 30	Tier 2	2 QL NM PA
doxepin hcl (sleep) (generic of SILENOR) TABS 3mg, 6mg QL (30 tabs / 30 days)		QL	days) ergotamine w/ caffeine tab 1-100 mg QL (40 tabs / 28 days)	Tier 2	QL PA
tasimelteon (generic of HETLIOZ) CAPS 20mg	Tier 1	QL NM PA	NURTEC TBDP 75mg QL (16 tabs / 30 days)	Tier 2	QL PA
QL (30 caps / 30 days	)		QULIPTA TABS 10mg, 30mg, 60mg QL (30 tabs / 30 days)	Tier 2	QL PA
			rizatriptan benzoate TABS 5mg; TBDP 5mg QL (18 tabs / 30 days)	Tier 2	2 QL

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
rizatriptan benzoate (generi of MAXALT) TABS 10mg QL (18 tabs / 30 days		2 QL	AUSTEDO XR TB24 12mg QL (120 tabs / 30 days)	Tier 2	QL NM PA
rizatriptan benzoate (generi of MAXALT-MLT) TBDP 10mg		QL	AUSTEDO XR TB24 18mg, 24mg QL (60 tabs / 30 days)	Tier 2	QL NM PA
QL (18 tabs / 30 days sumatriptan SOLN 5mg/ac QL (24 units / 30 days	t Tier 2	QL	AUSTEDO XR TB24 30mg, 36mg, 42mg, 48mg QL (30 tabs / 30 days)	Tier 2	QL NM PA
sumatriptan SOLN 20mg/act QL (12 units / 30 days	Tier 2	2 QL	AUSTEDO XR TAB TITR KIT QL (2 packs / year)	Tier 2	QL NM PA
sumatriptan succinate SOAJ 4mg/0.5ml; SOCT 4mg/0.5ml QL (18 injections / 30 days)	Tier 2	? QL	lithium SOLN 8meq/5ml lithium carbonate CAPS 150mg, 300mg, 600mg; TABS 300mg; TBCR 450mg lithium carbonate (generic of		
sumatriptan succinate (generic of IMITREX STATDOSE SYSTEM) SOAJ 6mg/0.5ml QL (12 injections / 30	Tier 2	? QL	LITHOBID) TBCR 300mg  NUEDEXTA CAP 20-10MG  QL (60 caps / 30 days)  pyridostigmine bromide (generic of MESTINON)	Tier 2	QL PA
days) sumatriptan succinate (generic of IMITREX	Tier 2	? QL	TABS 60mg  riluzole TABS 50mg  tetrabenazine (generic of	Tier 2	QL NM PA
STATDOSE REFILL) SOCT 6mg/0.5ml QL (12 injections / 30 days)			XENAZINE) TABS 12.5mg QL (90 tabs / 30 days) tetrabenazine (generic of		QL NM PA
sumatriptan succinate SOLN 6mg/0.5ml QL (12 injections / 30	Tier 2	QL	XENAZINE) TABS 25mg QL (120 tabs / 30 days)		
days)			MULTIPLE SCLEROSIS		
sumatriptan succinate (generic of IMITREX) TABS 25mg, 50mg, 100mg	Tier 1	QL	BAFIERTAM CPDR 95mg QL (120 caps / 30 days)	Tier 2	? QL NM PA
QL (12 tabs / 30 days UBRELVY TABS 50mg,	Tier 2	QL PA	BETASERON KIT .3mg QL (14 syringes / 28 days)	Tier 2	QL NM PA
100mg QL (16 tabs / 30 days <b>MISCELLANEOUS</b>	)	<del>.</del>	COPAXONE SOSY 20mg/ml	Tier 2	QL NM PA
AUSTEDO TABS 6mg QL (60 tabs / 30 days		QL NM PA	QL (30 syringes / 30 days)  COPAXONE SOSY	Tier 2	2 QL NM PA
AUSTEDO TABS 9mg, 12mg QL (120 tabs / 30 days)	Tier 2	2 QL NM PA	40mg/ml QL (12 syringes / 28 days)	1101 2	. QLINIVIFA
AUSTEDO XR TB24 6mg QL (90 tabs / 30 days		2 QL NM PA			

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
dalfampridine (generic of AMPYRA) TB12 10mg	Tier 2	QL NM PA	armodafinil (generic of NUVIGIL) TABS 150mg,	Tier 2	QL PA
QL (60 tabs / 30 days) fingolimod hcl (generic of	Tier 1	QL NM PA	200mg, 250mg QL (30 tabs / 30 days)		
GILENYA) CAPS .5mg	i iei i	QL MINI FA	modafinil (generic of	Tier 2	QL PA
QL (30 caps / 30 days		OL NIM DA	PROVIGIL) TABS 100mg		. QLIA
glatiramer acetate (generic of COPAXONE) SOSY	Tier 1	QL NM PA	QL (30 tabs / 30 days) modafinil (generic of	Tier 2	2 QL PA
20mg/ml			PROVIGIL) TABS 200mg	1161 2	QLFA
QL (30 syringes / 30			QL (60 tabs / 30 days)		
days)			SODIUM OXYBATE SOLN		QL NM PA
glatiramer acetate (generic	Tier 1	QL NM PA	500mg/ml		
of COPAXONE) SOSY			QL (540 mL / 30 days)	)	
40mg/ml			<b>PSYCHOTHERAPEUTIC</b>	-MISC	
QL (12 syringes / 28			acamprosate calcium TBE0	CTier 2	<u> </u>
days)			333mg		
glatopa (generic of	Tier 1	QL NM PA	buprenorphine hcl SUBL	Tier 2	2 QL
COPAXONE) SOSY			2mg, 8mg		
20mg/ml			QL (90 tabs / 30 days)	•	
QL (30 syringes / 30 days)			buprenorphine hcl-naloxone	Tier 2	2 QL
glatopa (generic of	Tier 1	QL NM PA	hcl sl film 2-0.5 mg (base		
COPAXONE) SOSY	1101 1	QL IVIII / (	<i>equiv)</i> (generic of SUBOXONE)		
40mg/ml			QL (90 films / 30 days	١	
QL (12 syringes / 28			buprenorphine hcl-naloxone		2 QL
days)			hcl sl film 4-1 mg (base		-
OCREVUS SOLN	Tier 2	NM PA	equiv) (generic of		
300mg/10ml			SÚBÓXONE)		
MUSCULOSKELETAL T			QL (90 films / 30 days		
baclofen TABS 5mg	Tier 2	QL	buprenorphine hcl-naloxone	Tier 2	2 QL
QL (90 tabs / 30 days)			hcl sl film 8-2 mg (base		
baclofen TABS 10mg,	Tier 2		equiv) (generic of		
20mg	Tior 2	OL DA	SUBOXONE)	١	
cyclobenzaprine hcl TABS 5mg, 10mg	Her Z	QL PA	QL (90 films / 30 days buprenorphine hcl-naloxone		QL
QL (90 tabs / 30 days)	١		hcl sl film 12-3 mg (base	11012	. QL
PA applies if 70 years and			equiv) (generic of		
older after a 30 day	-		SUBOXONE)		
supply in a calendar year			QL (60 films / 30 days	)	
tizanidine hcl TABS 2mg	Tier 1		buprenorphine hcl-naloxone		QL
tizanidine hcl (generic of	Tier 1		hcl sl tab 2-0.5 mg (base		
ZANAFLEX) TABS 4mg			equiv)		
NARCOLEPSY/CATAPL	EXY		QL (90 tabs / 30 days)		
armodafinil (generic of	Tier 2	QL PA	buprenorphine hcl-naloxone	lier 1	QL
NUVIGIL) TABS 50mg			hcl sl tab 8-2 mg (base		
QL (60 tabs / 30 days)	)		<i>equiv)</i> QL (90 tabs / 30 days)		
			QL (30 labs / 30 days)		

Drug Name	Drug Tier	Requirements/ Limits
bupropion hcl (smoking deterrent) TB12 150mg QL (60 tabs / 30 days)	Tier 1	QL
disulfiram TABS 250mg, 500mg	Tier 2	
naloxone hcl LIQD 4mg/0.1ml	Tier 2	
naloxone hcl SOCT .4mg/ml; SOLN .4mg/ml, 4mg/10ml; SOSY .4mg/ml, 2mg/2ml	Tier 1	
naltrexone hcl TABS 50mg	Tier 2	) -
NICOTROL INHALER INHA 10mg	Tier 2	
NICOTROL NS SOLN 10mg/ml	Tier 2	
varenicline tartrate TABS .5mg, 1mg QL (56 tabs / 28 days)	Tier 2	. QL
varenicline tartrate tab 11 x 0.5 mg & 42 x 1 mg start pack QL (2 packs / year)	Tier 2	QL
VIVITROL SUSR 380mg	Tier 2	. NM
ENDOCRINE AND META ANDROGENS	BOLI	С
danazol CAPS 50mg, 100mg, 200mg	Tier 2	
depo-testosterone SOLN 100mg/ml, 200mg/ml	Tier 2	PA
methyltestosterone CAPS 10mg	Tier 1	QL PA
QL (600 caps / 30 days)		
testosterone GEL 1%, 25mg/2.5gm, 50mg/5gm QL (300 gm / 30 days)	Tier 2	QL PA
testosterone (generic of ANDROGEL PUMP) GEL 1.62% QL (150 gm / 30 days)	Tier 2	QL PA
testosterone cypionate SOLN 100mg/ml, 200mg/ml	Tier 2	PA
testosterone enanthate SOLN 200mg/ml	Tier 2	PA
ANTIDIABETICS	-	-
acarbose TABS 25mg, 50mg, 100mg	Tier 2	2

Drug Name	Drug Tier	Requirements/ Limits
FARXIGA TABS 5mg,	Tier 2	QL
10mg		
QL (30 tabs / 30 days)		
glimepiride TABS 1mg,	Tier 1	QL
2mg		
QL (90 tabs / 30 days)		
glimepiride TABS 4mg	Tier 1	QL
QL (60 tabs / 30 days)		
glipizide TABS 5mg	Tier 1	QL
QL (240 tabs / 30		
days)		
glipizide TABS 10mg	Tier 1	QL
QL (120 tabs / 30		
days)		
glipizide TB24 2.5mg	Tier 1	QL
QL (90 tabs / 30 days)		
glipizide (generic of	Tier 1	QL
GLUCOTROL XL) TB24		
5mg		
QL (90 tabs / 30 days)		
glipizide (generic of	Tier 1	QL
GLUCOTROL XL) TB24		<b>α</b> =
10mg		
QL (60 tabs / 30 days)		
glipizide xl TB24 2.5mg	Tier 1	QL
QL (90 tabs / 30 days)		<b>α</b> =
glipizide xl (generic of	Tier 1	QL
GLUCOTROL XL) TB24		<b>α</b> =
5mg		
QL (90 tabs / 30 days)		
glipizide xl (generic of	Tier 1	QL
GLUCOTROL XL) TB24		<b>Q</b> L
10mg		
QL (60 tabs / 30 days)		
glipizide-metformin hcl tab	Tier 2	QL
2.5-250 mg	1101 2	
QL (240 tabs / 30		
days)		
	Tier 2	. QL
2.5-500 mg		. <u> </u>
QL (120 tabs / 30		
days)		
glipizide-metformin hcl tab	Tier 2	. QL
5-500 mg		~=
QL (120 tabs / 30		
days)		
GLYXAMBI TAB 10-5 MG	Tier 2	. QL
QL (30 tabs / 30 days)	. 101 2	. <u> </u>
<u> </u>		_

Drug Name	Drug Tier	Requirements/ Limits
GLYXAMBI TAB 25-5 MG	Tier 2	QL
QL (30 tabs / 30 days)	T: C	<u> </u>
JANUMET TAB 50-500MG QL (60 tabs / 30 days)	Tier 2	2 QL
JANUMET TAB 50-1000	Tier 2	QL
QL (60 tabs / 30 days)		
JANUMET XR TAB 50- 500MG	Tier 2	2 QL
QL (60 tabs / 30 days)		
JANUMET XR TAB 50-1000	Tier 2	QL
QL (60 tabs / 30 days)		
JANUMET XR TAB 100-	Tier 2	QL
1000		
QL (30 tabs / 30 days)		
JANUVIA TABS 25mg,	Tier 2	QL
50mg, 100mg		
QL (30 tabs / 30 days)		
JARDIANCE TABS 10mg,		2 QL
25mg	1101 2	. QL
QL (30 tabs / 30 days)		
JENTADUETO TAB 2.5-500	Tior 2	2 QL
QL (60 tabs / 30 days)	11612	. QL
JENTADUETO TAB 2.5-850	Tior	· QL
	i i lei 2	. QL
QL (60 tabs / 30 days) JENTADUETO TAB 2.5-	T: 0 # C	2 QL
	Tier 2	. QL
1000		
QL (60 tabs / 30 days)	T: C	<u> </u>
JENTADUETO TAB XR 2.5-	· Her 2	2 QL
1000MG		
QL (60 tabs / 30 days)	·	
JENTADUETO TAB XR 5-	Lier 2	2 QL
1000MG		
QL (30 tabs / 30 days)		<del></del>
metformin hcl TABS 500mg	Tier 1	QL
QL (150 tabs / 30		
days)		_
metformin hcl TABS 850mg	Tier 1	QL
QL (90 tabs / 30 days)		
metformin hcl TABS	Tier 1	QL
1000mg		
QL (75 tabs / 30 days)		
metformin hcl TB24 500mg	Tier 1	QL
QL (120 tabs / 30		
days)		
(generic of		
GLUCOPHAGE XR)		

Drug Name	Drug Tier	Requirements/ Limits
metformin hcl TB24 750mg QL (60 tabs / 30 days) (generic of GLUCOPHAGE XR)	Tier 1	QL
MOUNJARO SOPN 2.5mg/0.5ml, 5mg/0.5ml, 7.5mg/0.5ml, 10mg/0.5ml, 12.5mg/0.5ml, 15mg/0.5ml QL (4 pens / 28 days)	Tier 2	QL PA
nateglinide TABS 60mg, 120mg QL (90 tabs / 30 days)	Tier 2	QL
OZEMPIC (0.25 OR 0.5 MG/DOSE) SOPN 2mg/1.5ml QL (1 pen / 28 days)	Tier 2	QL PA
OZEMPIC (0.25 OR 0.5MG/DOSE) SOPN 2mg/3ml QL (1 pen / 28 days)	Tier 2	QL PA
OZEMPIC (1MG/DOSE) SOPN 4mg/3ml QL (1 pen / 28 days)	Tier 2	QL PA
OZEMPIC (2MG/DOSE) SOPN 8mg/3ml QL (1 pen / 28 days)	Tier 2	QL PA
pioglitazone hcl (generic of ACTOS) TABS 15mg, 30mg, 45mg QL (30 tabs / 30 days)	Tier 1	QL
repaglinide TABS 2mg QL (240 tabs / 30 days)	Tier 1	QL
repaglinide TABS .5mg, 1mg QL (120 tabs / 30 days)	Tier 1	QL
RYBELSUS TABS 3mg, 7mg, 14mg QL (30 tabs / 30 days)	Tier 2	QL PA
SYNJARDY TAB 5-500MG QL (120 tabs / 30 days)	Tier 2	QL
SYNJARDY TAB 5-1000MG QL (60 tabs / 30 days)	Tier 2	QL
	Tier 2	QL

Drug Name	Drug R Tier	Requirements/ Limits	D	rug Name	Drug Tier	Requirements/ Limits
SYNJARDY TAB 12.5- 1000MG	Tier 2	QL		DMELOG SOLOSTAR OPN 100unit/ml	Tier 2	2
QL (60 tabs / 30 days) SYNJARDY XR TAB 5-	Tier 2	QL		LCOHOL SWABS: BD- MBECTA/MHC/RUGBY	Tier 2	PA
1000MG QL (60 tabs / 30 days)		QL.	В	ASAGLAR KWIKPEN OPN 100unit/ml	Tier 2	2
SYNJARDY XR TAB 10-	Tier 2	QL		IASP SOLN 100unit/ml	Tier 2	2
1000 QL (60 tabs / 30 days)	)			IASP FLEXTOUCH SOPN 00unit/ml	Tier 2	2
SYNJARDY XR TAB 12.5-		QL		IASP PENFILL SOCT	Tier 2	2
1000 OL (60 taba / 30 daya)				00unit/ml	<u> </u>	
QL (60 tabs / 30 days) SYNJARDY XR TAB 25-	Tier 2	QL		IASP PUMPCART SOCT	Tier 2	2 B/D
1000	1101 2	QL.		AUZE PADS 2" X 2"	Tier 2	2 PA
QL (30 tabs / 30 days)	)			UMULIN R U-500	Tier 2	
TRADJENTA TABS 5mg	Tier 2	QL		CONCENTR SOLN	1101 2	- D/D
QL (30 tabs / 30 days)			50	00unit/ml		
TRIJARDY XR TAB ER	Tier 2	QL		UMULIN R U-500	Tier 2	2
24HR 5-2.5-1000MG QL (60 tabs / 30 days)				WIKPEN SOPN		
TRIJARDY XR TAB ER	Tier 2	QL		00unit/ml	T: C	D A
24HR 10-5-1000MG	1101 2	QL		ISULIN PEN NEEDLES: D-EMBECTA	Tier 2	PA
QL (30 tabs / 30 days)	)			ISULIN SAFETY	Tier 2	PA
TRIJARDY XR TAB ER	Tier 2	QL		EEDLES: BD-EMBECTA	1101 2	- 170
24HR 12.5-2.5-1000MG				ISULIN SYRINGES: BD-	Tier 2	PA
QL (60 tabs / 30 days)			_E	MBECTA		
TRIJARDY XR TAB ER 24HR 25-5-1000MG	Tier 2	QL	N	OVOLIN INJ 70/30	Tier 2	2
QL (30 tabs / 30 days)	١			(brand RELION not		
TRULICITY SOPN	Tier 2	QL PA		covered) OVOLIN INJ 70/30 FP	Tion	<u> </u>
.75mg/0.5ml, 1.5mg/0.5ml,			IN	(brand RELION not	Tier 2	<u> </u>
3mg/0.5ml, 4.5mg/0.5ml				covered)		
QL (4 pens / 28 days)			N	OVOLIN N SUSP	Tier 2	2
XIGDUO XR TAB 2.5-1000		QL		00unit/ml		
QL (60 tabs / 30 days)				(brand RELION not		
XIGDUO XR TAB 5-500MG QL (60 tabs / 30 days)		QL		covered)		
XIGDUO XR TAB 5-	Tier 2	QL		OVOLIN N FLEXPEN	Tier 2	<u>}</u>
1000MG	1101 2	QL	5	UPN 100unit/ml (brand RELION not		
QL (60 tabs / 30 days)	)			covered)		
XIGDUO XR TAB 10-	Tier 2	QL	N	OVOLIN R SOLN	Tier 2	2
500MG				00unit/ml		
QL (30 tabs / 30 days)				(brand RELION not		
	Tier 2	QL		covered)	<u> </u>	
QL (30 tabs / 30 days)  ANTIDIABETICS, INSUL				OVOLIN R FLEXPEN	Tier 2	2
ADMELOG SOLN	Tier 2		S	OPN 100unit/ml		
100unit/ml	1161 4			(brand RELION not covered)		
				3010104)		

Drug Name	Drug Tier	Requirements/ Limits
NOVOLOG MIX INJ 70/30 (brand RELION not covered)	Tier 2	)
NOVOLOG MIX INJ FLEXPEN	Tier 2	2
(brand RELION not covered)		
OMNIPOD 5 G6 KIT INTRO QL (1 kit / year)		
OMNIPOD 5 G6 MIS PODS QL (15 pods / 30 days	)	
OMNIPOD 5 G7 KIT INTRO QL (1 kit / year)		· 
OMNIPOD 5 G7 MIS PODS QL (15 pods / 30 days	)	
OMNIPOD DASH KIT INTRO	Tier 2	2 QL PA
QL (1 kit / year) OMNIPOD DASH MIS PODS	Tier 2	QL PA
QL (15 pods / 30 days) OMNIPOD GO KIT 10UNT/DY	Tier 2	QL PA
QL (15 pods / 30 days) OMNIPOD GO KIT	) Tier 2	QL PA
15UNT/DY QL (15 pods / 30 days)		ge i / i
OMNIPOD GO KIT 20UNT/DY QL (15 pods / 30 days)	Tier 2	QL PA
OMNIPOD GO KIT 25UNT/DY QL (15 pods / 30 days)	Tier 2	QL PA
OMNIPOD GO KIT 30UNT/DY QL (15 pods / 30 days)	Tier 2	
OMNIPOD GO KIT 35UNT/DY QL (15 pods / 30 days) OMNIPOD GO KIT		QL PA
OMNIPOD GO KIT 40UNT/DY QL (15 pods / 30 days)		QL PA
	Tier 2	QL PA
SOLIQUA INJ 100/33 QL (5 pens / 25 days)	Tier 2	QL
TRESIBA SOLN 100unit/ml	Tier 2	2

	Drug Name	Drug Tier	Requirements/ Limits
,	TRESIBA FLEXTOUCH SOPN 100unit/ml, 200unit/ml	Tier 2	
	XULTOPHY INJ 100/3.6 QL (5 pens / 30 days)	Tier 2	QL QL
	CALCIUM REGULATORS	S	
	alendronate sodium TABS 10mg, 35mg	Tier 1	
	alendronate sodium (generion of FOSAMAX) TABS 70mg	Tier 1	
	SOLN 200unit/act	Tier 2	
	ibandronate sodium TABS 150mg		•
	PAMIDRONATE DISODIUM SOLN 6mg/ml	Tier 2	B/D
	<i>pamidronate disodium</i> SOLN 30mg/10ml, 90mg/10ml	Tier 2	. 2,2
	PROLIA SOSY 60mg/ml QL (1 syringe / 180 days)	Tier 2	P. QL NM
	TERIPARATIDE SOPN 620mcg/2.48ml	Tier 2	NM PA
	XGEVA SOLN 120mg/1.7ml	Tier 2	NM PA
	zoledronic acid CONC 4mg/5ml	Tier 2	B/D NM
	zoledronic acid (generic of RECLAST) SOLN 5mg/100ml	Tier 2	B/D NM
	CHELATING AGENTS		
	CHEMET CAPS 100mg	Tier 2	
_	deferasirox (generic of JADENU) TABS 90mg	Tier 2	
,	deferasirox (generic of JADENU) TABS 180mg, 360mg	Tier 2	NM PA
	deferasirox (generic of EXJADE) TBSO 125mg	Tier 2	NM PA
	deferasirox (generic of EXJADE) TBSO 250mg, 500mg	Tier 1	NM PA
	kionex SUSP 15gm/60ml	Tier 2	
	LOKELMA PACK 5gm, 10gm	Tier 2	2

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
penicillamine (generic of DEPEN TITRATABS)	Tier 1	NM	eluryng (generic of NUVARING)	Tier 2	2
TABS 250mg			emzahh TABS .35mg	Tier 2	2
sodium polystyrene sulfonate powder	Tier 2	2	enilloring (generic of NUVARING)	Tier 2	2
sps SUSP 15gm/60ml	Tier 2	2	enpresse-28	Tier 2	2
trientine hcl (generic of	Tier 1	NM PA	enskyce	Tier 2	2
SYPRINE) CAPS 250mg	•	<u>.</u>	errin TABS .35mg	Tier 2	2
CONTRACEPTIVES			estarylla	Tier 2	2
afirmelle	Tier 2		ethynodiol diacetate &	Tier 2	2
altavera	Tier 2	-	ethinyl estradiol tab 1 mg-3	5	
alyacen 1/35	Tier 2		mcg		
alyacen 7/7/7	Tier 2	· · · · · · · · · · · · · · · · · · ·	ethynodiol diacetate &	Tier 2	2
apri	Tier 2		ethinyl estradiol tab 1 mg-5	)	
aranelle	Tier 2		mcg etonogestrel-ethinyl	Tier 2	<u> </u>
aubra eq	Tier 2		estradiol va ring 0.12-0.015		2
aurovela 1/20	Tier 2	· · · · · · · · · · · · · · · · · · ·	mg/24hr (generic of		
aurovela fe 1.5/30	Tier 2		NUVARING)		
aurovela fe 1/20	Tier 2	2	falmina	Tier 2	2
aviane	Tier 2	2	hailey 1.5/30	Tier 2	2
ayuna	Tier 2	2	haloette (generic of	Tier 2	2
azurette	Tier 2	2	NUVARING)		
balziva	Tier 2	2	heather TABS .35mg	Tier 2	2
blisovi fe 1.5/30	Tier 2	2	iclevia	Tier 2	2
briellyn	Tier 2	2	incassia TABS .35mg	Tier 2	2
camila TABS .35mg	Tier 2	2	introvale	Tier 2	2
chateal eq	Tier 2	2	isibloom	Tier 2	2
cryselle-28	Tier 2	2	jasmiel (generic of YAZ)	Tier 2	2
cyred eq	Tier 2	2	jolessa	Tier 2	2
dasetta 1/35	Tier 2	2	juleber	Tier 2	2
dasetta 7/7/7	Tier 2	2	junel 1.5/30	Tier 2	2
deblitane TABS .35mg	Tier 2	2	junel 1/20	Tier 2	2
DEPO-SUBQ PROVERA	Tier 2	2	junel fe 1.5/30	Tier 2	2
104 SUSY 104mg/0.65ml			junel fe 1/20	Tier 2	2
desogest-eth estrad & eth	Tier 2	2	kariva	Tier 2	2
estrad tab 0.15-0.02/0.01			kelnor 1/35	Tier 2	2
mg(21/5)	Tion	<u></u>	kelnor 1/50	Tier 2	2
drospirenone-ethinyl estradiol tab 3-0.02 mg	Tier 2	2	kurvelo	Tier 2	2
(generic of YAZ)			larin 1.5/30	Tier 2	2
drospirenone-ethinyl	Tier 2	·	larin 1/20	Tier 2	2
estradiol tab 3-0.03 mg		-	larin fe 1.5/30	Tier 2	
(generic of YASMIN 28)			larin fe 1/20	Tier 2	
elinest	Tier 2	2	leena	Tier 2	
			lessina	Tier 2	

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
levonest	Tier 2	2	norethindrone ac-ethinyl	Tier 2	2
levonorgestrel & ethinyl	Tier 2	<u> </u>	estrad-fe tab 1-20/1-30/1-35		
estradiol (91-day) tab 0.15-		-	mg-mcg	T: 0	
0.03 mg	T: 6	<del></del> -	norethindrone ace & ethinyl	Her 2	_
levonorgestrel & ethinyl	Tier 2		estradiol tab 1 mg-20 mcg norethindrone ace & ethinyl	Tior 2	)
estradiol tab 0.1 mg-20 mcg levonorgestrel & ethinyl	Tier 2	)	estradiol tab 1.5 mg-30 mcg		-
estradiol tab 0.15 mg-30	1161 2	•	norethindrone ace & ethinyl		<u>,                                      </u>
mcg			estradiol-fe tab 1 mg-20		
levonorgestrel-eth estra tab	Tier 2	<u> </u>	mcg		
0.05-30/0.075-40/0.125-			norgestimate & ethinyl	Tier 2	2
_30mg-mcg			estradiol tab 0.25 mg-35		
levora 0.15/30-28	Tier 2		mcg	Tion 0	<u> </u>
LILETTA IUD 20.1mcg/day	Tier 2		norgestimate-eth estrad tab 0.18-25/0.215-25/0.25-25	ner z	
loestrin 1.5/30-21	Tier 2		mg-mcg (generic of ORTHO		
loestrin 1/20-21	Tier 2	<del> </del>	TRI-CYCLEN LO)		
loestrin fe 1.5/30	Tier 2		norgestimate-eth estrad tab	Tier 2	<u> </u>
loestrin fe 1/20	Tier 2		0.18-35/0.215-35/0.25-35		
loryna (generic of YAZ)	Tier 2	<del>.</del>	mg-mcg		
low-ogestrel	Tier 2	<del>.</del>	norlyroc TABS .35mg	Tier 2	
lutera	Tier 2	<del> </del>	nortrel 0.5/35 (28)	Tier 2	
lyleq TABS .35mg	Tier 2		nortrel 1/35 (21)	Tier 2	
lyza TABS .35mg	Tier 2		nortrel 1/35 (28)	Tier 2	
marlissa	Tier 2		nortrel 7/7/7	Tier 2	
medroxyprogesterone	Tier 2	<u>.</u>	nylia 1/35	Tier 2	
acetate (contraceptive) (generic of DEPO-		-	nylia 7/7/7	Tier 2	
PROVERA		<u>-</u>	путуо	Tier 2	
CONTRACEPTIV) SUSP			ocella (generic of YASMIN	Tier 2	2
150mg/ml; SUSY 150mg/ml			28)	T: 0	
microgestin 1.5/30	Tier 2	<u> </u>	philith	Tier 2	•
microgestin 1/20	Tier 2	<u> </u>	pimtrea	Tier 2	
microgestin fe 1.5/30	Tier 2	<u>.</u>	portia-28	Tier 2	
microgestin fe 1/20	Tier 2	2	reclipsen	Tier 2	
mili	Tier 2	2	setlakin	Tier 2	
mono-linyah	Tier 2	<u> </u>	sharobel TABS .35mg	Tier 2	
necon 0.5/35-28	Tier 2	<u>)</u>	simliya	Tier 2	
NEXPLANON IMPL 68mg	Tier 2	2 NM	sprintec 28	Tier 2	
nikki (generic of YAZ)	Tier 2	2	sronyx	Tier 2	
nora-be TABS .35mg	Tier 2		syeda (generic of YASMIN 28)	Tier 2	
norelgestromin-ethinyl estradiol td ptwk 150-35	Tier 2	-	tarina fe 1/20 eq	Tier 2	·
mcg/24hr		-	tilia fe	Tier 2	<u> </u>
norethindrone	Tier 2	<u> </u>	tri-estarylla	Tier 2	2
(contraceptive) TABS		•	tri-legest fe	Tier 2	2
.35mg		<u> </u>	tri-linyah	Tier 2	

Drug Name	Drug Requirements/ Tier Limits	Drug Name	Drug Tier	Requirements/ Limits
tri-lo-estarylla (generic of ORTHO TRI-CYCLEN LO)	Tier 2	estradiol & norethindrone acetate tab 0.5-0.1 mg	Tier 2	2
tri-lo-marzia (generic of ORTHO TRI-CYCLEN LO) tri-lo-mili (generic of ORTHO	Tier 2	estradiol & norethindrone acetate tab 1-0.5 mg (generic of ACTIVELLA)	Tier 2	2
TRI-CYCLEN LO)		estradiol vaginal (generic of		2
tri-lo-sprintec (generic of ORTHO TRI-CYCLEN LO)	Tier 2	ESTRACE) CREA .1mg/gm estradiol vaginal (generic of	•	2
tri-mili	Tier 2	VAGIFEM) TABS 10mcg		
tri-nymyo	Tier 2	estradiol valerate (generic of	Tier 2	2
tri-sprintec	Tier 2	DELESTROGEN) OIL		
tri-vylibra	Tier 2	10mg/ml, 20mg/ml, 40mg/m		
tri-vylibra lo (generic of	Tier 2	fyavolv tab 0.5mg-2.5mcg	Tier 2	2
ORTHO TRI-CYCLEN LO)	1101 2	fyavolv tab 1mg-5mcg	Tier 2	
trivora-28	Tier 2	jinteli	Tier 2	<del></del>
turqoz	Tier 2	lyllana (generic of	Tier 2	2
velivet	Tier 2	MINIVELLE) PTTW		
vestura (generic of YAZ)	Tier 2	.025mg/24hr, .037mg/24hr, .05mg/24hr, .075mg/24hr,		
vienva	Tier 2	.0311g/24111, .07311g/24111, .1mg/24hr		
viorele	Tier 2	mimvey (generic of	Tier 2	)
vyfemla	Tier 2	ACTIVELLA)		_
vylibra	Tier 2	norethindrone acetate-	Tier 2	2
wera	Tier 2	ethinyl estradiol tab 0.5 mg-		
xulane	Tier 2	2.5 mcg		
zafemy	Tier 2	norethindrone acetate-	Tier 2	2
zovia 1/35	Tier 2	ethinyl estradiol tab 1 mg-5 mcg		
zumandimine (generic of YASMIN 28)	Tier 2	yuvafem (generic of VAGIFEM) TABS 10mcg	Tier 2	2
<b>ESTROGENS</b>	<del></del>	GLUCOCORTICOIDS	•	<del>.</del>
dotti (generic of VIVELLE-DOT) PTTW .025mg/24hr, .037mg/24hr, .05mg/24hr, .075mg/24hr	Tier 2	dexamethasone ELIX .5mg/5ml; SOLN .5mg/5ml; TABS .5mg, .75mg, 1mg, 1.5mg, 2mg, 4mg, 6mg	Tier 2	2
estradiol (generic of VIVELLE-DOT) PTTW .025mg/24hr, .037mg/24hr, .05mg/24hr, .075mg/24hr, .1mg/24hr	Tier 2	dexamethasone sodium phosphate SOLN 4mg/ml, 10mg/ml, 20mg/5ml, 100mg/10ml, 120mg/30ml; SOSY 4mg/ml	Tier 2	2
estradiol (generic of CLIMARA) PTWK .025mg/24hr, .05mg/24hr, .06mg/24hr, .075mg/24hr,	Tier 2	fludrocortisone acetate TABS .1mg hydrocortisone (generic of CORTEF) TABS 5mg,	Tier 1	
.1mg/24hr, 37.5mcg/24hr estradiol (generic of ESTRACE) TABS .5mg, 1mg, 2mg	Tier 1	10mg, 20mg methylprednisolone (generic of MEDROL) TABS 4mg, 8mg, 16mg	Tier 2	B/D

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
methylprednisolone TABS 32mg	Tier 2	2 B/D	cinacalcet hcl (generic of SENSIPAR) TABS 30mg,	Tier 2	B/D QL NM
methylprednisolone (generi of MEDROL DOSEPAK) TBPK 4mg	c Tier ′	1	60mg QL (60 tabs / 30 days cinacalcet hcl (generic of		B/D QL NM
methylprednisolone acetate (generic of DEPO- MEDROL) SUSP 40mg/ml		2 B/D	SENSIPAR) TABS 90mg QL (120 tabs / 30 days)	-	
80mg/ml methylprednisolone sod	Tier 2	2 B/D	CYSTAGON CAPS 50mg, 150mg	Tier 2	2 NM PA
succ SOLR 40mg, 125mg methylprednisolone sod	Tier 2	<del></del>	desmopressin acetate (generic of DDAVP) SOLN	Tier 1	
succ (generic of SOLU- MEDROL) SOLR 1000mg		,-	4mcg/ml  desmopressin acetate	Tier 2	)
prednisolone SOLN 15mg/5ml	Tier '	1 B/D	(generic of DDAVP) TABS .1mg, .2mg	1101 2	-
prednisolone sodium phosphate (generic of	Tier 2	2 B/D	desmopressin acetate spra SOLN .01%	y Tier 2	2
PEDIAPRED) SOLN 5mg/5ml			desmopressin acetate spra refrigerated SOLN .01%	y Tier 2	2
prednisolone sodium phosphate SOLN 15mg/5n	Tier ′	1 B/D	GENOTROPIN CART 5mg	g, Tier 2	2 NM PA
prednisolone sodium phosphate SOLN 25mg/5n	Tier 2	B/D	GENOTROPIN MINIQUICK PRSY .2mg	Tier 2	2 NM PA
prednisone SOLN 5mg/5m	I Tier 2		GENOTROPIN MINIQUICA	Tier 2	NM PA
prednisone TABS 1mg, 2.5mg, 5mg, 10mg, 20mg, 50mg	Tier '	I B/D	PRSY .4mg, .6mg, .8mg, 1mg, 1.2mg, 1.4mg, 1.6mg 1.8mg, 2mg	,	
prednisone TBPK 5mg, 10mg	Tier 2	2	INCRELEX SOLN 40mg/4ml	Tier 2	2 NM PA
SOLU-CORTEF SOLR 100mg, 250mg, 500mg, 1000mg	Tier 2	2	javygtor (generic of KUVAN PACK 100mg, 500mg; TABS 100mg	l) Tier 1	NM PA
GLUCOSE ELEVATING			lanreotide acetate SOLN 120mg/0.5ml	Tier 1	NM PA
diazoxide (generic of PROGLYCEM) SUSP	Tier '	ļ	levocarnitine (metabolic	Tier 2	2 B/D
50mg/ml ZEGALOGUE SOAJ .6mg/0.6ml; SOSY	Tier 2	2	modifiers) (generic of CARNITOR) SOLN 1gm/10ml; TABS 330mg		
.6mg/0.6ml			mifepristone	Tier 1	NM PA
MISCELLANEOUS	Tion	1 NIM	(hyperglycemia) (generic of KORLYM) TABS 300mg	Ī	
betaine powder for oral solution (generic of CYSTADANE)	Tier '	I NM	nitisinone (generic of ORFADIN) CAPS 2mg,	Tier 1	NM PA
cabergoline TABS .5mg	Tier 2		5mg, 10mg, 20mg octreotide acetate (generic	Tier 2	2 NM PA
carglumic acid (generic of CARBAGLU) TBSO 200mg			of SANDOSTATIN) SOLN 50mcg/ml, 100mcg/ml	1101 2	- IVIVIIA
CERDELGA CAPS 84mg	Tier 2	NM PA			

Drug Name	Drug   Tier	Requirements/ Limits
octreotide acetate SOLN 200mcg/ml; SOSY 50mcg/ml, 100mcg/ml	Tier 2	NM PA
octreotide acetate (generic of SANDOSTATIN) SOLN 500mcg/ml	Tier 1	NM PA
octreotide acetate SOLN 1000mcg/ml; SOSY 500mcg/ml	Tier 1	NM PA
raloxifene hcl (generic of EVISTA) TABS 60mg	Tier 2	
sapropterin dihydrochloride (generic of KUVAN) PACK 100mg, 500mg; TABS 100mg	Tier 1	NM PA
SIGNIFOR SOLN .3mg/ml, .6mg/ml, .9mg/ml	Tier 2	NM PA
sodium phenylbutyrate (generic of BUPHENYL) POWD 3gm/tsp; TABS 500mg	Tier 1	NM PA
SOMATULINE DEPOT SOLN 60mg/0.2ml, 90mg/0.3ml, 120mg/0.5ml	Tier 2	NM PA
SOMAVERT SOLR 10mg, 15mg, 20mg, 25mg, 30mg	Tier 2	NM PA
SYNAREL SOLN 2mg/ml	Tier 2	PA
VEOZAH TABS 45mg	Tier 2	PA
PROGESTINS	<del>-</del>	
medroxyprogesterone acetate (generic of PROVERA) TABS 2.5mg, 5mg, 10mg	Tier 1	
megestrol acetate SUSP 40mg/ml	Tier 2	
norethindrone acetate TABS 5mg	Tier 2	
progesterone (generic of PROMETRIUM) CAPS 100mg, 200mg	Tier 2	
THYROID AGENTS	<u>.</u>	
euthyrox (generic of SYNTHROID) TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg	Tier 1	

Drug Name	Drug Tier	Requirements/ Limits
levo-t (generic of	Tier 1	
SYNTHROID) TABS		
25mcg, 50mcg, 75mcg,		
88mcg, 100mcg, 112mcg,		
125mcg, 137mcg, 150mcg,		
175mcg, 200mcg, 300mcg	T: 4	
levothyroxine sodium (generic of SYNTHROID)	Tier 1	
TABS 25mcg, 50mcg,		
75mcg, 88mcg, 100mcg,		
112mcg, 125mcg, 137mcg,		
150mcg, 175mcg, 200mcg,		
300mcg		
levoxyl (generic of	Tier 1	
SYNTHROID) TABS		
25mcg, 50mcg, 75mcg,		
88mcg, 100mcg, 112mcg,		
125mcg, 137mcg, 150mcg,		
175mcg, 200mcg		
liothyronine sodium (generic	Tier 2	) -
of CYTOMEL) TABS 5mcg,		
25mcg, 50mcg	•	
methimazole TABS 5mg,	Tier 1	
10mg		
propylthiouracil TABS 50mg		
SYNTHROID TABS 25mcg,	Tier 2	<u>.</u>
50mcg, 75mcg, 88mcg,		
100mcg, 112mcg, 125mcg,		
137mcg, 150mcg, 175mcg,		
200mcg, 300mcg	T: a # 4	
unithroid (generic of	Tier 1	
SYNTHROID) TABS		
25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg,		
125mcg, 137mcg, 150mcg,		
175mcg, 200mcg, 300mcg		
VITAMIN D ANALOGS		
calcitriol (generic of	Tier 1	B/D
ROCALTROL) CAPS	1101 1	<i>D/D</i>
.25mcg, .5mcg		
calcitriol (oral) (generic of	Tier 2	B/D
ROCALTROL) SOLN		-, <b>-</b> , -
1mcg/ml		
paricalcitol (generic of	Tier 2	B/D
ZEMPLAR) CAPS 1mcg,	_	
2mcg		
paricalcitol CAPS 4mcg	Tier 2	B/D
		<u> </u>

Drug Name	Drug Tier	Requirements/ Drug Name Limits				Drug Tier	Requirements/ Limits
GASTROINTESTINAL ANTIEMETICS			scopolamine (generic of TRANSDERM-SCOP)	Tier 2			
aprepitant CAPS 40mg, 125mg	Tier 2	2 B/D	PT72 1mg/3days QL (10 patches / 30				
aprepitant (generic of EMEND) CAPS 80mg	Tier 2	B/D	days) PA applies if 70 years an	d			
aprepitant capsule therapy pack 80 & 125 mg	Tier 2	2 B/D	older after a 30 day supply in a calendar year		<del>,</del>		
compro SUPP 25mg	Tier 2	2	ANTISPASMODICS		_		
dronabinol (generic of MARINOL) CAPS 2.5mg,	Tier 2	2 B/D QL	dicyclomine hcl CAPS 10mg; TABS 20mg	Tier 2			
5mg, 10mg QL (60 caps / 30 days			dicyclomine hcl SOLN 10mg/5ml	Tier 2			
meclizine hcl TABS 12.5mg, 25mg	Tier 1		glycopyrrolate (generic of ROBINUL) TABS 1mg QL (90 tabs / 30 days	Tier 2	. QL		
metoclopramide hcl SOLN 5mg/5ml, 5mg/ml metoclopramide hcl (generic			glycopyrrolate (generic of ROBINUL FORTE) TABS	Tier 2	QL		
of REGLAN) TABS 5mg, 10mg			2mg QL (120 tabs / 30 days)				
ondansetron TBDP 4mg,	Tier 2	2 B/D	H2-RECEPTOR ANTAG	ONIST			
8mg ondansetron hcl SOLN	Tier 2	<u> </u>	famotidine SOLN	Tier 2			
4mg/2ml, 40mg/20ml; SOS) 4mg/2ml		_	20mg/2ml, 40mg/4ml, 200mg/20ml	1101 2			
ondansetron hcl TABS 4mg, 8mg	Tier 2	2 B/D	famotidine (generic of PEPCID) TABS 20mg,	Tier 1			
prochlorperazine SUPP 25mg	Tier 2		40mg famotidine in nacl 0.9% iv soln 20 mg/50ml	Tier 2	<u>.</u>		
prochlorperazine edisylate SOLN 10mg/2ml	Tier 2		nizatidine CAPS 150mg, 300mg	Tier 2			
prochlorperazine maleate	Tier 1		INFLAMMATORY BOW	FI DIS	FASE		
TABS 5mg, 10mg promethazine hcl SOLN 6.25mg/5ml; TABS 12.5mg, 25mg, 50mg	Tier 2	PA	balsalazide disodium (generic of COLAZAL) CAPS 750mg	Tier 2			
PA applies if 70 years and older after a 30 day	d		budesonide CPEP 3mg QL (90 caps / 30 days	Tier 2	QL PA		
supply in a calendar year promethazine hcl (generic o	f Tier 2	2 PA	budesonide (generic of UCERIS) TB24 9mg	Tier 1	QL PA		
PHENERGAN) SOLN 25mg/ml, 50mg/ml PA applies if 70 years and older after a 30 day	d		QL (30 tabs / 30 days hydrocortisone (intrarectal) (generic of CORTENEMA) ENEM 100mg/60ml	) Tier 2			
supply in a calendar year			mesalamine (generic of APRISO) CP24 .375gm QL (120 caps / 30 days)	Tier 2	QL		

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
mesalamine (generic of	Tier 2	QL	MISCELLANEOUS		
DELZICOL) CPDR 400mg			alosetron hcl (generic of	Tier 1	QL PA
QL (180 caps / 30			LOTRONEX) TABS 1mg		
days)		<del></del>	QL (60 tabs / 30 days)		
mesalamine ENEM 4gm	Tier 2	2 QL	alosetron hcl (generic of	Tier 2	QL PA
QL (1680 mL / 28			LOTRONEX) TABS .5mg		
days)	T: (	<u> </u>	QL (60 tabs / 30 days)	•	<del></del>
mesalamine (generic of CANASA) SUPP 1000mg	Tier 2	2 QL	CREON CAP 3000UNIT	Tier 2	
QL (30 suppositories	,		CREON CAP 6000UNIT	Tier 2	
30 days)			CREON CAP 12000UNT	Tier 2	
mesalamine (generic of	Tier 2	2 QL	CREON CAP 24000UNT	Tier 2	
LIALDA) TBEC 1.2gm		- ~-	CREON CAP 36000UNT	Tier 2	<u> </u>
QĹ (120 tabs / 30			cromolyn sodium	Tier 2	<u> </u>
days)			(mastocytosis) (generic of		
mesalamine w/ cleanser	Tier 2	QL	GASTROCROM) CONC		
(generic of ROWASA) KIT			100mg/5ml	<del></del>	<del></del>
4gm			diphenoxylate w/ atropine	Tier 2	<u>'</u>
QL (28 bottles / 28			tab 2.5-0.025 mg (generic o LOMOTIL)	ī	
days)			GATTEX KIT 5mg	Tier 2	NM PA
sulfasalazine (generic of	Tier 1		LINZESS CAPS 72mcg,	Tier 2	
AZULFIDINE) TABS 500m	<b>-</b>	<del> </del>	145mcg, 290mcg	1161 2	. QL
sulfasalazine (generic of	Tier 2	<u>′</u>	QL (30 caps / 30 days	)	
AZULFIDINE EN-TABS) TBEC 500mg			loperamide hcl CAPS 2mg	Tier 2	)
LAXATIVES			misoprostol (generic of	Tier 2	
constulose SOLN	Tier 2	)	CYTOTEC) TABS 100mcg,		•
10gm/15ml	1101 2	-	200mcg		
enulose SOLN 10gm/15ml	Tier 2	)	MOVANTIK TABS 12.5mg,	Tier 2	QL
gavilyte-c	Tier 1		25mg		
gavilyte-g (generic of	Tier 1		QL (30 tabs / 30 days)		
GOLYTELY)	1101	•	RELISTOR SOLN	Tier 2	QL PA
gavilyte-n/flavor pack	Tier 1		8mg/0.4ml, 12mg/0.6ml		
generlac SOLN 10gm/15m			QL (28 syringes / 28		
lactulose SOLN 10gm/15m			days)	Tier 2	<u> </u>
lactulose (encephalopathy)			sucralfate (generic of CARAFATE) TABS 1gm	Hei 2	<u>-</u>
SOLN 10gm/15ml	1101 2	=	ursodiol CAPS 300mg	Tier 2	)
peg 3350-kcl-na bicarb-nac	/-Tier 1		ursodiol TABS 250mg	Tier 2	
na sulfate for soln 236 gm		•			
(generic of GOLYTELY)			ursodiol (generic of URSO FORTE) TABS 500mg	Tier 2	<u>-</u>
peg 3350-kcl-sod bicarb-	Tier 1		VOWST CAP	Tier 2	2 QL NM PA
nacl for soln 420 gm			QL (12 caps / 30 days		. QLIVIVIA
PLENVU SOL	Tier 2	2	XERMELO TABS 250mg	Tier 2	QL NM PA
sod sulfate-pot sulf-mg sulf	Tier 2	2	QL (84 tabs / 28 days)		<u> </u>
oral sol 17.5-3.13-1.6			XIFAXAN TABS 550mg	Tier 2	PA
gm/177ml (generic of			ZENPEP CAP 3000UNIT	Tier 2	
SUPREP BOWEL PREP			ZENPEP CAP 5000UNIT	Tier 2	-
KIT)					

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
ZENPEP CAP 10000UNT	Tier 2	2	potassium citrate	Tier 2	2
ZENPEP CAP 15000UNT	Tier 2	2	(alkalinizer) (generic of		
ZENPEP CAP 20000UNT	Tier 2	2	UROCIT-K 10) TBCR		
ZENPEP CAP 25000UNT	Tier 2		1080mg	<u>.</u>	
ZENPEP CAP 40000UNT	Tier 2		URINARY ANTISPASM	<b>ODICS</b>	<u> </u>
ZENPEP CAP 60000UNT	Tier 2		MYRBETRIQ SRER	Tier 2	2 QL
PROTON PUMP INHIBIT		<u>-</u>	8mg/ml	,	
lansoprazole CPDR 15mg	Tier 2		QL (300 mL / 28 days		
QL (60 caps / 30 days	s)		MYRBETRIQ TB24 25mg, 50mg		2 QL
lansoprazole (generic of	Tier 2	2 QL	QL (30 tabs / 30 days		
PREVACID) CPDR 30mg QL (60 caps / 30 days			oxybutynin chloride SOLN 5mg/5ml	Tier 2	2 QL
omeprazole CPDR 10mg,	Tier '	1	QL (600 mL / 30 days		
_20mg, 40mg			oxybutynin chloride TABS	Tier 2	2 QL
pantoprazole sodium (generic of PROTONIX) SOLR 40mg	Tier 2	2	5mg QL (120 tabs / 30 days)		
pantoprazole sodium	Tier '	1	oxybutynin chloride TB24	Tier 2	2 QL
(generic of PROTONIX)			5mg		
TBEC 20mg, 40mg			QL (30 tabs / 30 days	s)	
GENITOURINARY			oxybutynin chloride TB24	Tier 2	2 QL
BENIGN PROSTATIC H	YPER	PLASIA	10mg, 15mg		
alfuzosin hcl (generic of	Tier 1	1 QL	QL (60 tabs / 30 days		
UROXATRAL) TB24 10mg			solifenacin succinate	Tier 2	2 QL
QL (30 tabs / 30 days		<u>.                                    </u>	(generic of VESICARE)		
dutasteride (generic of	Tier 2	2 QL	TABS 5mg, 10mg	`	
AVODART) CAPS .5mg			QL (30 tabs / 30 days		OL CT
QL (30 caps / 30 days	•	. 01	tolterodine tartrate (generic		2 QLST
finasteride (generic of	Tier '	l QL	of DETROL LA) CP24 2mg	<b>J</b> ,	
PROSCAR) TABS 5mg QL (30 tabs / 30 days	`		QL (30 caps / 30 day	e)	
tadalafil (generic of CIALIS)		QL PA	tolterodine tartrate (generic		2 QL
TABS 5mg	1161 2	Z QLFA	of DETROL) TABS 1mg,	11012	- QL
QL (30 tabs / 30 days	١		2mg		
tamsulosin hcl (generic of	Tier ′	l QL	QL (60 tabs / 30 days	s)	
FLOMAX) CAPS .4mg	1101	. QL	trospium chloride TABS	Tier 2	2 QL
QL (60 caps / 30 days	;)		20mg		
MISCELLANEOUS	,	_	QL (60 tabs / 30 days	s)	
acetic acid SOLN .25%	Tier '	1	VAGINAL ANTI-INFECT	<b>TVES</b>	
bethanechol chloride TABS			clindamycin phosphate	Tier 2	2
5mg, 10mg, 25mg, 50mg		_	vaginal (generic of		
potassium citrate	Tier 2	2	CLEOCIN) CREA 2%		
(alkalinizer) (generic of	• . •		metronidazole vaginal GE	_ Tier 2	2
UROCIT-K 15) TBCR			.75%		
15meq			terconazole vaginal CREA	Tier 2	2
potassium citrate	Tier 2	2	.4%, .8%		_
(alkalinizer) TBCR 540mg					

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
HEMATOLOGIC			XARELTO TABS 10mg,	Tier 2	: QL
ANTICOAGULANTS			15mg, 20mg		
dabigatran etexilate	Tier 2	2 QL	QL (30 tabs / 30 days)	Tion 0	
mesylate (generic of			XARELTO STAR TAB 15/20MG	Tier 2	. QL
PRADAXA) CAPS 75mg,			QL (51 tabs / 30 days)		
150mg QL (60 caps / 30 days	١		HEMATOPOIETIC GROV	VTH F	ACTORS
dabigatran etexilate	Tier 2	2 QL	FULPHILA SOSY		QL NM PA
mesylate (generic of	1101 2	- QL	6mg/0.6ml	1101 2	. QLIMIII
PRADAXA) CAPS 110mg			QL (2 syringes / 28		
QL (120 caps / 30			days)		
days)			PROCRIT SOLN	Tier 2	NM PA
ELIQUIS TABS 2.5mg	Tier 2	2 QL	2000unit/ml, 3000unit/ml,		
QL (60 tabs / 30 days)			4000unit/ml, 10000unit/ml		
ELIQUIS TABS 5mg	Tier 2	2 QL	PROCRIT SOLN	Tier 2	NM PA
QL (74 tabs / 30 days)			20000unit/ml, 40000unit/ml		
ELIQUIS STARTER PACK	Her 2	2 QL	ZARXIO SOSY	Tier 2	NM PA
TBPK 5mg			300mcg/0.5ml,		
QL (74 tabs / 30 days) enoxaparin sodium (generic	•	)	480mcg/0.8ml  MISCELLANEOUS		
of LOVENOX) SOLN	1161 2	<u>-</u>	ALVAIZ TABS 9mg, 54mg	Tior 2	QL NM PA
300mg/3ml; SOSY			QL (60 tabs / 30 days)	Her 2	QL NIVI PA
30mg/0.3ml, 40mg/0.4ml,			ALVAIZ TABS 18mg, 36mg	Tier 2	OL NM PA
60mg/0.6ml, 80mg/0.8ml,			QL (90 tabs / 30 days)	1101 2	. QLINIVITA
100mg/ml, 120mg/0.8ml,			anagrelide hcl CAPS 1mg	Tier 2	
150mg/ml		<u> </u>	anagrelide hcl (generic of	Tier 2	
fondaparinux sodium	Tier 2	2	AGRYLIN) CAPS .5mg		•
(generic of ARIXTRA)			BERINERT KIT 500unit	Tier 2	QL NM PA
SOLN 2.5mg/0.5ml,			QL (24 boxes / 30		
5mg/0.4ml, 7.5mg/0.6ml, 10mg/0.8ml			days)		
HEP SOD/NACL INJ	Tier 2	<u> </u>	cilostazol TABS 50mg,	Tier 1	
25000UNT	1101 2	-	100mg		
heparin sodium (porcine)	Tier 2	2 B/D	DOPTELET TABS 20mg	Tier 2	_
SOLN 1000unit/ml,		= / <b>=</b>	DROXIA CAPS 200mg,	Tier 2	
5000unit/ml, 10000unit/ml,			300mg, 400mg	T: 0	OL NIM DA
20000unit/ml			HAEGARDA SOLR 2000unit	Her 2	QL NM PA
jantoven TABS 1mg, 2mg,	Tier 1	ĺ	QL (30 vials / 30 days)		
2.5mg, 3mg, 4mg, 5mg,			HAEGARDA SOLR	Tier 2	QL NM PA
6mg, 7.5mg, 10mg			3000unit	1101 2	. QLIMIII
warfarin sodium TABS	Tier 1		QL (20 vials / 30 days)		
1mg, 2mg, 2.5mg, 3mg,			icatibant acetate (generic of	•	QL NM PA
4mg, 5mg, 6mg, 7.5mg, 10mg			FIRAZYR) SOSY 30mg/3m		
XARELTO SUSR 1mg/ml	Tier 2		QL (9 syringes / 30		
QL (620 mL / 30 days)		. <u>Q</u> L	days)	<del></del>	
XARELTO TABS 2.5mg	Tier 2	2 QL	I-glutamine (sickle cell)	Tier 1	NM PA
QL (60 tabs / 30 days)			(generic of ENDARI) PACK		
			5gm		

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
pentoxifylline TBCR 400m	g Tier 1		COSENTYX		QL NM PA
sajazir (generic of	Tier 1	QL NM PA	SENSOREADY PEN SOAJ		
FIRAZYR) SOSY 30mg/3n	nl		150mg/ml		
QL (9 syringes / 30			QL (32 pens / 365		
days)			days)		
TAVNEOS CAPS 10mg	Tier 2	QL NM PA	COSENTYX UNOREADY	Her 2	QL NM PA
QL (180 caps / 30			SOAJ 300mg/2ml		
days)	T: 0		QL (16 pens / 365 days)		
tranexamic acid (generic of	Her 2		DUPIXENT SOPN	Tier 2	QL NM PA
CYKLOKAPRON) SOLN 1000mg/10ml			200mg/1.14ml, 300mg/2ml	1101 2	. QLIMITA
tranexamic acid TABS	Tier 2		QL (4 pens / 28 days)		
650mg	1101 2		DUPIXENT SOSY	Tier 2	NM PA
PLATELET AGGREGAT	TION IN	IHIBITORS	100mg/0.67ml		
aspirin-dipyridamole cap er	-	Inditorio	DUPIXENT SOSY	Tier 2	QL NM PA
12hr 25-200 mg	1101 2		200mg/1.14ml, 300mg/2ml		
BRILINTA TABS 60mg,	Tier 2	<del>.</del>	QL (4 syringes / 28		
90mg			days)		
clopidogrel bisulfate	Tier 1	_	ENBREL SOLN	Tier 2	QL NM PA
(generic of PLAVIX) TABS			25mg/0.5ml		
75mg			QL (16 vials / 28 days)		
dipyridamole TABS 25mg,	Tier 2	PA	ENBREL SOSY	Her 2	QL NM PA
50mg, 75mg			25mg/0.5ml QL (16 syringes / 28		
PA applies if 70 years an	d		days)		
older	T: 0		ENBREL SOSY 50mg/ml	Tier 2	QL NM PA
prasugrel hcl (generic of	Tier 2		QL (8 syringes / 28	1101 2	. QLIMITA
EFFIENT) TABS 5mg, 10mg			days)		
IMMUNOLOGIC AGENT	·C		ENBREL MINI SOCT	Tier 2	QL NM PA
AUTOIMMUNE AGENTS	_		50mg/ml		
ADALIMUMAB-AACF (2	Tier 2	QL NM PA	QL (8 cartridges / 28		
PEN) AJKT 40mg/0.8ml	1161 2	QL MINI FA	days)		
QL (56 pens / 365			ENBREL SURECLICK	Tier 2	QL NM PA
days)			SOAJ 50mg/ml		
ADALIMUMAB-AACF (2	Tier 2	QL NM PA	QL (8 pens / 28 days)	IT: 0	OL NIM DA
SYRING PSKT 40mg/0.8m	าไ		HUMIRA PSKT 10mg/0.1m QL (2 syringes / 28	i i ier z	QL NIVI PA
QL (56 syringes / 365			days)		
days)			HUMIRA PSKT 20mg/0.2m	l Tier 2	OL NM PA
COSENTYX SOLN	Tier 2	NM PA	QL (4 syringes / 28	1 1101 2	. QLIMIII
125mg/5ml			days)		
COSENTYX SOSY	Tier 2	QL NM PA	HUMIRA PSKT	Tier 2	QL NM PA
75mg/0.5ml			40mg/0.4ml, 40mg/0.8ml		
QL (16 syringes / 365			QL (6 syringes / 28		
days) COSENTYX SOSY	Tior 2	QL NM PA	days)		
150mg/ml	i i <del>e</del> i Z	QL INIVI FA	HUMIRA PEN PNKT	Tier 2	QL NM PA
QL (32 syringes / 365			40mg/0.4ml, 40mg/0.8ml		
days)			QL (6 pens / 28 days)		

Drug Name	Drug Tier	Requirements/ Limits		orug F Tier	Requirements/ Limits
HUMIRA PEN PNKT	Tier 2	QL NM PA		Tier 2	QL NM PA
80mg/0.8ml			45mg/0.5ml		
QL (4 pens / 28 days)		01.1114.04	QL (1 vial / 28 days)		
HUMIRA PEN KIT PS/UV		QL NM PA		Tier 2	NM PA
QL (3 pens / 28 days) HUMIRA PEN-CD/UC/HS		QL NM PA	130mg/26ml STELARA SOSY T	Tior 2	QL NM PA
START PNKT 80mg/0.8ml	1161 2	QLINIVITA	45mg/0.5ml, 90mg/ml	161 2	QLINIVITA
QL (3 pens / 28 days)			QL (1 syringe / 28		
HUMIRA PEN-PEDIATRIC		QL NM PA	days)		
UCS PNKT 80mg/0.8ml				Tier 2	QL NM PA
QL (4 pens / 28 days)			100mg/ml		
IDACIO (2 PEN) AJKT	Tier 2	QL NM PA	QL (1 pen / 28 days)	<u>-</u> . 0	
40mg/0.8ml				ier 2	QL NM PA
QL (56 pens / 365 days)			100mg/ml QL (1 syringe / 28		
IDACIO (2 SYRINGE)	Tier 2	QL NM PA	days)		
PSKT 40mg/0.8ml	1101 2	QL MWT 7		Tier 2	QL NM PA
QL (56 syringes / 365			162mg/0.9ml		
days)			QL (4 pens / 28 days)		
IDACIO CROHN INJ	Tier 2	QL NM PA	TYENNE SOLN 80mg/4ml, T	Tier 2	NM PA
DISEASE AJKT			200mg/10ml, 400mg/20ml		
40mg/0.8ml				Tier 2	QL NM PA
QL (2 packs / year) IDACIO PLAQU INJ	Tior 2	QL NM PA	162mg/0.9ml		
PSORIASIS AJKT	Hel Z	QL NIVI PA	QL (4 syringes / 28 days)		
40mg/0.8ml				Tier 2	QL NM PA
QL (2 packs / year)			QL (30 tabs / 30 days)	.0	α
RINVOQ TB24 15mg,	Tier 2	QL NM PA		Tier 2	QL NM PA
30mg			QL (480 mL / 24 days)		
QL (30 tabs / 30 days	·		<b>3</b> ,	Tier 2	QL NM PA
RINVOQ TB24 45mg	Her 2	QL NM PA	10mg		
QL (168 tabs / year)	l Tior 2		QL (60 tabs / 30 days)	T: O	OL NIM DA
RINVOQ LQ SOLN 1mg/m QL (360 mL / 30 days		QL NIVI PA	XELJANZ XR TB24 11mg, T 22mg	ier 2	QL NIVI PA
SKYRIZI SOCT	<i>'</i>	QL NM PA	QL (30 tabs / 30 days)		
180mg/1.2ml, 360mg/2.4ml		QL MM 170	DISEASE-MODIFYING AN	ITI-RI	HEUMATIC
QL (1 cartridge / 56			DRUGS (DMARDS)		
days)				Tier 2	
SKYRIZI SOLN	Tier 2	NM PA	(generic of PLAQUENIL)		
600mg/10ml			TABS 200mg		
SKYRIZI SOSY 150mg/ml	Her 2	QL NM PA		Tier 2	B/D
QL (6 syringes / 365 days)			ν.Ο	Tier 2	QL
SKYRIZI PEN SOAJ	Tier 2	QL NM PA	ARAVA) TABS 10mg,		
150mg/ml	1101 2	SE MINITA	20mg		
QL (6 pens / 365 days	s)		QL (30 tabs / 30 days) methotrexate sodium TABS T	Tier 2	
SOTYKTU TABS 6mg		QL NM PA	2.5mg	101 2	
QL (30 tabs / 30 days	)			Tier 2	B/D

Drug Name	Drug Tier	Requirements/ Limits
IMMUNOGLOBULINS		
ALYGLO SOLN 5gm/50ml,	Tier 2	PA
10gm/100ml, 20gm/200ml	_	
BIVIGAM SOLN 5gm/50ml,	Tier 2	NM PA
10%		_
FLEBOGAMMA DIF SOLN	Tier 2	NM PA
5gm/100ml, 10gm/200ml,		
20gm/400ml		
GAMASTAN INJ	Tier 2	B/D NM
GAMMAGARD LIQUID	Tier 2	NM PA
SOLN 1gm/10ml,		
2.5gm/25ml, 5gm/50ml,		
10gm/100ml, 20gm/200ml,		
_30gm/300ml		
GAMMAGARD S/D IGA	Tier 2	NM PA
LESS TH SOLR 5gm,		
_10gm		
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,		
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		
<b>IMMUNOMODULATORS</b>	-	
ACTIMMUNE SOLN	Tier 2	NM PA
100mcg/0.5ml		
ARCALYST SOLR 220mg	Tier 2	NM PA
IMMUNOSUPPRESSANT		
ASTAGRAF XL CP24 5mg		B/D NM
7.017.010 II AL OI 24 OIIIg	. 101 2	<i>5,5</i> 14101

Drug Name	Drug Tier	Requirements/ Limits
ASTAGRAF XL CP24 .5mg, 1mg	Tier 2	B/D NM
azathioprine (generic of IMURAN) TABS 50mg	Tier 2	B/D
BENLYSTA SOAJ 200mg/ml; SOSY 200mg/ml QL (8 syringes / 28 days)	Tier 2	QL NM PA
	Tier 2	NM PA
cyclosporine (generic of SANDIMMUNE) CAPS 25mg, 100mg	Tier 2	B/D NM
cyclosporine modified (for microemulsion) (generic of NEORAL) CAPS 25mg, 100mg; SOLN 100mg/ml	Tier 2	B/D NM
cyclosporine modified (for microemulsion) CAPS 50mg	Tier 2	B/D NM
everolimus (immunosuppressant) (generic of ZORTRESS) TABS .25mg, .5mg, .75mg, 1mg	Tier 1	B/D NM
gengraf (generic of NEORAL) CAPS 25mg, 100mg; SOLN 100mg/ml	Tier 2	B/D NM
mycophenolate mofetil (generic of CELLCEPT) CAPS 250mg; TABS 500mg	Tier 2	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 2	B/D NM
PROGRAF PACK .2mg, 1mg	Tier 2	B/D NM
REZUROCK TABS 200mg QL (30 tabs / 30 days)	Tier 2	QL NM PA
sirolimus (generic of RAPAMUNE) SOLN 1mg/ml	Tier 1	B/D NM
sirolimus (generic of RAPAMUNE) TABS .5mg, 1mg, 2mg	Tier 2	B/D NM

Drug Name	Drug Tier	Requirements/ Limits
tacrolimus (generic of	Tier 2	B/D NM
PROGRAF) CAPS .5mg,		
1mg, 5mg		
VACCINES		
ABRYSVO SOLR	Tier 1	
120mcg/0.5ml		
ACTHIB INJ	Tier 1	
ADACEL INJ	Tier 1	
AREXVY SUSR	Tier 1	
120mcg/0.5ml		
BCG VACCINE SOLR	Tier 1	
50mg	<u> </u>	
BEXSERO INJ	Tier 1	
BOOSTRIX INJ	Tier 1	
DAPTACEL INJ	Tier 1	
DENGVAXIA SUS	Tier 1	
DIP/TET PED INJ 25-5LFU	Tier 1	B/D
ENGERIX-B SUSP	Tier 1	B/D
20mcg/ml; SUSY		
10mcg/0.5ml, 20mcg/ml		
GARDASIL 9 INJ	Tier 1	
HAVRIX SUSP	Tier 1	
720elu/0.5ml, 1440elu/ml		
HEPLISAV-B SOSY	Tier 1	B/D
20mcg/0.5ml		
HIBERIX SOLR 10mcg	Tier 1	
IMOVAX RABIES	Tier 1	B/D
(H.D.C.V.) SUSR 2.5unit/ml		
INFANRIX INJ	Tier 1	
IPOL INJ INACTIVE	Tier 1	
IXCHIQ INJ	Tier 1	
IXIARO INJ	Tier 1	
JYNNEOS SUSP .5ml	Tier 1	B/D
KINRIX INJ	Tier 1	
M-M-R II INJ	Tier 1	•
MENACTRA INJ	Tier 1	
MENQUADFI INJ	Tier 1	
MENVEO INJ	Tier 1	
MENVEO SOL	Tier 1	
MRESVIA SUSY	Tier 1	
50mcg/0.5ml	1101 1	
PEDIARIX INJ 0.5ML	Tier 1	•
PEDVAX HIB SUSP	Tier 1	
7.5mcg/0.5ml		
PENBRAYA INJ	Tier 1	

Drug Name	Drug Tier	Requirements/ Limits
PENTACEL INJ	Tier 1	
PREHEVBRIO SUSP	Tier 1	B/D
10mcg/ml		
PRIORIX INJ	Tier 1	
PROQUAD INJ	Tier 1	
QUADRACEL INJ	Tier 1	_
QUADRACEL INJ 0.5ML	Tier 1	
RABAVERT INJ	Tier 1	
RECOMBIVAX HB SUSP	Tier 1	
5mcg/0.5ml, 10mcg/ml,	1101	5,5
40mcg/ml; SUSY		
5mcg/0.5ml, 10mcg/ml		
ROTARIX SUS	Tier 1	
ROTATEQ SOL	Tier 1	<del>.</del>
SHINGRIX SUSR	Tier 1	QL
50mcg/0.5ml		α
QL (2 vials per		
lifetime)		
TDVAX INJ 2-2 LF	Tier 1	B/D
TENIVAC INJ 5-2LF	Tier 1	B/D
TICOVAC SUSY	Tier 1	
1.2mcg/0.25ml,		
2.4mcg/0.5ml		
TRUMENBA INJ	Tier 1	
TWINRIX INJ	Tier 1	•
TYPHIM VI SOLN	Tier 1	
25mcg/0.5ml; SOSY		
25mcg/0.5ml		
VAQTA SUSP 25unit/0.5ml	Tier 1	
50unit/ml		
VARIVAX INJ	Tier 1	
1350pfu/0.5ml	-	
YF-VAX INJ	Tier 1	
NUTRITIONAL/SUPPLEM	MENT	S
ELECTROLYTES/MINER	RALS,	
INJECTABLE		
D2.5W/NACL INJ 0.45%	Tier 2	<u> </u>
D10W/NACL INJ 0.2%	Tier 2	)
dextrose 2.5% w/ sodium	Tier 2	2
chloride 0.45% (generic of		
DEXTROSE 2.5%/SODIUM		
CHLO)		
dextrose 5% in lactated	Tier 2	<u></u>
ringers		
dextrose 5% w/ sodium	Tier 2	<u> </u>
chloride 0.2%		

Drug Name	Drug Requirements/ Tier Limits	Drug Na
dextrose 5% w/ sodium	Tier 2	kcl 40 m
chloride 0.3% (generic of		0.9% inj
DEXTROSE 5%/SODIUM		POTAS
CHLORI)		CHLOR
dextrose 5% w/ sodium	Tier 2	KCL/D5
chloride 0.9%		0.3/0.9%
dextrose 5% w/ sodium	Tier 2	lactated
chloride 0.45%		MAGNE
dextrose 5% w/ sodium	Tier 2	SOLN 2
chloride 0.225% (generic of		4gm/100
DEXTROSE/SODIUM		20gm/50
CHLORIDE)		magnes
dextrose 10% w/ sodium	Tier 2	of MAG
chloride 0.45%		SOLN 2
ISOLYTE-P INJ /D5W	Tier 2	4gm/100
ISOLYTE-S INJ PH 7.4	Tier 2	20gm/50
kcl 10 meq/l (0.075%) in	Tier 2	magnes
dextrose 5% & nacl 0.45%		50%
inj		magnes
kcl 20 meq/l (0.15%) in	Tier 2	dextros
dextrose 5%`& nacl´0.2% inj		gm/100
kcl 20 meq/l (0.15%) in	Tier 2	MAGNE
dextrose 5% & nacl 0.9% inj		D5W)
kcl 20 meq/l (0.15%) in	Tier 2	multiple
dextrose 5% & nacl 0.45%		multiple
inj		(generic
kcl 20 meq/l (0.15%) in nacl	Tier 2	<u>A)</u>
0.9% inj (generic of		POT CH
POTASSIUM		NACL 0
CHLORIDE/SODIUM)		POT CH
kcl 20 meq/l (0.15%) in nacl	Tier 2	NACL 0
0.45% inj (generic of		POT CH
POTASSIUM		NACL 0
CHLORIDE/SODIUM)		potassii
kcl 20 meq/l (0.149%) in	Tier 2	_2meq/m
nacl 0.45% inj		potassii
kcl 30 meq/l (0.224%) in	Tier 2	of POTA
dextrose 5% & nacl 0.45%		CHLOR
inj		10meq/
kcl 40 meq/l (0.3%) in	Tier 2	20meq/
dextrose 5% & nacl 0.9% inj		40meq/
(generic of KCL		potassii
0.3%/D5W/NACL 0.9%)		(0.15%)
kcl 40 meq/l (0.3%) in	Tier 2	sodium
dextrose 5% & nacl 0.45%		.45%, .9
inj		TPN EL

Drug Name	Drug Tier	Requirements/ Limits
kcl 40 meq/l (0.3%) in nacl 0.9% inj (generic of POTASSIUM	Tier 2	
CHLORIDE/SODIUM)		
KCL/D5W/NACL INJ 0.3/0.9%	Tier 2	
lactated ringer's solution	Tier 2	
MAGNESIUM SULFATE SOLN 2gm/50ml, 4gm/100ml, 4gm/50ml, 20gm/500ml, 40gm/1000ml	Tier 2	
magnesium sulfate (generic of MAGNESIUM SULFATE) SOLN 2gm/50ml, 4gm/100ml, 4gm/50ml, 20gm/500ml, 40gm/1000ml	Tier 2	
magnesium sulfate SOLN 50%	Tier 2	
magnesium sulfate in dextrose 5% iv soln 1 gm/100ml (generic of MAGNESIUM SULFATE IN D5W)	Tier 2	
multiple electrolytes ph 5.5	Tier 2	
multiple electrolytes ph 7.4 (generic of PLASMA-LYTE A)	Tier 2	
POT CHL 20MEQ/L IN NACL 0.9% INJ	Tier 2	
POT CHL 20MEQ/L IN NACL 0.45% INJ	Tier 2	!
POT CHL 40MEQ/L IN NACL 0.9% INJ	Tier 2	
potassium chloride SOLN 2meq/ml	Tier 2	
potassium chloride (generic of POTASSIUM CHLORIDE) SOLN	Tier 2	
10meq/100ml, 10meq/50ml, 20meq/100ml, 20meq/50ml, 40meq/100ml		
potassium chloride 20 meq/l (0.15%) in dextrose 5% inj	Tier 2	
sodium chloride SOLN .45%, .9%, 2.5meq/ml, 3%	Tier 2	!
TPN ELECTROL INJ	Tier 2	B/D

Drug Name	Drug Req Tier	uirements/ Limits
ELECTROLYTES/MINER ORAL	PALS/VITA	AMINS,
klor-con PACK 20meg	Tier 2	
klor-con 8 TBCR 8meg	Tier 1	
klor-con 10 TBCR 10meg	Tier 1	
klor-con m10 TBCR 10meg	Tier 1	
klor-con m15 TBCR 15meq	Tier 1	
klor-con m20 TBCR 20meg		
M-NATAL PLUS TAB	Tier 2	
potassium chloride CPCR	Tier 1	
8meq, 10meq; TBCR 8meq, 10meq		
potassium chloride PACK 20meq; SOLN 10%, 20%	Tier 2	
potassium chloride (generic of K-TAB) TBCR 20meq	Tier 1	
potassium chloride	Tier 1	
microencapsulated crystals		
er TBCR 10meq, 15meq,		
20meq	T: 0 = 0	
PRENATAL TAB PLUS	Tier 2	
PRENATAL TAB PLUS	Tier 2	
sodium fluoride chew; tab; 1.1 (0.5 f) mg/ml soln	Tier 1	
WESTAB PLUS TAB 27-	Tier 2	
1MG		
IV NUTRITION		
CLINIMIX INJ 4.25/D5W	Tier 2	B/D
CLINIMIX INJ 4.25/D10	Tier 2	B/D
CLINIMIX INJ 5%/D15W	Tier 2	B/D
CLINIMIX INJ 5%/D20W	Tier 2	B/D
CLINIMIX INJ 6/5 CLINIMIX INJ 8/10	Tier 2 Tier 2	B/D B/D
CLINIMIX INJ 8/14	Tier 2	B/D
clinisol sf 15%	Tier 2	B/D
CLINOLIPID EMU 20%	Tier 2	B/D
dextrose SOLN 5%, 10%	Tier 2	
dextrose SOLN 50%, 70%	Tier 2	B/D
INTRALIPID EMUL	Tier 2	B/D
20gm/100ml, 30gm/100ml		
NUTRILIPID EMUL	Tier 2	B/D
20gm/100ml		
plenamine	Tier 2	B/D
PREMASOL SOL 10%	Tier 1	B/D
PROSOL INJ 20%	Tier 2	B/D
TRAVASOL INJ 10%	Tier 2	B/D

Drug Name	Drug Tier	Requirements/ Limits
TROPHAMINE INJ 10%	Tier 2	B/D
OPHTHALMIC		_
ANTI-INFECTIVE/ANTI-II	<b>VFLA</b>	MMATORY
bacitracin-polymyxin-	Tier 2	
neomycin-hc ophth oint 1%		
neo-polycin hc ophth oint	Tier 2	
1%	T: 4	
neomycin-polymyxin-	Tier 1	
dexamethasone ophth oint 0.1% (generic of		
MAXITROL)		
neomycin-polymyxin-	Tier 1	
dexamethasone ophth susp	i i <del>c</del> i i	
0.1% (generic of		
MAXITROL)		
sulfacetamide sodium-	Tier 1	
prednisolone ophth soln 10-	i i <del>c</del> i i	
0.23(0.25)%		
TOBRADEX OIN 0.3-0.1%	Tier 2	<u>.</u>
tobramycin-dexamethasone	Her 2	
ophth susp 0.3-0.1% ZYLET SUS 0.5-0.3%	Tier 2	<del></del>
	Her Z	<u> </u>
ANTI-INFECTIVES	·	
bacitracin (ophthalmic) OINT 500unit/gm	Tier 2	
bacitracin-polymyxin b ophthoint	Tier 1	
BESIVANCE SUSP .6%	Tier 2	
CILOXAN OINT .3%	Tier 2	
ciprofloxacin hcl (ophth)	Tier 1	
SOLN .3% erythromycin (ophth) OINT	Tier 1	
5mg/gm		
gentamicin sulfate (ophth) SOLN .3%	Tier 1	
moxifloxacin hcl (ophth)	Tier 2	QL
(generic of VIGAMOX)		
SOLN .5%		
QL (12 mL / 30 days)		
neo-polycin 5(3.5)mg-	Tier 2	
400unt-10000unt op oin		
neomycin-bacitrac zn-	Tier 2	
polymyx 5(3.5)mg-400unt-		
10000unt op oin		
neomycin-polymy-gramicid	Tier 2	!
op sol 1.75-10000-0.025mg-	•	
unt-mg/ml		

Drug Name	Drug Tier	Requirements/ Limits
ofloxacin (ophth) (generic of OCUFLOX) SOLN .3%	Tier 1	
polycin ophth oint	Tier 1	
polymyxin b-trimethoprim ophth soln 10000 unit/ml-0.1%	Tier 1	
sulfacetamide sodium (ophth) OINT 10%; SOLN 10%	Tier 2	
tobramycin (ophth) SOLN .3%	Tier 1	
trifluridine SOLN 1%	Tier 2	
XDEMVY SOLN .25%	Tier 2	NM PA
ZIRGAN GEL .15%	Tier 2	2
ANTI-INFLAMMATORIES	3	
bromfenac sodium (ophth) (generic of PROLENSA) SOLN .07%	Tier 2	
bromfenac sodium (ophth) (generic of BROMSITE) SOLN .075%	Tier 2	
dexamethasone sodium phosphate (ophth) SOLN .1%	Tier 2	
diclofenac sodium (ophth) SOLN .1%	Tier 1	
FLAREX SUSP .1%	Tier 2	
fluorometholone (ophth) (generic of FML LIQUIFILM) SUSP .1%	Tier 2	
flurbiprofen sodium SOLN .03%	Tier 2	
ketorolac tromethamine (ophth) (generic of ACULAR LS) SOLN .4%	Tier 2	
ketorolac tromethamine (ophth) (generic of ACULAR) SOLN .5%	Tier 1	
LOTEMAX OINT .5%	Tier 2	
loteprednol etabonate (generic of ALREX) SUSP .2%	Tier 2	
prednisolone acetate (ophth) (generic of PRED FORTE) SUSP 1%	Tier 2	2
ANTIALLERGICS	<b>T</b> : 4	<del>.</del>
azelastine hcl (ophth) SOLN .05%	Tier 1	

Drug Name	Drug Tier	Requirements/ Limits
cromolyn sodium (ophth) SOLN 4%	Tier 1	
ANTIGLAUCOMA		
betaxolol hcl (ophth) SOLN .5%	Tier 2	2
BETOPTIC-S SUSP .25%	Tier 2	
brimonidine tartrate SOLN .2%	Tier 1	
brimonidine tartrate (generic of ALPHAGAN P) SOLN .15%	Tier 2	!
brinzolamide (generic of AZOPT) SUSP 1%	Tier 2	2
carteolol hcl (ophth) SOLN 1%	Tier 1	
COMBIGAN SOL 0.2/0.5%	Tier 2	
dorzolamide hcl SOLN 2%	Tier 1	<del>,</del>
dorzolamide hcl-timolol maleate ophth soln 2-0.5% (generic of COSOPT)	Tier 1	
latanoprost (generic of XALATAN) SOLN .005%	Tier 1	
levobunolol hcl SOLN .5%	Tier 1	
pilocarpine hcl SOLN 1%, 2%, 4%	Tier 2	
RHOPRESSA SOLN .02%	Tier 2	2
ROCKLATAN DRO	Tier 2	-
SIMBRINZA SUS 1-0.2%	Tier 2	
timolol maleate (ophth) SOLG .25%, .5%	Tier 2	
timolol maleate (ophth) SOLN .25%, .5%	Tier 1	
VYZULTA SOLN .024%	Tier 2	
MISCELLANEOUS		_
ATROPINE SULFATE SOLN 1%	Tier 2	
atropine sulfate (ophthalmic) SOLN 1%	Tier 2	
CYSTADROPS SOLN .37%	Tier 2	NM PA
CYSTARAN SOLN .44%	Tier 2	NM PA
EYSUVIS SUSP .25%	Tier 2	<u> </u>
MIEBO SOLN 1.338gm/ml	Tier 2	
proparacaine hcl (generic of ALCAINE) SOLN .5%	Tier 2	!
RESTASIS EMUL .05%	Tier 2	<u> </u>

Drug Name	Drug Tier	Requirements/ Limits		Drug Tier	Requirements/ Limits
RESTASIS MULTIDOSE EMUL .05%	Tier 2	2	TRELEGY AER ELLIPTA 200-62.5-25 MCG	Tier 2	
XIIDRA SOLN 5% OTIC	Tier 2	<u>2</u>	QL (60 blisters / 30 days)		
OTIC AGENTS			ANTICHOLINERGICS	•	
acetic acid (otic) SOLN 2%	Tier 2	2	ATROVENT HFA AERS	Tier 2	2 QL
ciprofloxacin- dexamethasone otic susp 0.3-0.1%	Tier 2	2	17mcg/act QL (2 inhalers / 30 days)		
flac (generic of DERMOTIC OIL .01%	) Tier 2	2	INCRUSE ELLIPTA AEPB 62.5mcg/inh	Tier 2	2 QL
fluocinolone acetonide (otic (generic of DERMOTIC)	) Tier 2	2	QL (30 blisters / 30 days)		
ÖIL .01%	Tion	<u> </u>	ipratropium bromide SOLN .02%	Tier 1	I B/D
neomycin-polymyxin-hc otio			ipratropium bromide (nasal) SOLN .03%, .06%	Tier 2	2
neomycin-polymyxin-hc otion susp 3.5 mg/ml-10000	Tier 2	2	ANTIHISTAMINES		
unit/ml-1%			azelastine hcl SOLN .1%	Tier 2	2
ofloxacin (otic) SOLN .3%	Tier 2	2	cetirizine hcl SOLN	Tier 1	1 QL
RESPIRATORY	•	•	5mg/5ml		
ANTICHOLINERGIC/BE COMBINATIONS	TA AC	GONIST	7, ,	Tier 2	2 PA
ANORO ELLIPT AER 62.5- 25 QL (60 blisters / 30	Tier 2	QL	2mg/5ml; TABS 4mg PA applies if 70 years and older after a 30 day supply in a calendar year	I	
days) BEVESPI AER 9-4.8MCG	Tier 2	2 QL	diphenhydramine hcl SOLN 50mg/ml	Tier 2	2
QL (1 inhaler / 30 days)			hydroxyzine hcl SOLN	Tier 2	2 PA
BREZTRI AERO AER SPHERE	Tier 2	2 QL	25mg/ml, 50mg/ml PA applies if 70 years and older	I	
QL (1 inhaler / 30 days)			hydroxyzine hcl SYRP	Tier 2	2 PA
BREZTRI AERO AER SPHERE (INSTITUTIONAL PACK) QL (4 inhalers / 28	Tier 2	2 QL	10mg/5ml; TABS 10mg, 25mg, 50mg PA applies if 70 years and older after a 30 day supply in a calendar year	I	
days) COMBIVENT AER 20-100 QL (2 inhalers / 30 days)	Tier 2	2 QL	hydroxyzine pamoate (generic of VISTARIL) CAPS 25mg	Tier 2	2 PA
ipratropium-albuterol nebu soln 0.5-2.5(3) mg/3ml	Tier 2	2 B/D	PA applies if 70 years and older after a 30 day	ı	
TRELEGY AER ELLIPTA 100-62.5-25 MCG QL (60 blisters / 30 days)	Tier 2	2 QL	supply in a calendar year		

Drug Name	Drug F Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
hydroxyzine pamoate CAPS 50mg PA applies if 70 years an older after a 30 day supply in a calendar year		PA	VENTOLIN HFA (INSTITUTIONAL PACK) AERS 108mcg/act QL (6 inhalers / 30 days)	Tier 2	QL
levocetirizine	Tier 1	QL	LEUKOTRIENE MODU	LATOR	<u></u> S
dihydrochloride TABS 5mg QL (30 tabs / 30 days BETA AGONISTS	)		montelukast sodium (generic of SINGULAIR) CHEW 4mg, 5mg; TABS	Tier 1	
albuterol sulfate AERS 108mcg/act QL (2 inhalers / 30 days)	Tier 2	QL	10mg montelukast sodium (generic of SINGULAIR) PACK 4mg	Tier 2	
(generic of Proair HFA)  albuterol sulfate AERS  108mcg/act	Tier 2	QL	zafirlukast (generic of ACCOLATE) TABS 10mg	Tier 2 J,	
QL (2 inhalers / 30			MISCELLANEOUS		
days) (generic of Ventolin HFA			acetylcysteine SOLN 10% 20%	6, Tier 2	
albuterol sulfate (generic of PROVENTIL HFA) AERS	Tier 2	QL	ARALAST NP SOLR 500mg, 1000mg	Tier 2	NM PA
108mcg/act QL (2 inhalers / 30 days)			BRONCHITOL CAPS 40r QL (560 caps / 28 days)	ng Tier 2	QL NM PA
(generic of Proventil HFA albuterol sulfate NEBU	Tier 2	B/D	cromolyn sodium NEBU 20mg/2ml	Tier 2	B/D
.63mg/3ml, 1.25mg/3ml, 2.5mg/0.5ml	<del></del> , ,		epinephrine (anaphylaxis) (generic of EPIPEN 2-PA		
albuterol sulfate NEBU .083%	Tier 1	B/D	SOAJ .3mg/0.3ml (generic of EpiPen)		
albuterol sulfate SYRP 2mg/5ml	Tier 2		epinephrine (anaphylaxis) (generic of EPIPEN-JR 2-	Tier 2	
albuterol sulfate TABS 2mg, 4mg	Tier 2		PAK) SOAJ .15mg/0.3ml (generic of EpiPen)		
levalbuterol tartrate AERO 45mcg/act QL (2 inhalers / 30 days)	Tier 2	QL ST	epinephrine (anaphylaxis) SOAJ .15mg/0.15ml, .3mg/0.3ml (generic of Adrenaclick)		
SEREVENT DISKUS AEP 50mcg/dose QL (60 inhalations / 3 days)	0	QL	FASENRA SOSY 10mg/0.5ml, 30mg/ml QL (1 syringe / 28 days)		QL NM PA
terbutaline sulfate TABS 2.5mg, 5mg	Tier 2		FASENRA PEN SOAJ 30mg/ml	Tier 2	QL NM PA
VENTOLIN HFA AERS 108mcg/act QL (2 inhalers / 30 days)	Tier 2	QL 	QL (1 pen / 28 days)		

Drug Name	Drug Tier	Requirements/ Limits
KALYDECO PACK 5.8mg, 13.4mg, 25mg, 50mg, 75mg QL (56 packets / 28 days)		QL NM PA
KALYDECO TABS 150mg QL (60 tabs / 30 days)		
OFEV CAPS 100mg, 150mg QL (60 caps / 30 days)		QL NM PA
ORKAMBI GRA 75-94MG QL (56 packets / 28 days)	Tier 2	QL NM PA
ORKAMBI GRA 100-125 QL (56 packets / 28 days)	Tier 2	QL NM PA
ORKAMBI GRA 150-188 QL (56 packets / 28 days)	Tier 2	QL NM PA
ORKAMBI TAB 100-125 QL (112 tabs / 28 days)	Tier 2	QL NM PA
ORKAMBI TAB 200-125 QL (112 tabs / 28 days)	Tier 2	QL NM PA
pirfenidone (generic of ESBRIET) CAPS 267mg QL (270 caps / 30 days)	Tier 1	QL NM PA
pirfenidone (generic of ESBRIET) TABS 267mg QL (270 tabs / 30 days)	Tier 1	QL NM PA
pirfenidone TABS 534mg QL (90 tabs / 30 days)	Tier 1	QL NM PA
pirfenidone (generic of ESBRIET) TABS 801mg QL (90 tabs / 30 days)	Tier 1	QL NM PA
PROLASTIN-C SOLN 1000mg/20ml	Tier 2	NM PA
PULMOZYME SOLN 2.5mg/2.5ml	Tier 2	NM PA
roflumilast (generic of DALIRESP) TABS 250mcg QL (56 tabs / year)	Tier 2	QL
roflumilast (generic of DALIRESP) TABS 500mcg QL (30 tabs / 30 days)	Tier 2	QL

Drug Name	Drug Tier	Requirements/ Limits
SYMDEKO TAB 50-75MG QL (56 tabs / 28 days)	Tier 2	QL NM PA
SYMDEKO TAB 100-150 QL (56 tabs / 28 days)	Tier 2	QL NM PA
theophylline TB12 100mg, 200mg, 300mg, 450mg	Tier 2	
theophylline TB24 400mg, 600mg	Tier 2	
TRIKAFTA PAK 59.5MG QL (56 packs / 28 days)	Tier 2	QL NM PA
TRIKAFTA PAK 75MG QL (56 packs / 28 days)	Tier 2	QL NM PA
TRIKAFTA TAB 50-25- 37.5MG & 75MG QL (84 tabs / 28 days)	Tier 2	QL NM PA
TRIKAFTA TAB 100-50- 75MG & 150MG QL (84 tabs / 28 days)	Tier 2	QL NM PA
XOLAIR SOAJ 75mg/0.5ml, 300mg/2ml QL (4 pens / 28 days)	Tier 2	QL NM PA
XOLAIR SOAJ 150mg/ml QL (8 pens / 28 days)	Tier 2	QL NM PA
XOLAIR SOLR 150mg QL (8 vials / 28 days)	Tier 2	QL NM PA
XOLAIR SOSY 75mg/0.5ml, 300mg/2ml QL (4 syringes / 28 days)	Tier 2	QL NM PA
XOLAIR SOSY 150mg/ml QL (8 syringes / 28 days)		QL NM PA
ZEMAIRA SOLR 1000mg, 4000mg, 5000mg	Tier 2	NM PA
NASAL STEROIDS flunisolide (nasal) SOLN .025% QL (3 bottles / 30 days)	Tier 2	QL
fluticasone propionate (nasal) SUSP 50mcg/act QL (1 bottle / 30 days)	Tier 1	QL
XHANCE EXHU 93mcg/act QL (32 mL / 30 days)	Tier 2	QL PA

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
STEROID INHALANTS			budesonide-formoterol	Tier 2	
ALVESCO AERS	Tier 2	QL	fumarate dihyd aerosol 160-	-	
80mcg/act			4.5 mcg/act (generic of		
QL (3 inhalers / 30			SYMBICORT)		
days)			QL (3 inhalers / 30		
ALVESCO AERS	Tier 2	QL	days)		
160mcg/act			DULERA AER 50-5MCG	Tier 2	QL
QL (2 inhalers / 30			QL (3 inhalers / 30		
days)			days)		
ARNUITY ELLIPTA AEPB	Tier 2	QL	DULERA AER 100-5MCG	Tier 2	QL
50mcg/act, 100mcg/act,			QL (3 inhalers / 30		
200mcg/act			days)		
QL (30 inhalations / 30	)		DULERA AER 200-5MCG	Tier 2	QL
days)			QL (3 inhalers / 30		
budesonide (inhalation)	Tier 2	2 B/D	days)		
(generic of PULMICORT)			fluticasone-salmeterol aer	Tier 2	QL
SUSP .25mg/2ml, .5mg/2ml			powder ba 100-50 mcg/act		
STEROID/BETA-AGONI			generic of ADVAIR		
COMBINATIONS	-		ĎISKUS)		
ADVAIR HFA AER 45/21	Tier 2	QL	QL (60 inhalations / 30	)	
QL (1 inhaler / 30	1101 2		days)		
days)			(generic PRASCO not		
ADVAIR HFA AER 115/21	Tier 2	QL	covered)		
QL (1 inhaler / 30	1101 2	. QL	fluticasone-salmeterol aer	Tier 2	QL
days)			powder ba 250-50 mcg/act		
ADVAIR HFA AER 230/21	Tier 2	2 QL	(generic of ADVAIR		
QL (1 inhaler / 30	1161 2	. QL	DISKUS)		
days)			QL (60 inhalations / 30	)	
BREO ELLIPTA INH 50-	Tier 2		days)		
25MCG	1161 2	. QL	(generic PRASCO not		
QL (60 blisters / 30			covered)		
days)			fluticasone-salmeterol aer	Tier 2	QL
BREO ELLIPTA INH 100-25	5 Tier 2	QL	powder ba 500-50 mcg/act		
QL (60 blisters / 30	7 1101 2	. QL	(generic of ADVAIR		
days)			DISKUS)		
BREO ELLIPTA INH 200-25	Tior 2	QL	QL (60 inhalations / 30	)	
QL (60 blisters / 30	7 1101 2	. QL	days)		
days)			(generic PRASCO not		
breyna (generic of	Tier 2	QL	covered)		
SYMBICORT)	1101 2	. QL	wixela inhub (generic of	Tier 2	2 QL
QL (3 inhalers / 30			ADVAIR DISKUS)		
days)			QL (60 inhalations / 30	)	
budesonide-formoterol	Tier 2	QL	days)		
fumarate dihyd aerosol 80-	1101 2	. QL	TOPICAL		
4.5 mcg/act (generic of			DERMATOLOGY, ACNE	•	
SYMBICORT)			accutane CAPS 10mg,	Tier 2	PA
QL (3 inhalers / 30			20mg, 30mg, 40mg		
days)			amnesteem CAPS 10mg,	Tier 2	PA
			20mg, 40mg		

Drug Name	Drug Tier	Requirements/ Limits
claravis CAPS 10mg, 20mg, 30mg, 40mg	Tier 2	PA
clindamycin phosphate (topical) (generic of CLEOCIN-T) LOTN 1% QL (60 mL / 30 days)	Tier 2	? QL
clindamycin phosphate (topical) SOLN 1% QL (60 mL / 30 days)	Tier 2	2 QL
erythromycin (acne aid) SOLN 2% QL (60 mL / 30 days)	Tier 2	2 QL
isotretinoin CAPS 10mg, 20mg, 30mg, 40mg	Tier 2	PA
sulfacetamide sodium (acne) (generic of KLARON) LOTN 10% QL (118 mL / 30 days)	Tier 2	2 QL
tretinoin (generic of RETIN- A) CREA .025%, .05%, .1%; GEL .01%, .025% QL (45 gm / 30 days)	Tier 2	2 QL PA
zenatane CAPS 10mg, 20mg, 30mg, 40mg	Tier 2	
DERMATOLOGY, ANTIB	IOTIC	<u>es</u>
gentamicin sulfate (topical) CREA .1%; OINT .1% QL (30 gm / 30 days)	Tier 2	2 QL
mupirocin OINT 2% QL (220 gm / 30 days)	Tier 1	QL
silver sulfadiazine (generic of SILVADENE) CREA 1%	Tier 1	
ssd (generic of SILVADENE) CREA 1%	Tier 1	
DERMATOLOGY, ANTIF	UNG	ALS
ciclopirox olamine CREA .77% QL (90 gm / 30 days)	Tier 2	2 QL
ciclopirox olamine SUSP .77%	Tier 2	QL
QL (60 mL / 30 days) clotrimazole (topical) CREA	Tier 1	QL
1% QL (45 gm / 30 days) clotrimazole (topical) SOLN	Tier 2	QL
1% QL (60 mL / 30 days)		

Drug Name	Drug Tier	Requirements/ Limits
clotrimazole w/	Tier 2	QL
betamethasone cream 1-		
0.05%		
QL (45 gm / 30 days)		
ketoconazole (topical)	Tier 2	QL
CREA 2%		
QL (60 gm / 30 days)		
ketoconazole (topical)	Tier 1	QL
SHAM 2%		
QL (120 mL / 30 days)	)	
klayesta POWD	Tier 2	QL
100000unit/gm		
QL (60 gm / 30 days)		
nyamyc POWD	Tier 2	QL
100000unit/gm		· ~-
QL (60 gm / 30 days)		
nystatin (topical) CREA	Tier 1	QL
100000unit/gm; OINT	1101	QL
100000unit/gm		
QL (30 gm / 30 days)		
nystatin (topical) POWD	Tier 2	2 QL
100000unit/gm	1101 2	. QL
QL (60 gm / 30 days)		
nystop POWD	Tier 2	2 QL
100000unit/gm	1101 2	. QL
QL (60 gm / 30 days)		
selenium sulfide LOTN	Tier 1	
2.5%		
DERMATOLOGY, ANTIF	PSORI	ATICS
acitretin CAPS 10mg,	Tier 2	PA
17.5mg, 25mg		
calcipotriene SOLN .005%	Tier 2	QL PA
QL (120 mL / 30 days)	)	
ENSTILAR AER	Tier 2	QL PA
QL (120 gm / 30 days)	)	
tazarotene (generic of	Tier 2	QL PA
TAZORAC) CREA .1%		
QL (60 gm / 30 days)		
TAZORAC CREA .05%	Tier 2	QL PA
QL (60 gm / 30 days)		
DERMATOLOGY, CORT	icos	TEROIDS
ala-cort CREA 1%	Tier 1	
alclometasone dipropionate		
CREA .05%; OINT .05%	1101 2	. QL
QL (60 gm / 30 days)		
betamethasone dipropionat	aTior 1	QL
(topical) CREA .05%	C 1 1 <del>C</del> 1 Z	. QL
· • •	١	
QL (120 gm / 30 days)	<u> </u>	

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
betamethasone dipropiona (topical) LOTN .05% QL (120 mL / 30 days	teTier 2	•	fluocinolone acetonide (generic of DERMA- SMOOTHE/FS SCALP) OI	Tier 2	
betamethasone dipropiona (topical) OINT .05% QL (120 gm / 30 days		QL	.01% QL (118.28 mL / 30 days)		
betamethasone dipropiona augmented CREA .05% QL (120 gm / 30 days	s)		fluocinolone acetonide (generic of SYNALAR) OINT .025%	Tier 2	2 QL
betamethasone dipropiona augmented GEL .05% QL (120 gm / 30 days	s)		QL (120 gm / 30 days fluocinolone acetonide SOLN .01%	) Tier 2	2 QL
betamethasone dipropiona augmented LOTN .05% QL (120 mL / 30 days			QL (60 mL / 30 days) fluocinonide CREA .05% QL (120 gm / 30 days	• • • • • • • • • • • • • • • • • • • •	
betamethasone dipropiona augmented (generic of DIPROLENE) OINT .05%	teTier 2	QL	fluocinonide GEL .05%; OINT .05% QL (60 gm / 30 days)	Tier 2	
QL (120 gm / 30 days betamethasone valerate	Tier 2	2 QL	fluocinonide SOLN .05% QL (60 mL / 30 days)	Tier 2	· 
CREA .1%; OINT .1%  QL (120 gm / 30 days betamethasone valerate	s) Tier 2	2 QL	fluocinonide emulsified bas CREA .05% QL (120 gm / 30 days		2 QL
LOTN .1% QL (120 mL / 30 days		<u>z</u> QL	fluticasone propionate CREA .05%; OINT .005%	Tier 2	2
clobetasol propionate CREA .05%; GEL .05%; OINT .05%	Tier 2	QL	halobetasol propionate CREA .05%; OINT .05% QL (50 gm / 30 days)	Tier 2	
QL (60 gm / 30 days) clobetasol propionate SOLN .05%	Tier 2	QL	hydrocortisone (topical) CREA 1%, 2.5%; LOTN 2.5%; OINT 2.5%	Tier 1	
QL (50 mL / 30 days) clobetasol propionate e CREA .05%	Tier 2	2 QL	hydrocortisone (topical) OINT 1% QL (30 gm / 30 days)	Tier '	
QL (60 gm / 30 days) fluocinolone acetonide CREA .01% QL (60 gm / 30 days)	Tier 2		hydrocortisone valerate CREA .2% QL (60 gm / 30 days) mometasone furoate CREA	Tier 2	
fluocinolone acetonide (generic of SYNALAR) CREA .025% QL (120 gm / 30 days	Tier 2	2 QL	.1%; OINT .1%; SOLN .1% triamcinolone acetonide (topical) CREA .025%, .1% .5%	Tier ′	1 QL
fluocinolone acetonide (generic of DERMA- SMOOTHE/FS BODY) OII .01% QL (118.28 mL / 30 days)	Tier 2	2 QL	QL (454 gm / 30 days triamcinolone acetonide (topical) LOTN .025%, .1% triamcinolone acetonide (topical) OINT .025%, .1%, .5%	Tier 2	

Drug Name	Drug   Tier	Requirements/ Limits
triderm CREA .5% QL (454 gm / 30 days)	Tier 1	QL
DERMATOLOGY, LOCA		STHETICS
glydo PRSY 2%	Tier 2	QL PA
QL (60 mL / 30 days)		α=
lidocaine OINT 5%	Tier 2	QL PA
QL (50 gm / 30 days)		
lidocaine (generic of	Tier 2	QL PA
LIDODERM) PTCH 5%		
QL (3 patches / 1 day)		
lidocaine hcl SOLN 4%	Tier 2	QL PA
QL (50 mL / 30 days)		
lidocaine-prilocaine cream	Tier 1	B/D QL
2.5-2.5%		
QL (30 gm / 30 days)		
lidocan (generic of	Tier 2	QL PA
LIDODERM) PTCH 5%		
QL (3 patches / 1 day)		
tridacaine ii (generic of	Tier 2	QL PA
LIDODERM) PTCH 5%		
QL (3 patches / 1 day)		
DERMATOLOGY, MISCE		EOUS SKIN
AND MUCOUS MEMBRA	ANE	
bexarotene (topical)	Tier 1	QL NM PA
(generic of TARGRETIN)		
GEL 1%		
QL (60 gm / 30 days)	<del>.</del>	
diclofenac sodium (topical)	Tier 2	QL
SOLN 1.5%		
QL (300 mL / 28 days)		
fluorouracil (topical) (generic	c Her 2	QL
of EFUDEX) CREA 5%		
QL (40 gm / 30 days)	T: 0	<u> </u>
fluorouracil (topical) SOLN	Her 2	QL
2%, 5%		
QL (10 mL / 30 days)	Tier 2	
hydrocortisone (rectal) CREA 1%	Hel Z	
hydrocortisone (rectal)	Tier 2	
(generic of ANUSOL-HC)	1161 2	
CREA 2.5%		
imiquimod CREA 5%	Tier 2	QL
QL (24 packets / 30	1101 2	QL
days)		
lactic acid (ammonium	Tier 1	
lactate) CREA 12%; LOTN		
12%		

Drug Name	Drug Tier	Requirements/ Limits
metronidazole (topical)	Tier 2	QL
(generic of METROCREAM)		
CREA .75%		
QL (45 gm / 30 days)		
metronidazole (topical) GEL	Tier 2	QL
.75%		
QL (45 gm / 30 days)		
nitroglycerin (intra-anal)	Tier 2	QL
(generic of RECTIV) OINT		
.4%		
QL (30 gm / 30 days)		
PANRETIN GEL .1%	Tier 2	QL PA
QL (60 gm / 30 days)		
pimecrolimus (generic of	Tier 2	QL PA
ELIDEL) CREA 1%		
QL (100 gm / 30 days)		
podofilox SOLN .5%	Tier 2	QL
QL (7 mL / 28 days)		_
procto-med hc (generic of	Tier 2	
ANUSOL-HC) CREA 2.5%		
proctocort CREA 1%	Tier 2	
proctosol hc (generic of	Tier 2	
ANUSOL-HC) CREA 2.5%		
proctozone-hc (generic of	Tier 2	
ANUSOL-HC) ČREA 2.5%		
tacrolimus (topical) OINT	Tier 2	QL PA
.03%, .1%		
QL (100 gm / 30 days)		
VALCHLOR GEL .016%	Tier 2	QL NM PA
QL (60 gm / 30 days)		
DERMATOLOGY, SCABI	CIDE	SAND
PEDICULIDES	<b>U.</b> –	· /
malathion LOTN .5%	Tier 2	QL
QL (59 mL / 30 days)	1101 2	QL
permethrin CREA 5%	Tier 2	QL
QL (60 gm / 30 days)	1101 2	QL
DERMATOLOGY, WOUN	ID CA	DE AGENTS
REGRANEX GEL .01%	Tier 2	
	rier z	QL PA
QL (30 gm / 30 days)	T:0 = 0	01
SANTYL OINT 250unit/gm	ner 2	QL
QL (180 gm / 30 days)	T: 0	
sodium chloride (gu irrigant)	Her 2	
SOLN .9%	<b>T</b> : '	
Water ter irrigation oferile	Tier 1	
water for irrigation, sterile irrigation soln		

Drug Name	Drug Tier	Requirements/ Limits
MOUTH/THROAT/DENT	AL AG	GENTS
chlorhexidine gluconate	Tier 1	
(mouth-throat) (generic of		
PERIDEX) SOLN .12%		<del></del>
clotrimazole TROC 10mg	Tier 2	QL
QL (150 lozenges / 30		
days)		
kourzeq PSTE .1%	Tier 2	
lidocaine hcl (mouth-throat)	Tier 1	
SOLN 2%		
nystatin (mouth-throat)	Tier 2	
(generic of NYSTATIN)		
SUSP 100000unit/ml		
periogard (generic of	Tier 1	
PERIDEX) SOLN .12%		<del></del>
pilocarpine hcl (oral)	Tier 2	
(generic of SALAGEN)		
TABS 5mg, 7.5mg		
triamcinolone acetonide	Tier 2	
(mouth) PSTE .1%		

## Index acyclovir.....7 see amphetamineabacavir sulfate.....5 acvclovir sodium .....7 dextroamphetamine ADACEL INJ......52 cap er 24hr 30 mg ...32 abacavir sulfate-lamivudine ADALIMUMAB-AACF (2 see amphetaminetab 600-300 mg.....6 ABELCET ......4 PEN) ......49 dextroamphetamine **ABILIFY** ADALIMUMAB-AACF (2) cap er 24hr 5 mg .....32 see aripiprazole.....25 SYRING .....49 adefovir dipivoxil .....7 ADMELOG......38 abiraterone acetate......10 **ADCIRCA** ADMELOG SOLOSTAR .38 ABRYSVO ......52 see alyg......22 acamprosate calcium.....35 see tadalafil (pulmonary ADVAIR DISKUS acarbose......36 hypertension).....22 see fluticasone-**ACCOLATE ADDERALL** salmeterol aer powder see zafirlukast......57 see amphetamineba 100-50 mcg/act...59 see fluticasone-**ACCUPRIL** dextroamphetamine tab 10 mg.....32 see quinapril hcl.....17 salmeterol aer powder accutane......59 see amphetamineba 250-50 mcg/act...59 acebutolol hcl......20 dextroamphetamine see fluticasoneacetaminophen w/ codeine tab 12.5 mg.....32 salmeterol aer powder soln 120-12 mg/5ml......1 see amphetamineba 500-50 mcg/act...59 see wixela inhub......59 acetaminophen w/ codeine dextroamphetamine tab 300-15 mg.....1 ADVAIR HFA AER 115/21 tab 15 mg......32 acetaminophen w/ codeine see amphetamine-.....59 dextroamphetamine tab 300-30 mg.....1 ADVAIR HFA AER 230/21 acetaminophen w/ codeine tab 20 mg.....32 .....59 tab 300-60 mg.....1 see amphetamine-ADVAIR HFA AER 45/2159 acetazolamide .....21 dextroamphetamine AFINITOR acetic acid......47 tab 30 mg.....32 see everolimus......12 acetic acid (otic).....56 see amphetaminesee torpenz ......15 dextroamphetamine acetylcysteine ......57 AFINITOR DISPERZ acitretin.....60 tab 5 mg.....32 see everolimus......12 ACTHIB INJ ......52 see amphetamineafirmelle ......40 ACTIMMUNE ......51 dextroamphetamine **AGRYLIN** see anagrelide hcl......48 **ACTIVELLA** tab 7.5 mg.....32 ADDERALL XR see estradiol & AIMOVIG ......33 norethindrone acetate see amphetamine-AKEEGA TAB 100/500 ... 10 dextroamphetamine AKEEGA TAB 50/500MG tab 1-0.5 mg ......42 see *mimvey*......42 cap er 24hr 10 mg ...32 .....10 see amphetamine-**ACTOS** ala-cort......60 see pioglitazone hcl.....37 dextroamphetamine albendazole ......3 cap er 24hr 15 mg ...32 ACULAR albuterol sulfate ......57 see ketorolac see amphetamine-**ALCAINE** dextroamphetamine tromethamine (ophth) see proparacaine hcl...55 cap er 24hr 20 mg ...32 alclometasone dipropionate .....55 **ACULAR LS** see amphetamine-.....60 dextroamphetamine ALCOHOL SWABS: BDsee ketorolac cap er 24hr 25 mg ...32 EMBECTA/MHC/RUGBY tromethamine (ophth)

.....55

.....38

ALDACTONE	amlodipine besylate-	amphetamine-
see spironolactone17	benazepril hcl cap 2.5-10	dextroamphetamine cap
ALECENSA11	<i>mg</i> 16	er 24hr 10 mg32
alendronate sodium39	amlodipine besylate-	amphetamine-
alfuzosin hcl47	benazepril hcl cap 5-10	dextroamphetamine cap
aliskiren fumarate21	<i>mg</i> 16	er 24hr 15 mg32
allopurinol1	amlodipine besylate-	amphetamine-
alosetron hcl46	benazepril hcl cap 5-20	dextroamphetamine cap
ALPHAGAN P	<i>mg</i> .16	er 24hr 20 mg32
see brimonidine tartrate	amlodipine besylate-	amphetamine-
55	benazepril hcl cap 5-40	dextroamphetamine cap
alprazolam22	<i>mg</i> 16	er 24hr 25 mg32
ÁLREX	amlodipine besylate-	amphetamine-
see loteprednol	valsartan tab 10-160 mg	dextroamphetamine cap
etabonate55	17	er 24hr 30 mg32
ALTACE	amlodipine besylate-	amphetamine-
see <i>ramipril</i> 17	valsartan tab 10-320 mg	dextroamphetamine cap
altavera40	17	er 24hr 5 mg32
ALUNBRIG11	amlodipine besylate-	amphetamine-
ALUNBRIG PAK11	valsartan tab 5-160 mg17	dextroamphetamine tab
ALVAIZ48	amlodipine besylate-	10 mg32
ALVESCO59	valsartan tab 5-320 mg17	amphetamine-
alyacen 1/3540	amnesteem59	dextroamphetamine tab
alyacen 7/7/740	amoxapine23	12.5 mg32
ALYGLO51	amoxicillin8	amphetamine-
alyq22	AMOXICILLIN	dextroamphetamine tab
amantadine hcl24	see amoxicillin8	15 mg32
AMBIEN	amoxicillin & k clavulanate	amphetamine-
see zolpidem tartrate33	chew tab 400-57 mg8	dextroamphetamine tab
AMBISOME	amoxicillin & k clavulanate	20 mg32
see amphotericin b	for susp 200-28.5 mg/5ml	amphetamine-
liposome4	9	dextroamphetamine tab
ambrisentan22	amoxicillin & k clavulanate	30 mg32
amikacin sulfate3	for susp 250-62.5 mg/5ml	amphetamine-
amiloride &	9	dextroamphetamine tab 5
hydrochlorothiazide tab	amoxicillin & k clavulanate	mg32
<i>5-50 mg</i> 21	for susp 400-57 mg/5ml 9	amphetamine-
amiloride hcl21	amoxicillin & k clavulanate	dextroamphetamine tab
amiodarone hcl18	for susp 600-42.9 mg/5ml	7.5 mg32
amitriptyline hcl23	9	amphotericin b4
amlodipine besylate20	amoxicillin & k clavulanate	amphotericin b liposome4
amlodipine besylate-	tab 250-125 mg9	ampicillin9
benazepril hcl cap 10-20	amoxicillin & k clavulanate	ampicillin & sulbactam
<i>mg</i> 16	tab 500-125 mg9	sodium for inj 1.5 (1-0.5)
amlodipine besylate-	amoxicillin & k clavulanate	gm9
benazepril hcl cap 10-40	tab 875-125 mg9	ampicillin & sulbactam
<i>mg</i> 16	Č	sodium for inj 3 (2-1) gm
-		9

ampicillin & sulbactam	aripiprazole25	see <i>amoxicillin</i> & k
sodium for iv soln 1.5 (1-	ARISTADA25	clavulanate for susp
0.5) gm9	ARISTADA INITIO25	600-42.9 mg/5ml9
ampicillin & sulbactam	ARIXTRA	AUGTYRO11
sodium for iv soln 15 (10-	see fondaparinux sodium	aurovela 1/2040
<i>5) gm</i> 9	48	aurovela fe 1.5/3040
ampicillin & sulbactam	armodafinil35	aurovela fe 1/2040
sodium for iv soln 3 (2-1)	ARNUITY ELLIPTA59	AUSTEDO34
<i>gm</i> 9	AROMASIN	AUSTEDO XR34
ampicillin sodium9	see exemestane10	AUSTEDO XR TAB TITR
AMPYRA	asenapine maleate25	KIT34
see dalfampridine35	aspirin-dipyridamole cap er	<b>AUVELITY TAB 45-105MG</b>
ANAFRANIL	12hr 25-200 mg49	23
see clomipramine hcl23	ASTAGRAF XL51	AVALIDE
anagrelide hcl48	ATACAND	see irbesartan-
anastrozole10	see candesartan cilexetil	hydrochlorothiazide tab
ANCOBON	18	150-12.5 mg17
see flucytosine4	atazanavir sulfate5	see irbesartan-
ANDROGEL PUMP	atenolol20	hydrochlorothiazide tak
see testosterone36	atenolol & chlorthalidone	300-12.5 mg17
ANORO ELLIPT AER 62.5-	tab 100-25 mg20	AVAPRO
2556	atenolol & chlorthalidone	see irbesartan18
ANUSOL-HC	tab 50-25 mg20	aviane40
see hydrocortisone	ATIVAN	AVODART
(rectal)62	see lorazepam22	see dutasteride47
see procto-med hc62	atomoxetine hcl32	ayuna40
see proctosol hc62	atorvastatin calcium19	AYVAKIT11
see <i>proctozone-hc</i> 62	atovaquone3	AZACTAM
aprepitant45	atovaquone-proguanil hcl	see aztreonam3
aprepitant capsule therapy	tab 250-100 mg5	azathioprine51
pack 80 & 125 mg45	atovaquone-proguanil hcl	azelastine hcl56
apri40	tab 62.5-25 mg5	azelastine hcl (ophth)55
APRISO	ATRIPLA	AZILECT
see <i>mesalamine</i> 45	see efavirenz-	see rasagiline mesylate
APTIOM28	emtricitabine-tenofovir	
APTIVUS5	df tab 600-200-300 mg	azithromycin8
ARALAST NP57	6	AZOPT
aranelle40	ATROPINE SULFATE55	see brinzolamide55
ARAVA	atropine sulfate	aztreonam3
see leflunomide50	(ophthalmic)55	AZULFIDINE
ARCALYST51	ATROVENT HFA56	see sulfasalazine46
AREXVY52	aubra eq40	AZULFIDINE EN-TABS
ARICEPT	AUGMENTIN	see sulfasalazine46
	see amoxicillin & k	azurette40
see donepezil hydrochloride22	clavulanate tab 500-	<b>B</b>
ARIKAYCE3	125 mg9	bacitracin (ophthalmic)54
ARIMIDEX	AUGMENTIN ES-600	bacitracin-polymyxin b
see anastrozole10	ACCIVILITING EO-000	ophth oint54
300 anasirozoro10		οριαι οπι

bacitracin-polymyxin-	see olmesartan	bisoprolol fumarate2	0
neomycin-hc ophth oint	medoxomil-	BIVIGAM5	1
1%54	hydrochlorothiazide tab	blisovi fe 1.5/304	0
baclofen35	<i>4</i> 0-25 mg18	BOOSTRIX INJ5	2
BACTRIM	BENLYSTA51	bosentan2	2
see sulfamethoxazole-	benztropine mesylate24	BOSULIF1	1
trimethoprim tab 400-	BERINERT48	BRAFTOVI1	1
80 mg4	BESIVANCE54	BREO ELLIPTA INH 100-	
BACTRIM DS	BESREMI11	255	9
see sulfamethoxazole-	betaine powder for oral	BREO ELLIPTA INH 200-	
trimethoprim tab 800-	solution43	255	9
160 mg4	betamethasone	BREO ELLIPTA INH 50-	
BAFIERTAM34	dipropionate (topical)60,	25MCG5	9
balsalazide disodium45	61	breyna5	9
BALVERSA11	betamethasone	BREZTRI AERO AER	
<i>balziva</i> 40	dipropionate augmented	SPHERE5	6
BANZEL	61	BREZTRI AERO AER	
see rufinamide30, 31	betamethasone valerate .61	SPHERE	
BARACLUDE7	BETAPACE	(INSTITUTIONAL PACK	)
see entecavir7	see sotalol hcl19	5	6
BASAGLAR KWIKPEN38	BETAPACE AF	briellyn4	0
BCG VACCINE52	see sotalol hcl (afib/afl)19	BRILINTA4	9
benazepril &	BETASERON34	brimonidine tartrate5	5
hydrochlorothiazide tab	betaxolol hcl (ophth)55	brinzolamide5	5
<i>10-12.5 mg</i> 16	bethanechol chloride47	BRIVIACT2	8
benazepril &	BETOPTIC-S55	bromfenac sodium (ophth)	
hydrochlorothiazide tab	BEVESPI AER 9-4.8MCG	5	5
<i>20-12.5 mg</i> 16	56	bromocriptine mesylate2	5
benazepril &	bexarotene11	BROMSITE	
hydrochlorothiazide tab	bexarotene (topical)62	see bromfenac sodium	
<i>20-25 mg</i> 16	BEXSERO INJ52	(ophth)5	
benazepril &	bicalutamide10	BRONCHITOL5	
hydrochlorothiazide tab	BICILLIN L-A9	BRUKINSA1	1
<i>5-6.25mg</i> 16	BIKTARVY TAB 30-120-15	budesonide4	
benazepril hcl17	MG6	budesonide (inhalation)5	9
BENICAR	BIKTARVY TAB 50-200-25	budesonide-formoterol	
see olmesartan	MG6	fumarate dihyd aerosol	
medoxomil18	BILTRICIDE	160-4.5 mcg/act5	9
BENICAR HCT	see <i>praziquantel</i> 4	budesonide-formoterol	
see olmesartan	bisoprolol &	fumarate dihyd aerosol	
medoxomil-	hydrochlorothiazide tab	80-4.5 mcg/act5	
hydrochlorothiazide tab	<i>10-6.25 mg</i> 20	bumetanide2	1
<i>20-12.5 mg</i> 18	bisoprolol &	BUMEX	
see olmesartan	hydrochlorothiazide tab	see bumetanide2	1
medoxomil-	2.5-6.25 mg20	BUPHENYL	
hydrochlorothiazide tab	bisoprolol &	see sodium	
<i>40-12.5 mg</i> 18	hydrochlorothiazide tab	phenylbutyrate4	
	<i>5-6.25 mg</i> 20	buprenorphine hcl3	5

buprenorphine hcl-	carb/levo orally	carglumic acid	43
naloxone hcl sl film 12-3	disintegrating tab 25-	CARNITOR	
mg (base equiv)35	100mg25	see levocarnitine	
buprenorphine hcl-	carb/levo orally	(metabolic modifier	S)
naloxone hcl sl film 2-0.5	disintegrating tab 25-		,
mg (base equiv)35	250mg25	carteolol hcl (ophth)	
buprenorphine hcl-	CARBAĞLU	cartia xt	
naloxone hcl sl film 4-1	see carglumic acid43	carvedilol	20
mg (base equiv)35	carbamazepine28	CASODEX	
buprenorphine hcl-	CARBATROL .	see bicalutamide	10
naloxone hcl sl film 8-2	see carbamazepine28	caspofungin acetate	4
mg (base equiv)35	carbidopa & levodopa tab	CATAPRES-TTS-1	
buprenorphine hcl-	<i>10-100 mg</i> 25	see clonidine	21
naloxone hcl sl tab 2-0.5	carbidopa & levodopa tab	CATAPRES-TTS-2	
mg (base equiv)35	<i>25-100 mg</i> 25	see clonidine	21
buprenorphine hcl-	carbidopa & levodopa tab	CATAPRES-TTS-3	
naloxone hcl sl tab 8-2	<i>25-250 mg</i> 25	see clonidine	21
mg (base equiv)35	carbidopa & levodopa tab	CAYSTON	3
bupropion hcl23	er 25-100 mg25	cefaclor	7
bupropion hcl (smoking	carbidopa & levodopa tab	cefadroxil	7
deterrent)36	er 50-200 mg25	CEFAZOLIN	7
buspirone hcl22	carbidopa-levodopa-	CEFAZOLIN INJ	
BYSTOLIC	entacapone tabs 12.5-	1GM/50ML	7
see nebivolol hcl20	<i>50-200 mg</i> 25	cefazolin sodium	7
С	carbidopa-levodopa-	CEFAZOLIN SOLN	
cabergoline43	entacapone tabs 18.75-	2GM/100ML-4%	8
CABOMETYX11	<i>75-200 mg</i> 25	cefdinir	8
calcipotriene60	carbidopa-levodopa-	cefepime hcl	8
calcitonin (salmon) spray 39	entacapone tabs 25-100-	cefixime	
calcitriol44	200 mg25	cefoxitin sodium	8
calcitriol (oral)44	carbidopa-levodopa-	cefpodoxime proxetil	8
CALQUENCE11	entacapone tabs 31.25-	cefprozil	8
camila40	125-200 mg25	ceftazidime	8
CANASA	carbidopa-levodopa-	ceftriaxone sodium	8
see <i>mesalamine</i> 46	entacapone tabs 37.5-	cefuroxime axetil	8
CANCIDAS	<i>150-200 mg</i> 25	cefuroxime sodium	8
see caspofungin acetate	carbidopa-levodopa-	CELEBREX	
4	entacapone tabs 50-200-	see <i>celecoxib</i>	1
candesartan cilexetil18	<i>200 mg</i> 25	celecoxib	1
CAPLYTA25	CARDIZEM	CELEXA	
CAPRELSA11	see diltiazem hcl20	see citalopram	
CARAFATE	CARDIZEM CD	hydrobromide	23
see sucralfate46	see cartia xt20	CELLCEPT	
carb/levo orally	see diltiazem hcl coated	see mycophenolate	
disintegrating tab 10-	<i>beads</i> 20	mofetil	51
<i>100mg</i> 25	CARDURA	CELONTIN	
	see doxazosin mesylate	see methsuximide	
	17	cephalexin	8

CERDELGA43	clindamycin phosphate	COMETRIQ (60MG DOSE)
cetirizine hcl56	vaginal47	12
chateal eq40	CLINIMIX INJ 4.25/D1054	COMETRIQ KIT 100MG.12
CHEMET39	CLINIMIX INJ 4.25/D5W.54	COMETRIQ KIT 140MG.12
chlorhexidine gluconate	CLINIMIX INJ 5%/D15W.54	COMPLERA TAB6
(mouth-throat)63	CLINIMIX INJ 5%/D20W.54	compro45
chloroquine phosphate5	CLINIMIX INJ 6/554	constulose46
chlorpromazine hcl26	CLINIMIX INJ 8/1054	COPAXONE34
chlorthalidone21	CLINIMIX INJ 8/1454	see glatiramer acetate.35
cholestyramine19	clinisol sf 15%54	see glatopa35
cholestyramine light19	CLINOLIPID EMU 20%54	COPIKTRA12
CIALIS	clobazam28	COREG
see tadalafil47	clobetasol propionate61	see <i>carvedilol</i> 20
ciclopirox olamine60	clobetasol propionate e61	CORLANOR21
cilostazol48	clomipramine hcl23	see ivabradine hcl22
CILOXAN54	clonazepam28	CORTEF
CIMDUO TAB 300-3006	clonidine21	see hydrocortisone42
cinacalcet hcl43	clonidine hcl21	CORTENEMA
CIPRO	clopidogrel bisulfate49	see hydrocortisone
see ciprofloxacin hcl8	clorazepate dipotassium .28	(intrarectal)45
ciprofloxacin 200 mg/100ml	clotrimazole63	COSENTYX49
in d5w8	clotrimazole (topical)60	COSENTYX
ciprofloxacin 400 mg/200ml	clotrimazole w/	SENSOREADY PEN49
in d5w8	betamethasone cream 1-	COSENTYX UNOREADY
ciprofloxacin hcl8	<i>0.05</i> %60	49
ciprofloxacin hcl (ophth)54	clozapine26	COSOPT
ciprofloxacin-	CLOZARIL	see dorzolamide hcl-
dexamethasone otic susp	see <i>clozapine</i> 26	timolol maleate ophth
0.3-0.1%56	COARTEM TAB 20-120MG	soln 2-0.5%55
citalopram hydrobromide 23	5	COTELLIC12
claravis60	COLAZAL	COZAAR
clarithromycin8	see balsalazide disodium	see losartan potassium
CLEOCIN	45	18
see clindamycin hcl3	colchicine1	CREON CAP 12000UNT 46
see clindamycin	colchicine w/ probenecid	CREON CAP 24000UNT 46
phosphate vaginal47	tab 0.5-500 mg1	CREON CAP 3000UNIT .46
CLEOCIN PHOSPHATE	COLESTID	CREON CAP 36000UNT 46
see <i>clindamycin</i>	see colestipol hcl19	CREON CAP 6000UNIT .46
phosphate3	colestipol hcl19	CRESTOR
CLEOCIN-T	colistimethate sodium3	see rosuvastatin calcium
see <i>clindamycin</i>	COLY-MYCIN M	19
phosphate (topical)60	see colistimethate	cromolyn sodium57
CLIMARA	sodium3	cromolyn sodium
see estradiol42	COMBIGAN SOL 0.2/0.5%	(mastocytosis)46
clindamycin hcl3	55	cromolyn sodium (ophth) 55
clindamycin phosphate3	COMBIVENT AER 20-100	cryselle-2840
clindamycin phosphate	56	cyclobenzaprine hcl35
(topical)60		cyclophosphamide10

CYCLOPHOSPHAMIDE.10	DELESTROGEN	desmopressin acetate
cycloserine6	see estradiol valerate42	spray refrigerated43
cyclosporine51	DELSTRIGO TAB6	desogest-eth estrad & eth
cyclosporine modified (for	DELZICOL	estrad tab 0.15-0.02/0.01
microemulsion)51	see mesalamine46	<i>mg(21/5)</i> 40
CYKLOKAPRON	DEMSER	desvenlafaxine succinate23
see tranexamic acid49	see metyrosine22	DETROL
CYMBALTA	DENGVAXIA SUS52	see tolterodine tartrate 47
see duloxetine hcl23	DEPAKOTE	DETROL LA
cyproheptadine hcl56	see divalproex sodium 29	see tolterodine tartrate 47
cyred eq40	DEPAKOTÉ ER	dexamethasone42
CYSTADANE	see divalproex sodium 29	dexamethasone sodium
see betaine powder for	DEPAKOTĖ SPRINKLES	phosphate42
oral solution43	see divalproex sodium 29	dexamethasone sodium
CYSTADROPS55	DEPEN TITRATABS	phosphate (ophth)55
CYSTAGON43	see penicillamine40	dexmethylphenidate hcl32
CYSTARAN55	DEPO-MEDROL	dextrose54
CYTOMEL	see methylprednisolone	dextrose 10% w/ sodium
see liothyronine sodium	acetate43	chloride 0.45%53
44	DEPO-PROVERA	dextrose 2.5% w/ sodium
CYTOTEC	CONTRACEPTIV	chloride 0.45%52
see misoprostol46	see	DEXTROSE 2.5%/SODIUM
D	medroxyprogesterone	CHLO
D10W/NACL INJ 0.2%52	acetate (contraceptive)	see dextrose 2.5% w/
D2.5W/NACL INJ 0.45%.52	41	sodium chloride 0.45%
dabigatran etexilate	DEPO-SUBQ PROVERA	52
mesylate48	10440	dextrose 5% in lactated
dalfampridine35	depo-testosterone36	ringers52
DALIRESP	DERMA-SMOOTHE/FS	dextrose 5% w/ sodium
see roflumilast58	BODY	chloride 0.2%52
danazol36	see fluocinolone	dextrose 5% w/ sodium
dapsone3	acetonide61	chloride 0.225%53
DAPTACEL INJ52	DERMA-SMOOTHE/FS	dextrose 5% w/ sodium
daptomycin3	SCALP	chloride 0.3%53
DAPTOMYCIN3	see fluocinolone	dextrose 5% w/ sodium
see daptomycin3	acetonide61	chloride 0.45%53
DARAPRIM	DERMOTIC	dextrose 5% w/ sodium
see pyrimethamine4	see <i>flac</i> 56	<i>chloride 0.9%</i> 53
darunavir5	see fluocinolone	DEXTROSE 5%/SODIUM
dasetta 1/3540	acetonide (otic)56	CHLORI
dasetta 7/7/740	DESCOVY TAB 120-15MG	see dextrose 5% w/
DAURISMO12	6	sodium chloride 0.3%
DAYVIGO33	DESCOVY TAB 200/25MG	53
DDAVP	6	DEXTROSE/SODIUM
see desmopressin	desipramine hcl23	CHLORIDE
acetate43	desmopressin acetate43	see dextrose 5% w/
deblitane40	desmopressin acetate	sodium chloride
deferasirox39	<i>spray</i> 43	<i>0.225%</i> 53

DIACOMIT28	see <i>valsartan-</i>	duloxetine hcl23
diazepam28	hydrochlorothiazide tab	DUPIXENT49
diazepam (anticonvulsant)	320-25 mg18	dutasteride47
28	see <i>valsartan-</i>	E
diazepam inj28	hydrochlorothiazide tab	EDURANT5
diazepam intensol29	80-12.5 mg18	efavirenz5
diazoxide43	DIP/TET PED INJ 25-5LFU	efavirenz-emtricitabine-
diclofenac potassium1	52	tenofovir df tab 600-200-
diclofenac sodium1	diphenhydramine hcl56	300 mg6
diclofenac sodium (ophth)	diphenoxylate w/ atropine	efavirenz-lamivudine-
55	tab 2.5-0.025 mg46	tenofovir df tab 400-300-
diclofenac sodium (topical)	DIPROLENE	300 mg6
62	see betamethasone	efavirenz-lamivudine-
dicloxacillin sodium9	dipropionate	tenofovir df tab 600-300-
dicyclomine hcl45	augmented61	300 mg6
DIFICID8	dipyridamole49	EFFEXOR XR
DIFLUCAN	disopyramide phosphate.18	see venlafaxine hcl24
see fluconazole4	disulfiram36	EFFIENT
digoxin21	divalproex sodium29	see prasugrel hcl49
dihydroergotamine	dofetilide18	EFUDÉX
mesylate33	donepezil hydrochloride22	see fluorouracil (topical)
DILANTIN29	DOPTELET48	62
see phenytoin sodium	dorzolamide hcl55	ELIDEL
extended30	dorzolamide hcl-timolol	see pimecrolimus62
DILANTIN INFATABS	maleate ophth soln 2-	ELIGARD10
see phenytoin30	<i>0.5%</i> 55	elinest40
DILANTIN-125	dotti42	ELIQUIS48
see phenytoin30	DOVATO TAB 50-300MG.6	ELIQUIS STARTER PACK
DILAUDID	doxazosin mesylate17	48
see hydromorphone hcl.2	doxepin hcl23	eluryng40
diltiazem hcl20	doxepin hcl (sleep)33	EMÉND
diltiazem hcl coated beads	doxy 1009	see aprepitant45
20	doxycycline (monohydrate)	EMGALITY33
diltiazem hcl extended	9	EMSAM23
release beads20	doxycycline hyclate9	emtricitabine5
<i>dilt-xr</i> 20	DRÍZÁLMA SPRINKLE23	emtricitabine-tenofovir
DIOVAN	dronabinol45	disoproxil fumarate tab
see valsartan18	drospirenone-ethinyl	100-150 mg6
DIOVAN HCT	estradiol tab 3-0.02 mg40	emtricitabine-tenofovir
see valsartan-	drospirenone-ethinyl	disoproxil fumarate tab
hydrochlorothiazide tab	estradiol tab 3-0.03 mg40	133-200 mg6
<i>160-12.5 mg</i> 18	DROXIA48	emtricitabine-tenofovir
see valsartan-	droxidopa21	disoproxil fumarate tab
hydrochlorothiazide tab	DULERA AER 100-5MCG	167-250 mg6
<i>160-25 mg</i> 18	59	emtricitabine-tenofovir
see valsartan-	DULERA AER 200-5MCG	disoproxil fumarate tab
hydrochlorothiazide tab	59	200-300 mg6
<i>320-12.5 mg</i> 18	DULERA AER 50-5MCG 59	EMTRIVA5

see <i>emtricitabine</i> 5	see <i>epinephrine</i>	ethynodiol diacetate &
EMVERM3	(anaphylaxis)57	ethinyl estradiol tab 1
<i>emzahh</i> 40	EPIPEN-JR 2-PAK	<i>mg-35 mcg</i> 40
enalapril maleate17	see epinephrine	ethynodiol diacetate &
enalapril maleate &	(anaphylaxis)57	ethinyl estradiol tab 1
hydrochlorothiazide tab	epitol29	<i>mg-50 mcg</i> 40
10-25 mg16	EPIVIR	etonogestrel-ethinyl
enalapril maleate &	see lamivudine5	estradiol va ring 0.12-
hydrochlorothiazide tab	eplerenone17	0.015 mg/24hr40
<i>5-12.5 mg</i> 16	EPRONTIA29	etravirine5
ENBREL49	EPZICOM	EULEXIN10
ENBREL MINI49	see abacavir sulfate-	euthyrox44
ENBREL SURECLICK49	lamivudine tab 600-	everolimus12
ENDARI	<i>300 mg</i> 6	everolimus
see <i>l-glutamine (sickle</i>	ergotamine w/ caffeine tab	(immunosuppressant) .51
<i>cell</i> )48	1-100 mg33	EVISTA
endocet tab 10-325mg2	ERIVEDGE12	see raloxifene hcl44
endocet tab 2.5-325mg2	ERLEADA10	EVOTAZ TAB 300-1506
endocet tab 5-325mg2	erlotinib hcl12	EXELON
endocet tab 7.5-325mg2	<i>errin</i> 40	see rivastigmine23
ENGERIX-B52	ertapenem sodium3	exemestane10
enilloring40	<i>ery-tab</i> 8	EXFORGE
enoxaparin sodium48	ERYTHROCIN	see amlodipine besylate-
<i>enpresse-28</i> 40	LACTOBIONATE8	valsartan tab 10-160
enskyce40	see <i>erythromycin</i>	<i>mg</i> 17
ENSTILAR AER60	lactobionate8	see amlodipine besylate-
entacapone25	erythromycin (acne aid)60	valsartan tab 10-320
entecavir7	erythromycin (ophth)54	<i>mg</i> 17
ENTRESTO CAP 15-16MG	erythromycin base8	see amlodipine besylate-
17	erythromycin lactobionate.8	valsartan tab 5-160 mg
ENTRESTO CAP 6-6MG 17	ESBRIET	17
ENTRESTO TAB 24-26MG	see <i>pirfenidone</i> 58	see amlodipine besylate-
17	escitalopram oxalate.23, 24	valsartan tab 5-320 mg
ENTRESTO TAB 49-51MG	estarylla40	17
17	ESTRACE	EXJADE
ENTRESTO TAB 97-	see estradiol42	see deferasirox39
103MG17	see estradiol vaginal42	EYSUVIS55
<i>enulose</i> 46	estradiol42	ezetimibe19
EPCLUSA PAK 150-37.57	estradiol & norethindrone	F
EPCLUSA PAK 200-50MG	acetate tab 0.5-0.1 mg 42	falmina40
7	estradiol & norethindrone	famotidine45
EPCLUSA TAB 200-50MG	acetate tab 1-0.5 mg42	famotidine in nacl 0.9% iv
7	estradiol vaginal42	soln 20 mg/50ml45
EPCLUSA TAB 400-1007	estradiol valerate42	FANAPT26
EPIDIOLEX29	ethambutol hcl6	FANAPT PAK26
epinephrine (anaphylaxis)	ethosuximide29	FARESTON
21, 57		see toremifene citrate10
EPIPEN 2-PAK		FARXIGA36

FASENRA57	fluoxetine hcl24	galantamine hydrobromide
FASENRA PEN57	fluphenazine decanoate26	23
felbamate29	fluphenazine hcl26	GAMASTAN INJ5
FELBATOL	flurbiprofen1	GAMMAGARD LIQUID5 <sup>2</sup>
see felbamate29	flurbiprofen sodium55	GAMMAGARD S/D IGA
felodipine20	fluticasone propionate61	LESS TH5
FEMARA	fluticasone propionate	GAMMAKED5
see letrozole10	(nasal)58	GAMMAPLEX5
fenofibrate19	fluticasone-salmeterol aer	GAMUNEX-C5
fenofibrate micronized19	powder ba 100-50	ganciclovir sodium
fentanyl1	mcg/act59	GARDASIL 9 INJ52
fentanyl citrate2	fluticasone-salmeterol aer	GASTROCROM
FETZIMA24	powder ba 250-50	see cromolyn sodium
FETZIMA CAP TITRATIO	mcg/act59	(mastocytosis)46
24	fluticasone-salmeterol aer	GATTEX46
FIASP38	powder ba 500-50	GAUZE PADS 238
FIASP FLEXTOUCH38	mcg/act59	gavilyte-c46
FIASP PENFILL38	fluvoxamine maleate22	gavilyte-g46
FIASP PUMPCART38	FML LIQUIFILM	gavilyte-n/flavor pack46
finasteride47	see fluorometholone	GAVRETO12
fingolimod hcl35	(ophth)55	gefitinib12
FINTEPLA29	FOCALIN	gemfibrozil19
FIRAZYR	see dexmethylphenidate	generlac46
see icatibant acetate48	hcl32	gengraf5
see <i>sajazir</i> 49	fondaparinux sodium48	GENOTROPIN43
FIRMAGON10	FOSÁMAX	GENOTROPIN MINIQUICK
flac56	see alendronate sodium	43
FLAREX55	39	gentamicin in saline inj 0.8
FLEBOGAMMA DIF51	fosamprenavir calcium5	mg/ml
flecainide acetate19	fosinopril sodium17	gentamicin in saline inj 2
FLOMAX	fosinopril sodium &	mg/ml
see tamsulosin hcl47	hydrochlorothiazide tab	gentamicin sulfate
fluconazole4	10-12.5 mg16	gentamicin sulfate (ophth)
fluconazole in nacl 0.9% inj	fosinopril sodium &	54
200 mg/100ml4	hydrochlorothiazide tab	gentamicin sulfate (topical)
fluconazole in nacl 0.9% inj	<i>20-12.5 mg</i> 16	60
400 mg/200ml4	FOTIVDA12	GENVOYA TAB6
flucytosine4	FRUZAQLA12	GEODON
fludrocortisone acetate42	FULPHILA48	see ziprasidone hcl27
flunisolide (nasal)58	furosemide21	see ziprasidone mesylate
fluocinolone acetonide61	furosemide inj21	28
fluocinolone acetonide	FUZEON5	GILENYA
(otic)56	fyavolv tab 0.5mg-2.5mcg	see fingolimod hcl35
fluocinonide61	42	GILOTRIF12
fluocinonide emulsified	fyavolv tab 1mg-5mcg42	glatiramer acetate35
<i>base</i> 61	FYCOMPA29	glatopa35
fluorometholone (ophth)55	G	GLEÉVEC
fluorouracil (topical)62	gabapentin29	see imatinib mesylate12

GLEOSTINE10	HARVONI TAB 90-400MG7	hydrocortisone (topical)61
glimepiride36	HAVRIX52	hydrocortisone valerate61
glipizide36	heather40	hydromorphone hcl2
glipizide xl36	HEP SOD/NACL INJ	hydroxychloroquine sulfate
glipizide-metformin hcl tab	25000UNT48	50
2.5-250 mg36	heparin sodium (porcine) 48	hydroxyurea11
glipizide-metformin hcl tab	HEPLISAV-B52	hydroxyzine hcl56
<i>2.5-500 mg</i> 36	HETLIOZ	hydroxyzine pamoate56, 57
glipizide-metformin hcl tab	see tasimelteon33	HYZAAR
<i>5-500 mg</i> 36	HIBERIX52	see losartan potassium &
GLUCOTROL XL	HIPREX	hydrochlorothiazide tab
see <i>glipizide</i> 36	see <i>methenamine</i>	<i>100-12.5 mg</i> 18
see glipizide xl36	hippurate3	see losartan potassium &
glycopyrrolate45	HUMIRA49	hydrochlorothiazide tab
<i>glydo</i> 62	HUMIRA PEN49, 50	<i>100-25 mg</i> 18
GLYXAMBI TAB 10-5 MG	HUMIRA PEN KIT PS/UV	see losartan potassium &
36	50	hydrochlorothiazide tab
GLYXAMBI TAB 25-5 MG	HUMIRA PEN-CD/UC/HS	<i>50-12.5 mg</i> 17
37	START50	
GOLYTELY	HUMIRA PEN-PEDIATRIC	ibandronate sodium39
see <i>gavilyte-g</i> 46	UC S50	IBRANCE12
see peg 3350-kcl-na	HUMULIN R U-500	<i>ibu</i> 1
bicarb-nacl-na sulfate	(CONCENTR38	ibuprofen1
for soln 236 gm46	HUMULIN R U-500	icatibant acetate48
griseofulvin microsize4	KWIKPEN38	<i>iclevia</i> 40
griseofulvin ultramicrosize 4	hydralazine hcl22	ICLUSIG12
guanfacine hcl21	HYDREA	IDACIO (2 PEN)50
guanfacine hcl (adhd)33	see <i>hydroxyurea</i> 11	IDACIO (2 SYRINGE)50
Н	hydrochlorothiazide21	IDACIO CROHN INJ
HAEGARDA48	hydrocodone bitartrate1	DISEASE50
hailey 1.5/3040	hydrocodone-	IDACIO PLAQU INJ
HALDOL DECANOATE	acetaminophen soln 7.5-	PSORIASIS50
100	325 mg/15ml2	IDHIFA12
see <i>haloperidol</i>	hydrocodone-	imatinib mesylate12
decanoate26	acetaminophen tab 10-	IMBRUVICA12
HALDOL DECANOATE 50	325 mg2	imipenem-cilastatin
see <i>haloperidol</i>	hydrocodone-	intravenous for soln 250
decanoate26	acetaminophen tab 5-325	<i>mg</i> 3
halobetasol propionate61	<i>mg</i> 2	imipenem-cilastatin
haloette40	hydrocodone-	intravenous for soln 500
haloperidol26	acetaminophen tab 7.5-	<i>mg</i> 3
haloperidol decanoate26	325 mg2	imipramine hcl24
haloperidol lactate26	hydrocodone-ibuprofen tab	imiquimod62
HARVONI PAK 33.75-	7.5-200 mg2	IMITREX
150MG7	hydrocortisone42	see sumatriptan
HARVONI PAK 45-200MG	hydrocortisone (intrarectal)	succinate34
7	45	IMITREX STATDOSE
HARVONI TAB 45-200MG7	hydrocortisone (rectal)62	REFILL

see sumatriptan	ipratropium-albuterol nebu	JENTADUETO TAB 2.5-
succinate34	soln 0.5-2.5(3) mg/3ml 56	100037
IMITREX STATDOSE	irbesartan18	JENTADUETO TAB 2.5-
SYSTEM	irbesartan-	50037
see sumatriptan	hydrochlorothiazide tab	JENTADUETO TAB 2.5-
succinate34	<i>150-12.5 mg</i> 17	85037
IMOVAX RABIES	irbesartan-	JENTADUETO TAB XR
(H.D.C.V.)52	hydrochlorothiazide tab	2.5-1000MG37
IMPAVIDO3	300-12.5 mg17	JENTADUETO TAB XR 5-
IMURAN	IRESSA	1000MG37
see azathioprine51	see <i>gefitinib</i> 12	jinteli42
INBRIJA25	ISENTRESS5	jolessa40
incassia40	ISENTRESS HD5	juleber40
INCRELEX43	isibloom40	JULUCA TAB 50-25MG6
INCRUSE ELLIPTA56	ISOLYTE-P INJ /D5W53	junel 1.5/3040
indapamide21	ISOLYTE-S INJ PH 7.453	junel 1/2040
INDERAL LA	isoniazid7	junel fe 1.5/3040
see propranolol hcl20	ISORDIL TITRADOSE	junel fe 1/2040
INFANRIX INJ52	see isosorbide dinitrate	JYLAMVO50
INLYTA12	22	JYNNEOS52
INQOVI TAB 35-100MG .10	isosorbide dinitrate22	K
INREBIC13	isosorbide mononitrate22	KALETRA
INSPRA	isotretinoin60	see lopinavir-ritonavir
see <i>eplerenone</i> 17	itraconazole4	soln 400-100 mg/5ml
INSULIN PEN NEEDLES:	ivabradine hcl22	(80-20 mg/ml)6
BD-EMBECTA38	ivermectin3	see lopinavir-ritonavir tab
INSULIN SAFETY	IWILFIN11	100-25 mg6
NEEDLES: BD-	IXCHIQ INJ52	see lopinavir-ritonavir tab
EMBECTA38	IXIARO INJ52	200-50 mg6
INSULIN SYRINGES: BD-	J	KALYDECO58
EMBECTA38	JADENU	kariva40
INTELENCE5	see deferasirox39	KCL 0.3%/D5W/NACL
see <i>etravirine</i> 5	JAKAFI13	0.9%
INTRALIPID54	jantoven48	see <i>kcl 40 meg/l (0.3%)</i>
introvale40	JANUMET TAB 50-1000.37	in dextrose 5% & nacl
INTUNIV	JANUMET TAB 50-500MG	0.9% inj53
see guanfacine hcl	37	kcl 10 meq/l (0.075%) in
(adhd)33	JANUMET XR TAB 100-	dextrose 5% & nacl
INVEGA	100037	0.45% inj53
see paliperidone27	JANUMET XR TAB 50-	kcl 20 meq/l (0.149%) in
INVEGA HAFYERA26	100037	nacl 0.45% inj53
INVEGA SUSTENNA26	JANUMET XR TAB 50-	kcl 20 meg/l (0.15%) in
INVEGA TRINZA26	500MG37	dextrose 5% & nacl 0.2%
IPOL INJ INACTIVE52	JANUVIA37	inj53
ipratropium bromide56	JARDIANCE37	kcl 20 meq/l (0.15%) in
ipratropium bromide (nasal)	jasmiel40	dextrose 5% & nacl
56	javygtor43	0.45% inj53
	JAYPIRCA13	2

kcl 20 meq/l (0.15%) in	see clonazepam28	larin fe 1.5/3040
dextrose 5% & nacl 0.9%	klor-con54	larin fe 1/2040
inj53	klor-con 1054	LASIX
kcl 20 meq/l (0.15%) in nacl	klor-con 854	see furosemide21
0.45% inj53	klor-con m1054	latanoprost55
kcl 20 meq/l (0.15%) in nacl	klor-con m1554	LATUDA
0.9% inj53	klor-con m2054	see lurasidone hcl26
kcl 30 meq/l (0.224%) in	KORLYM	leena40
dextrose 5% & nacl	see mifepristone	leflunomide50
0.45% inj53	(hyperglycemia)43	lenalidomide11
kcl 40 meq/l (0.3%) in	KOSELUGO13	LENVIMA 10 MG DAILY
dextrose 5% & nacl	kourzeq63	DOSE13
0.45% inj53	KRAZATI13	LENVIMA 12MG DAILY
kcl 40 meq/l (0.3%) in	K-TAB	DOSE13
dextrose 5% & nacl 0.9%	see potassium chloride54	LENVIMA 20 MG DAILY
inj53	kurvelo40	DOSE13
kcl 40 meq/l (0.3%) in nacl	KUVAN	LENVIMA 4 MG DAILY
0.9% inj53	see javygtor43	DOSE13
KCL/D5W/NACL INJ	see sapropterin	LENVIMA 8 MG DAILY
0.3/0.9%53	dihydrochloride44	DOSE13
kelnor 1/3540	I	LENVIMA CAP 14 MG13
kelnor 1/5040	labetalol hcl20	LENVIMA CAP 18 MG13
KEPPRA	lacosamide29	LENVIMA CAP 24 MG13
see levetiracetam29, 30	lacosamide oral29	lessina40
see roweepra30	lactated ringer's solution .53	LETAIRIS
KERENDIA17	lactic acid (ammonium	see ambrisentan22
ketoconazole4	lactate)62	letrozole10
ketoconazole (topical)60	lactulose46	leucovorin calcium16
ketoconazoie (topicar)00 ketorolac tromethamine	lactulose (encephalopathy)	leuprolide acetate10
		levalbuterol tartrate57
(ophth)55 KINRIX INJ52	46 LAMICTAL	levetiracetam29, 30
kionex39		LEVETIRACETAM
KISQALI 200 DOSE13	see lamotrigine29	
	see subvenite31	see levetiracetam in
KISQALI 200 PAK	LAMICTAL CHEWABLE	sodium chloride iv soln
FEMARA13	DISPERS	1000 mg/100ml30 see levetiracetam in
KISQALI 400 DOSE13	see lamotrigine29	
KISQALI 400 PAK	lamivudine5	sodium chloride iv soln
FEMARA13	lamivudine (hbv)7	1500 mg/100ml30
KISQALI 600 DOSE13	lamivudine-zidovudine tab	see levetiracetam in
KISQALI 600 PAK	150-300 mg6	sodium chloride iv soln
FEMARA13	lamotrigine29	500 mg/100ml30
KITABIS PAK	LANOXIN	levetiracetam in sodium
see tobramycin4	see digoxin21	chloride iv soln 1000
KLARON	lanreotide acetate43	mg/100ml30
see sulfacetamide	lansoprazole47	levetiracetam in sodium
sodium (acne)60	lapatinib ditosylate13	chloride iv soln 1500
klayesta60	larin 1.5/3040	<i>mg/100ml</i> 30
KLONOPIN	<i>larin 1/20</i> 40	

levetiracetam in sodium	lidocaine-prilocaine cream	lopinavir-ritonavir tab 100-
chloride iv soln 500	<i>2.5-2.5</i> %62	25 mg6
<i>mg/100ml</i> 30	lidocan62	lopinavir-ritonavir tab 200-
levobunolol hcl55	LIDODERM	50 mg6
levocarnitine (metabolic	see lidocaine62	LOPRESSOR
modifiers)43	see lidocan62	see metoprolol tartrate 20
levocetirizine	see tridacaine ii62	lorazepam22
dihydrochloride57	LILETTA41	lorazepam intensol22
levofloxacin8	linezolid3	LORBRENA13
levofloxacin in d5w iv soln	LINEZOLID INJ 2MG/ML3	loryna41
<i>250 mg/50ml</i> 8	LINZESS46	losartan potassium18
levofloxacin in d5w iv soln	liothyronine sodium44	losartan potassium &
<i>500 mg/100ml</i> 8	LIPITOR	hydrochlorothiazide tab
levofloxacin in d5w iv soln	see atorvastatin calcium	100-12.5 mg18
<i>750 mg/150ml</i> 8	19	losartan potassium &
levonest41	lisinopril17	hydrochlorothiazide tab
levonorgestrel & ethinyl	lisinopril &	100-25 mg18
estradiol (91-day) tab	hydrochlorothiazide tab	losartan potassium &
<i>0.15-0.03 mg</i> 41	<i>10-12.5 mg</i> 16	hydrochlorothiazide tab
levonorgestrel & ethinyl	lisinopril &	<i>50-12.5 mg</i> 17
estradiol tab 0.1 mg-20	hydrochlorothiazide tab	LOTEMAX55
<i>mcg</i> 41	<i>20-12.5 mg</i> 16	LOTENSIN
levonorgestrel & ethinyl	lisinopril &	see benazepril hcl17
estradiol tab 0.15 mg-30	hydrochlorothiazide tab	LOTENSIN HCT
<i>mcg</i> 41	<i>20-25 mg</i> 17	see <i>benazepril</i> &
levonorgestrel-eth estra tab	<i>lithium</i> 34	hydrochlorothiazide tab
0.05-30/0.075-40/0.125-	lithium carbonate34	<i>10-12.5 mg</i> 16
<i>30mg-mcg</i> 41	LITHOBID	see <i>benazepril</i> &
<i>levora 0.15/30-28</i> 41	see lithium carbonate34	hydrochlorothiazide tab
<i>levo-t</i> 44	LIVTENCITY7	<i>20-12.5 mg</i> 16
levothyroxine sodium44	loestrin 1.5/30-2141	see benazepril &
levoxyl44	loestrin 1/20-2141	hydrochlorothiazide tab
LEXAPRO	loestrin fe 1.5/3041	<i>20-25 mg</i> 16
see escitalopram oxalate	loestrin fe 1/2041	loteprednol etabonate55
24	LOKELMA39	LOTREL
LEXIVA	LOMOTIL	see amlodipine besylate-
see fosamprenavir	see diphenoxylate w/	benazepril hcl cap 10-
calcium5	atropine tab 2.5-0.025	<i>20 mg</i> 16
I-glutamine (sickle cell)48	<i>mg</i> 46	see amlodipine besylate-
LIALDA	LONSURF TAB 15-6.14 .10	benazepril hcl cap 10-
see <i>mesalamine</i> 46	LONSURF TAB 20-8.19 .10	<i>40 mg</i> 16
LIBERVANT30	loperamide hcl46	see amlodipine besylate-
lidocaine62	LOPID	benazepril hcl cap 5-10
lidocaine hcl62	see gemfibrozil19	<i>mg</i> 16
lidocaine hcl (local anesth.)	lopinavir-ritonavir soln 400-	see amlodipine besylate-
1	100 mg/5ml (80-20	benazepril hcl cap 5-20
lidocaine hcl (mouth-throat)	<i>mg/ml)</i> 6	<i>mg</i> 16
63		LOTRONEX

see alosetron hcl46	magnesium sulfate in	meloxicam′
lovastatin19	dextrose 5% iv soln 1	memantine hcl23
LOVAZA	gm/100ml53	MENACTRA INJ52
see omega-3-acid ethyl	MĂLARONE	MENQUADFI INJ52
esters cap 1 gm19	see atovaquone-	MENVEO INJ52
LOVENOX	proguanil hcl tab 250-	MENVEO SOL52
see enoxaparin sodium	100 mg5	MEPRON
48	see atovaquone-	see atovaquone
low-ogestrel41	proguanil hcl tab 62.5-	mercaptopurine10
loxapine succinate26	<i>25 mg</i> 5	meropenem
LUMAKRAS13	malathion62	mesalamine45, 46
LUPRON DEPOT (1-	maraviroc5	mesalamine w/ cleanser .46
MONTH)10	MARINOL	MESNEX16
LUPRON DEPOT (3-	see dronabinol45	MESTINON
MONTH)10	<i>marlissa</i> 41	see <i>pyridostigmine</i>
lurasidone hcl26	MARPLAN24	bromide34
lutera41	MATULANE11	metformin hcl37
<i>lyleq</i> 41	MAVYRET PAK 50-20MG 7	methadone hcl
lyllana42	MAVYRET TAB 100-40MG	methazolamide2
LYNPARZA13	7	methenamine hippurate3
LYRICA	MAXALT	methimazole44
see <i>pregabalin</i> 30	see rizatriptan benzoate	methotrexate sodium 10, 50
LYSODREN10	34	methsuximide30
LYTGOBI (12 MG DAILY	MAXALT-MLT	METHYLIN
DOSE)13	see rizatriptan benzoate	see methylphenidate hcl
LYTGOBI (16 MG DAILY	34	33
DOSE)13	MAXITROL	methylphenidate hcl33
LYTGOBI (20 MG DAILY	see neomycin-polymyxin-	methylprednisolone42, 43
DOSE)13	dexamethasone ophth	methylprednisolone acetate
<i>lyza</i> 41	oint 0.1%54	43
M	see neomycin-polymyxin-	methylprednisolone sod
MACROBID	dexamethasone ophth	succ43
see nitrofurantoin	susp 0.1%54	methyltestosterone36
monohyd macro3	meclizine hcl45	metoclopramide hcl45
MACRODANTIN	MEDROL	metolazone2
see nitrofurantoin	see methylprednisolone	metoprolol succinate20
macrocrystal3	42	metoprolol tartrate20
magnesium sulfate53	MEDROL DOSEPAK	METROCREAM
MAGNESIUM SULFATE 53	see methylprednisolone	see <i>metronidazole</i>
see magnesium sulfate	43	(topical)62
53	medroxyprogesterone	metronidazole
MAGNESIUM SULFATE IN	acetate44	METRONIDAZOLE
D5W	medroxyprogesterone	see metronidazole3
see magnesium sulfate in	acetate (contraceptive)41	metronidazole (topical)62
dextrose 5% iv soln 1	mefloquine hcl5	metronidazole vaginal47
<i>gm/100ml</i> 53	megestrol acetate10, 44	metyrosine22
	MEKINIST13	micafungin sodium
	MEKTOVI13	MICARDIS

see <i>telmisartan</i> 18	see <i>micafungin sodium</i> .4	neomycin-polymy-gramicid
microgestin 1.5/3041	MYCOBUTIN	op sol 1.75-10000-
microgestin 1/2041	see rifabutin7	0.025mg-unt-mg/ml54
microgestin fe 1.5/3041	mycophenolate mofetil51	neomycin-polymyxin-
microgestin fe 1/2041	mycophenolate sodium51	dexamethasone ophth
midodrine hcl22	MYFÓRTIC	oint 0.1%54
MIEBO55	see mycophenolate	neomycin-polymyxin-
mifepristone	sodium51	dexamethasone ophth
(hyperglycemia)43	MYRBETRIQ47	susp 0.1%54
MIGRANAL	MYSOLINE	neomycin-polymyxin-hc otic
see dihydroergotamine	see <i>primidone</i> 30	soln 1%56
mesylate33	N	neomycin-polymyxin-hc otic
<i>mili</i> 41	nabumetone1	susp 3.5 mg/ml-10000
<i>mimvey</i> 42	nafcillin sodium9	<i>unit/ml-1%</i> 56
MINIVELLE	nalbuphine hcl2	neo-polycin 5(3.5)mg-
see <i>lyllana</i> 42	naloxone hcl36	400unt-10000unt op oin
minocycline hcl9	naltrexone hcl36	54
minoxidil22	NAMENDA XR	neo-polycin hc ophth oint
mirtazapine24	see memantine hcl23	1%54
misoprostol46	NAMZARIC CAP 14-10MG	NEORAL
MITIGARE1	23	see <i>cyclosporine</i>
see colchicine1	NAMZARIC CAP 21-10MG	modified (for
M-M-R II INJ52	23	microemulsion)51
M-NATAL PLUS TAB54	NAMZARIC CAP 28-10MG	see <i>gengraf</i> 51
modafinil35	23	NERLYNX14
moexipril hcl17	NAMZARIC CAP 7-10MG	NEURONTIN
molindone hcl26	23	see gabapentin29
mometasone furoate61	NAMZARIC CAP PACK23	nevirapine5
mono-linyah41	NAPROSYN	NEXAVAR
montelukast sodium57	see <i>naproxen</i> 1	see sorafenib tosylate .14
morphine sulfate1, 2	naproxen1	NEXLETOL19
MOUNJARO37	NARDIL	NEXLIZET TAB 180/10MG
MOVANTIK46	see phenelzine sulfate 24	19
moxifloxacin hcl8	nateglinide37	NEXPLANON41
moxifloxacin hcl (ophth)54	NAYZILAM30	niacin (antihyperlipidemic)
moxifloxacin hcl 400	nebivolol hcl20	19
mg/250ml in sodium	NEBUPENT	NICOTROL INHALER36
chloride 0.8% inj8	see <i>pentamidine</i>	NICOTROL NS36
MRESVIA52	isethionate inh3	nifedipine20, 21
MS CONTIN	necon 0.5/35-2841	nikki41
see morphine sulfate1	nefazodone hcl24	NILANDRON
MULTAQ19	neomycin sulfate3	see nilutamide10
multiple electrolytes ph 5.5	neomycin-bacitrac zn-	nilutamide10
53	polymyx 5(3.5)mg-	nimodipine21
multiple electrolytes ph 7.4	400unt-10000unt op oin	NINLARO14
53	54	nitazoxanide3
<i>mupirocin</i> 60		nitisinone43
MYCAMINE		NITRO-BID22

nitrofurantoin macrocrystal3	NORTHERA	nystatin (topical)	30
nitrofurantoin monohyd	see droxidopa21	nystop	
macro3	nortrel 0.5/35 (28)41	o '	
nitroglycerin22	nortrel 1/35 (21)41	ocella	41
nitroglycerin (intra-anal)62	nortrel 1/35 (28)41	OCREVUS	
NITROSTAT	nortrel 7/7/741	OCTAGAM	
see nitroglycerin22	nortriptyline hcl24	octreotide acetate43,	
nizatidine45	NORVASC	OCUFLOX	77
nora-be41			55
	see amlodipine besylate	see ofloxacin (ophth)	
norelgestromin-ethinyl	20	ODEFSEY TAB	
estradiol td ptwk 150-35	NORVIR5	ODOMZO	
mcg/24hr41	see ritonavir6	OFEV	
norethindrone	NOVOLIN INJ 70/3038	ofloxacin (ophth)	
(contraceptive)41	NOVOLIN INJ 70/30 FP38	ofloxacin (otic)	
norethindrone ace & ethinyl	NOVOLIN N38	OGSIVEO	
estradiol tab 1 mg-20	NOVOLIN N FLEXPEN38	OJEMDA	14
<i>mcg</i> 41	NOVOLIN R38	OJJAARA	14
norethindrone ace & ethinyl	NOVOLIN R FLEXPEN38	olanzapine26, 2	27
estradiol tab 1.5 mg-30	NOVOLOG MIX INJ 70/30	olmesartan medoxomil	
mcg41	39	olmesartan medoxomil-	
norethindrone ace & ethinyl	NOVOLOG MIX INJ	hydrochlorothiazide tab	
estradiol-fe tab 1 mg-20	FLEXPEN39	20-12.5 mg	
mcg41	NOXAFIL	olmesartan medoxomil-	. •
norethindrone acetate44	see posaconazole4	hydrochlorothiazide tab	
norethindrone acetate-	NUBEQA10	40-12.5 mg	
	NUEDEXTA CAP 20-10MG	olmesartan medoxomil-	10
ethinyl estradiol tab 0.5			
mg-2.5 mcg42	34	hydrochlorothiazide tab	
norethindrone acetate-	NUPLAZID26	40-25 mg	
ethinyl estradiol tab 1	NURTEC33	omega-3-acid ethyl esters	
mg-5 mcg42	NUTRILIPID54	cap 1 gm	
norethindrone ac-ethinyl	NUVARING	omeprazole	47
estrad-fe tab 1-20/1-30/1-	see <i>eluryng</i> 40	OMNIPOD 5 G6 KIT	
<i>35 mg-mcg</i> 41	see <i>enilloring</i> 40	INTRO	
norgestimate & ethinyl	see etonogestrel-ethinyl	OMNIPOD 5 G6 MIS POD	S
estradiol tab 0.25 mg-35	estradiol va ring 0.12-		39
<i>mcg</i> 41	0.015 mg/24hr40	OMNIPOD 5 G7 KIT	
norgestimate-eth estrad tab	see haloette40	INTRO	39
0.18-25/0.215-25/0.25-25	NUVIGIL	OMNIPOD 5 G7 MIS POD	วร
<i>mg-mcg</i> 41	see armodafinil35		39
norgestimate-eth estrad tab	<i>nyamyc</i> 60	OMNIPOD DASH KIT	
0.18-35/0.215-35/0.25-35	nylia 1/3541		39
<i>mg-mcg</i> 41	nylia 7/7/741	OMNIPOD DASH MIS	-
norlyroc41	<i>nymy</i> o41		39
NORPACE	nystatin4	OMNIPOD GO KIT	ن ر
	NYSTATIN	10UNT/DY	30
see disopyramide		OMNIPOD GO KIT	ງປ
phosphate18	see nystatin (mouth-		20
NORPRAMIN	throat)63	15UNT/DY	59
see desipramine hcl23	nvstatin (mouth-throat)63		

OMNIPOD GO KIT	oxycodone w/	PENBRAYA INJ52
20UNT/DY39	acetaminophen tab 5-325	penicillamine40
OMNIPOD GO KIT	mg2	penicillin g potassium9
25UNT/DY39	oxycodone w/	penicillin g sodium9
OMNIPOD GO KIT	acetaminophen tab 7.5-	penicillin v potassium9
30UNT/DY39	<i>325 mg</i> 2	PENTACEL INJ52
OMNIPOD GO KIT	OZEMPIC (0.25 OR 0.5	PENTAM 300
35UNT/DY39	MG/DOSE)37	see <i>pentamidine</i>
OMNIPOD GO KIT	OZEMPIC (0.25 OR	isethionate inj4
40UNT/DY39	0.5MG/DOSE)37	pentamidine isethionate inh
OMNIPOD MIS CLASSIC	OZEMPIC (1MG/DOSE).37	3
39	OZEMPIC (2MG/DOSE) .37	pentamidine isethionate inj
ondansetron45	Р	4
ondansetron hcl45	pacerone19	pentoxifylline49
ONFI	paliperidone27	PEPCID
see <i>clobazam</i> 28	PAMELOR	see famotidine45
ONUREG10	see nortriptyline hcl24	PERCOCET
ORFADIN	pamidronate disodium39	see endocet tab 10-
see nitisinone43	PAMIDRONATE	325mg2
ORGOVYX10	DISODIUM39	see endocet tab 2.5-
ORKAMBI GRA 100-125 58	PANRETIN62	325mg2
ORKAMBI GRA 150-188 58	pantoprazole sodium47	see endocet tab 5-325mg
ORKAMBI GRA 75-94MG	PANZYGA51	2
58	paricalcitol44	see endocet tab 7.5-
ORKAMBI TAB 100-125.58	PARLODEL	325mg2
ORKAMBI TAB 200-125.58	see bromocriptine	see oxycodone w/
ORSERDU10	<i>mesylate</i> 25	acetaminophen tab 10-
ORTHO TRI-CYCLEN LO	PARNATE	325 mg3
see norgestimate-eth	see tranylcypromine	see oxycodone w/
estrad tab 0.18-	sulfate24	acetaminophen tab
25/0.215-25/0.25-25	paroxetine hcl24	2.5-325 mg2
mg-mcg41	PAXIL	see oxycodone w/
see tri-lo-estarylla42	see paroxetine hcl24	acetaminophen tab 5-
see tri-lo-marzia42	PAXLOVID TAB 150-1007	325 mg2
see <i>tri-lo-mili</i> 42	PAXLOVID TAB 300-1007	see oxycodone w/
see tri-lo-sprintec42	pazopanib hcl14	acetaminophen tab
see tri-vylibra lo42	PEDIAPRED	7.5-325 mg2
oseltamivir phosphate7	see prednisolone sodium	PERIDEX
oxcarbazepine30	phosphate43	see chlorhexidine
oxybutynin chloride47	PEDIARIX INJ 0.5ML52	gluconate (mouth-
oxycodone hcl2	PEDVAX HIB52	throat)63
oxycodone w/	peg 3350-kcl-na bicarb-	see periogard63
acetaminophen tab 10-	nacl-na sulfate for soln	perindopril erbumine17
325 mg3	236 gm46	periogard63
oxycodone w/	peg 3350-kcl-sod bicarb-	permethrin62
acetaminophen tab 2.5-	nacl for soln 420 gm46	perphenazine27
<i>325 mg</i> 2	PEGASYS7	pfizerpen9
	PEMAZYRE14	phenelzine sulfate24

PHENERGAN	see clopidogrel bisulfate	see prednisolone acetate
see promethazine hcl45	49	(ophth)55
phenobarbital30	plenamine54	prednisolone43
phenobarbital sodium30	PLENVU SOL46	prednisolone acetate
phenytek30	podofilox62	(ophth)55
phenytoin30	polycin ophth oint55	prednisolone sodium
phenytoin sodium30	polymyxin b-trimethoprim	phosphate43
phenytoin sodium extended	ophth soln 10000 unit/ml-	prednisone43
30	0.1%55	pregabalin30
philith41	POMALYST11	PREHEVBRIO52
PIFELTRO5	<i>portia-28</i> 41	PREMASOL SOL 10%54
pilocarpine hcl55	posaconazole4	PRENATAL TAB 27-1MG
pilocarpine hcl (oral)63	POT CHL 20MEQ/L IN	54
pimecrolimus62	NACL 0.45% INJ53	PRENATAL TAB PLUS54
pimozide27	POT CHL 20MEQ/L IN	PREVACID
<i>pimtrea</i> 41	NACL 0.9% INJ53	see lansoprazole47
<i>pindolol</i> 20	POT CHL 40MEQ/L IN	prevalite19
pioglitazone hcl37	NACL 0.9% INJ53	PREVYMIS7
piperacillin sod-tazobactam	potassium chloride53, 54	PREZCOBIX TAB 800-150
na for inj 3.375 gm (3-	POTASSIUM CHLORIDE	6
<i>0.375 gm)</i> 9	see potassium chloride53	PREZISTA5, 6
piperacillin sod-tazobactam	potassium chloride 20	see darunavir5
sod for inj 13.5 gm (12-	meq/I (0.15%) in	PRIFTIN7
1.5 gm)9	dextrose 5% inj53	primaquine phosphate5
piperacillin sod-tazobactam	potassium chloride	PRIMAQUINE
sod for inj 2.25 gm (2-	microencapsulated	PHOSPHATE5
<i>0.25 gm)</i> 9	crystals er54	see <i>primaquine</i>
piperacillin sod-tazobactam	POTASSIUM	phosphate5
sod for inj 4.5 gm (4-0.5	CHLORIDE/SODIUM	PRIMAXIN IV
<i>gm</i> )9	see <i>kcl 20 meq/l (0.15%)</i>	see imipenem-cilastatin
piperacillin sod-tazobactam	in nacl 0.45% inj53	intravenous for soln
sod for inj 40.5 gm (36-	see <i>kcl 20 meq/l (0.15%)</i>	<i>500 mg</i> 3
<i>4.5 gm)</i> 9	in nacl 0.9% inj53	primidone30
PIQRAY 200MG DAILY	see <i>kcl 40 meq/l (0.3%)</i>	PRIORIX INJ52
DOSE14	in nacl 0.9% inj53	PRISTIQ
PIQRAY 250MG TAB	potassium citrate	see desvenlafaxine
DOSE14	(alkalinizer)47	succinate23
PIQRAY 300MG DAILY	PRADAXA	PRIVIGEN51
DOSE14	see dabigatran etexilate	probenecid1
pirfenidone58	mesylate48	PROCARDIA XL
PLAQUENIL	pramipexole	see <i>nifedipine</i> 21
see hydroxychloroquine	dihydrochloride25	prochlorperazine45
<i>sulfate</i> 50	prasugrel hcl49	prochlorperazine edisylate
PLASMA-LYTE A	pravastatin sodium19	45
see multiple electrolytes	praziquantel4	prochlorperazine maleate
ph 7.453	prazosin hcl17	45
PLAVIX	PRED FORTE	PROCRIT48
		proctocort62

procto-med hc62	QUADRACEL INJ52	see temazepam33
proctosol hc62	QUADRACEL INJ 0.5ML 52	RETEVMO12
proctozone-hc62	QUALAQUIN	RETIN-A
progesterone44	see quinine sulfate5	see tretinoin60
PROGLYCEM	QUESTRAN	RETROVIR
see diazoxide43	see cholestyramine19	see zidovudine6
PROGRAF51	QUESTRAN ĹÍGHT	REVATIO
see tacrolimus52	see cholestyramine light	see sildenafil citrate
PROLASTIN-C58	19	(pulmonary
PROLENSA	see <i>prevalite</i> 19	hypertension)22
see bromfenac sodium	quetiapine fumarate27	REXÚĹTI27
(ophth)55	quinapril hcl17	REYATAZ6
PROLIA39	quinidine sulfate19	see atazanavir sulfate5
promethazine hcl45	, quinine sulfate5	REZLIDHIA14
, PROMETRIUM	QULIPTA33	REZUROCK51
see progesterone44	R	RHOPRESSA55
propafenone hcl19	RABAVERT INJ52	ribavirin (hepatitis c)7
proparacaine hcl55	raloxifene hcl44	rifabutin7
propranolol hcl20	ramipril17	RIFADIN
propylthiouracil44	ranolazine22	see rifampin
PROQUAD INJ52	RAPAMUNE	rifampin7
PROSCAR	see sirolimus51	riluzole34
see finasteride47	rasagiline mesylate25	rimantadine hydrochloride 7
PROSOL INJ 20%54	RECLAST	RINVOQ50
PROTONIX	see zoledronic acid39	RINVOQ LQ50
see pantoprazole sodium	reclipsen41	RISPERDAL
47	RECOMBIVAX HB52	see risperidone27
protriptyline hcl24	RECTIV	RISPERDAL CONSTA
PROVÉNTIL HFA	see nitroglycerin (intra-	see <i>risperidone</i>
see albuterol sulfate57	anal)62	microspheres27
PROVERA	REGLAŃ	risperidone27
see	see metoclopramide hcl	risperidone microspheres27
medroxyprogesterone	45	RITALIN ,
acetate44	REGRANEX62	see methylphenidate hcl
PROVIGIL	RELENZA DISKHALER7	33
see modafinil35	RELISTOR46	ritonavir6
PROZAC	REMERON	rivastigmine23
see fluoxetine hcl24	see mirtazapine24	rivastigmine tartrate23
PULMICORT	REMERON SOLTAB	rizatriptan benzoate33, 34
see budesonide	see mirtazapine24	ROBINUL
(inhalation)59	repaglinide37	see glycopyrrolate45
PULMOZYME58	REPATHA19	ROBINUL FORTE
PURIXAN10	REPATHA PUSHTRONEX	see glycopyrrolate45
pyrazinamide7	SYSTEM19	ROCALTROL
pyridostigmine bromide34	REPATHA SURECLICK .19	see calcitriol44
pyrimethamine4	RESTASIS55	see calcitriol (oral)44
, Q	RESTASIS MULTIDOSE 56	ROCKLATAN DRO55
QINLOCK14	RESTORIL	roflumilast58

ropinirole hydrochloride25	see quetiapine fumarate	solifenacin succinate	.47
rosuvastatin calcium19	27		
ROTARIX SUS52	SEROQUEL XR	SOLTAMOX	.10
ROTATEQ SOL52	see quetiapine fumarate	SOLU-CORTEF	.43
ROWASA	27	SOLU-MEDROL	
see mesalamine w/	sertraline hcl24	see methylprednisolon	ne
cleanser46	setlakin41	sod succ	
roweepra30	sharobel41	SOMATULINE DEPOT	.44
ROXICODONE	SHINGRIX52	SOMAVERT	.44
see oxycodone hcl2	SIGNIFOR44	sorafenib tosylate	.14
ROZLYTREK14	sildenafil citrate (pulmonary	sotalol hcl	
RUBRACA14	hypertension)22	sotalol hcl (afib/afl)	.19
rufinamide30, 31	SILENOR	SOTYKTU	
RUKOBIA6	see doxepin hcl (sleep)	spironolactone	.17
RYBELSUS37	33	spironolactone &	
RYDAPT14	SILVADENE	hydrochlorothiazide tal	b
S	see silver sulfadiazine .60	25-25 mg	
SABRIL	see <i>ssd</i> .60	SPORANOX	
see <i>vigabatrin</i> 31	silver sulfadiazine60	see itraconazole	4
see <i>vigadrone</i> 31	SIMBRINZA SUS 1-0.2%55	sprintec 28	.41
see <i>vigpoder</i> 31	simliya41	SPRITAM	
sajazir49	simvastatin19	SPRYCEL	.14
SALAGEN	SINEMET	sps	.40
see pilocarpine hcl (oral)	see <i>carbidopa</i> &	sronyx	.41
63	levodopa tab 10-100	ssd	.60
SANDIMMUNE	<i>mg</i> 25	STELARA	.50
see <i>cyclosporine</i> 51	see <i>carbidopa</i> &	STIVARGA	.14
SANDOSTATIN	levodopa tab 25-100	STRATTERA	
see octreotide acetate 43,	<i>mg</i> 25	see atomoxetine hcl	.32
44	SINGULAIR	streptomycin sulfate	4
SANTYL62	see montelukast sodium	STRIBILD TAB	6
SAPHRIS	57	STROMECTOL	
see asenapine maleate	sirolimus51	see ivermectin	3
25	SIRTURO7	SUBOXONE	
sapropterin dihydrochloride	SKYRIZI50	see buprenorphine hcl	
44	SKYRIZI PEN50	naloxone hcl sl film	
SCEMBLIX14	sod sulfate-pot sulf-mg sulf	3 mg (base equiv)	.35
scopolamine45	oral sol 17.5-3.13-1.6	see buprenorphine hcl	
SECUADO27	<i>gm/177ml</i> 46	naloxone hcl sl film 2	
selegiline hcl25	sodium chloride53	0.5 mg (base equiv)	
selenium sulfide60	sodium chloride (gu	see buprenorphine hcl	
SELZENTRY6	<i>irrigant)</i> 62	naloxone hcl sl film 4	
see <i>maraviroc</i> 5	sodium fluoride chew; tab;	mg (base equiv)	
SENSIPAR	1.1 (0.5 f) mg/ml soln54	see buprenorphine hcl	
see cinacalcet hcl43	SODIUM OXYBATE35	naloxone hcl sl film 8	
SEREVENT DISKUS57	sodium phenylbutyrate44	mg (base equiv)	
SEROQUEL	sodium polystyrene	subvenite	
	sulfonate powder40	sucralfate	.46

sulfacetamide sodium	SYMDEKO TAB 50-75MG	TAFINLAR15
(acne)60	58	TAGRISSO15
sulfaceťamide sodium	SYMFI	TALZENNA15
(ophth)55	see efavirenz-	TAMIFLU
sulfacetamide sodium-	lamivudine-tenofovir df	see oseltamivir
prednisolone ophth soln	tab 600-300-300 mg6	phosphate
10-0.23(0.25)%54	SYMFILO	tamoxifen citrate10
sulfadiazine4	see efavirenz-	tamsulosin hcl47
sulfamethoxazole-	lamivudine-tenofovir df	TARCEVA
trimethoprim iv soln 400-	tab 400-300-300 mg6	see erlotinib hcl12
80 mg/5ml4	SYMPAZAN31	TARGRETIN
sulfamethoxazole-	SYMTUZA TAB6	see bexarotene11
trimethoprim susp 200-40	SYNALAR	see bexarotene (topical)
mg/5ml4	see fluocinolone	62
sulfamethoxazole-	acetonide61	
	SYNAREL44	tarina fe 1/20 eq41 TASIGNA15
trimethoprim tab 400-80		
mg4	SYNJARDY TAB 12.5-	tasimelteon33
sulfamethoxazole-	1000MG38	TAVNEOS49
trimethoprim tab 800-160	SYNJARDY TAB 12.5-500	tazarotene60
mg4	37	tazicef
sulfasalazine46	SYNJARDY TAB 5-	TAZORAC60
sulindac1	1000MG37	see tazarotene60
sumatriptan34	SYNJARDY TAB 5-500MG	TAZVERIK15
sumatriptan succinate34	37	TDVAX INJ 2-2 LF52
sunitinib malate14	SYNJARDY XR TAB 10-	TEFLARO
SUNLENCA6	100038	TEGRETOL
SUPREP BOWEL PREP	SYNJARDY XR TAB 12.5-	see carbamazepine28
KIT	100038	see <i>epitol</i> 29
see sod sulfate-pot sulf-	SYNJARDY XR TAB 25-	TEGRETOL-XR
mg sulf oral sol 17.5-	100038	see carbamazepine28
3.13-1.6 gm/177ml46	SYNJARDY XR TAB 5-	TEKTURNA
SUSTIVA	1000MG38	see aliskiren fumarate.21
see efavirenz5	SYNTHROID44	telmisartan18
SUTENT	see euthyrox44	temazepam33
see sunitinib malate14	see <i>levo-t</i> 44	TENIVÁC INJ 5-2LF52
syeda41	see levothyroxine sodium	tenofovir disoproxil
SYMBICORT	44	fumarate6
see <i>breyna</i> 59	see <i>levoxyl</i> 44	TENORETIC 100
see budesonide-	see unithroid44	see atenolol &
formoterol fumarate	SYPRINE	chlorthalidone tab 100-
dihyd aerosol 160-4.5	see trientine hcl40	25 mg20
mcg/act59	Т	TENORETIC 50
see budesonide-	TABRECTA14	see atenolol &
formoterol fumarate	tacrolimus52	chlorthalidone tab 50-
dihyd aerosol 80-4.5	tacrolimus (topical)62	25 mg20
mcg/act59	tadalafil47	TENORMIN
SYMDEKO TAB 100-15058	tadalafil (pulmonary	see atenolol20
5 <i>5</i> 1 <i>5</i> 1 100 10000	hypertension)22	TEPMETKO15
	119 00101010111111111111111111111111111	

terazosin hcl17	see metoprolol succinate	trihexyphenidyl hcl25
terbinafine hcl5	20	TRIJARDY XR TAB ER
terbutaline sulfate57	toremifene citrate10	24HR 10-5-1000MG38
terconazole vaginal47	torpenz15	TRIJARDY XR TAB ER
TERIPARATIDE39	torsemide21	24HR 12.5-2.5-1000MG
testosterone36	TPN ELECTROL INJ53	38
testosterone cypionate36	TRACLEER	TRIJARDY XR TAB ER
testosterone enanthate36	see bosentan22	24HR 25-5-1000MG38
tetrabenazine34	TRADJENTA38	TRIJARDY XR TAB ER
tetracycline hcl9	tramadol hcl3	24HR 5-2.5-1000MG38
THALOMID11	trandolapril17	TRIKAFTA PAK 59.5MG 58
theophylline58	tranexamic acid49	TRIKAFTA PAK 75MG58
thioridazine hcl27	TRANSDERM-SCOP	TRIKAFTA TAB 100-50-
thiothixene27	see scopolamine45	75MG & 150MG58
tiadylt er21	tranylcypromine sulfate24	TRIKAFTA TAB 50-25-
tiagabine hcl31	TRÁVÁSOL INJ 10%54	37.5MG & 75MG58
TIĂZAC	trazodone hcl24	tri-legest fe41
see diltiazem hcl	TRECATOR7	TRILEPTAL
extended release	TRELEGY AER ELLIPTA	see oxcarbazepine30
beads20	100-62.5-25 MCG56	tri-linyah41
see tiadylt er21	TRELEGY AER ELLIPTA	tri-lo-estarylla42
TIBSOVO15	200-62.5-25 MCG56	tri-lo-marzia42
TICOVAC52	TREMFYA50	<i>tri-lo-mili</i> 42
tigecycline9	TRESIBA39	tri-lo-sprintec42
TIKOSYN	TRESIBA FLEXTOUCH39	trimethoprim4
see dofetilide18	<i>tretinoin</i> 60	tri-mili42
tilia fe41	tretinoin (chemotherapy).11	trimipramine maleate24
timolol maleate20	triamcinolone acetonide	TRINTELLIX24
timolol maleate (ophth)55	(mouth)63	<i>tri-nymy</i> o42
tinidazole4	triamcinolone acetonide	tri-sprintec42
TIVICAY6	(topical)61	TRIUMEQ PD TAB6
TIVICAY PD6	triamterene &	TRIUMEQ TAB6
tizanidine hcl35	hydrochlorothiazide cap	trivora-2842
TOBI PODHALER4	<i>37.5-25 mg</i> 21	tri-vylibra42
TOBRADEX OIN 0.3-0.1%	triamterene &	tri-vylibra lo42
54	hydrochlorothiazide tab	TRÓPHAMINE INJ 10% .54
tobramycin4	37.5-25 mg21	trospium chloride47
tobramycin (ophth)55	triamterene &	TRULICITY38
tobramycin sulfate4	hydrochlorothiazide tab	TRUMENBA INJ52
tobramycin-dexamethasone	75-50 mg21	TRUQAP15
ophth susp 0.3-0.1%54	TRICOR	TRUVADA
tolterodine tartrate47	see fenofibrate19	see emtricitabine-
TOPAMAX	tridacaine ii62	tenofovir disoproxil
see topiramate31	triderm62	fumarate tab 100-150
TOPAMAX SPRINKLE	trientine hcl40	<i>mg</i> 6
see topiramate31	tri-estarylla41	see emtricitabine-
topiramate31	trifluoperazine hcl27	tenofovir disoproxil
TOPROL XL	trifluridine55	

fumarate tab 133-200	V	varenicline tartrate36
<i>mg</i> 6	VAGIFEM varenicline tartrate tab	
see emtricitabine-	see estradiol vaginal42	0.5 mg & 42 x 1 mg start
tenofovir disoproxil	see <i>yuvafem</i> 42	pack36
fumarate tab 167-250	valacyclovir hcl7	VARIVAX52
<i>mg</i> 6	VALĆHLOR62	VASCEPA19
see <i>emtricitabine-</i>	VALCYTE	VASERETIC
tenofovir disoproxil	see valganciclovir hcl7	see enalapril maleate &
fumarate tab 200-300	valganciclovir hcl7	hydrochlorothiazide tab
<i>mg</i> 6	VAĽIUM	10-25 mg16
TUKYŠA15	see diazepam28	VASOTEC
TURALIO15	valproate sodium31	see <i>enalapril maleate</i> 17
turqoz42	valproic acid31	velivet42
TWINRIX INJ52	valsartan18	VELSIPITY50
TYBOST6	valsartan-	VENCLEXTA15
TYENNE50	hydrochlorothiazide tab	VENCLEXTA TAB START
TYGACIL	<i>160-12.5 mg</i> 18	PK15
see tigecycline9	valsartan-	venlafaxine hcl24
TYKERB	hydrochlorothiazide tab	VENTOLIN HFA57
see lapatinib ditosylate13	<i>160-25 mg</i> 18	VENTOLIN HFA
TYPHIM VI52	valsartan-	(INSTITUTIONAL PACK)
U	hydrochlorothiazide tab	57
UBRELVY34	320-12.5 mg18	VEOZAH44
UCERIS	valsartan-	verapamil hcl21
see budesonide45	hydrochlorothiazide tab	VERQUVO22
UNASYN	<i>320-25 mg</i> 18	VERSACLOZ27
see <i>ampicillin</i> &	valsartan-	VERZENIO15
sulbactam sodium for	hydrochlorothiazide tab	VESICARE
<i>inj 1.5 (1-0.5) gm</i> 9	<i>80-12.5 mg</i> 18	see solifenacin succinate
see <i>ampicillin</i> &	VALTOCO 10 MG DOSE31	47
sulbactam sodium for	VALTOCO 15 MG DOSE31	vestura42
inj 3 (2-1) gm9	VALTOCO 20 MG DOSE31	VFEND
UNASYN BULK PACK	VALTOCO 5 MG DOSE31	see voriconazole5
see <i>ampicillin</i> &	VALTREX	VFEND IV
sulbactam sodium for	see <i>valacyclovir hcl</i> 7	see voriconazole5
iv soln 15 (10-5) gm9	VANCOCIN	VIBRAMYCIN
unithroid44	see <i>vancomycin hcl</i> 4	see doxycycline hyclate.9
UROCIT-K 10	vancomycin hcl4	vienva42
see potassium citrate	VANCOMYCIN	vigabatrin31
(alkalinizer)47	HYDROCHLORIDE	vigadrone31
UROCIT-K 15	see vancomycin hcl4	VIGAFYDE31
see potassium citrate	VANCOMYCIN INJ 1 GM .4	VIGAMOX
(alkalinizer)47	VANCOMYCIN INJ 500MG	see moxifloxacin hcl
UROXATRAL	4	(ophth)54
see alfuzosin hcl47	VANCOMYCIN INJ 750MG	vigpoder31
URSO FORTE	4	VIIBRYD
see ursodiol46	VANFLYTA15	see vilazodone hcl24
<i>ursodiol</i> 46	VAQTA52	vilazodone hcl24

VIMPAT	XARELTO STAR TAB	<i>xulane</i> 42
see lacosamide29	15/20MG48	XULTOPHY INJ 100/3.6.39
see lacosamide oral29	XATMEP50	XYLOCAINE
viorele42	XCOPRI31	see lidocaine hcl (local
VIRACEPT6	XCOPRI PAK 100-15031	anesth.)1
VIREAD6	XCOPRI PAK 12.5-2531	XYLOCAINÉ-MPF
see tenofovir disoproxil	XCOPRI PAK 150-200MG	see lidocaine hcl (local
fumarate6	(MAINTENANCE)31	anesth.)1
VISTARIL	XCOPRI PAK 150-200MG	Υ
see hydroxyzine	(TITRATION)31	YASMIN 28
pamoate56	XCOPRI PAK 50-100MG31	see drospirenone-ethinyl
VITRAKVI15	XDEMVY55	estradiol tab 3-0.03 mg
VIVELLE-DOT	XELJANZ50	40
see <i>dotti</i> 42	XELJANZ XR50	see <i>ocella</i> 41
see estradiol42	XENAZINE	see syeda41
VIVITROL36	see tetrabenazine34	see syeda41 see zumandimine42
VIZIMPRO15	XERMELO46	YAZ
VONJO15	XGEVA39	see drospirenone-ethinyl
voriconazole5	XHANCE58	estradiol tab 3-0.02 mg
VOSEVI TAB7	XIFAXAN46	40
VOTRIENT	XIGDUO XR TAB 10-1000	see jasmiel40
see pazopanib hcl14	38	see loryna41
VOWST CAP46	XIGDUO XR TAB 10-	see <i>nikki</i> 41
VRAYLAR27	500MG38	see vestura42
VRAYLAR CAP 1.5-3MG27	XIGDUO XR TAB 2.5-1000	YF-VAX INJ52
vyfemla42	38	<i>yuvafem</i> 42
vylibra42	XIGDUO XR TAB 5-	Z
VYZULTA55	1000MG38	zafemy42
W	XIGDUO XR TAB 5-500MG	zafirlukast57
warfarin sodium48	38	ZANAFLEX
water for irrigation, sterile	XIIDRA56	see tizanidine hcl35
irrigation soln62	XOLAIR58	ZARONTIN
WELIREG11	XOSPATA15	see ethosuximide29
WELLBUTRIN SR	XPOVIO PAK (100 MG	ZARXIO48
see bupropion hcl23	ONCE WEEKLY)16	ZEGALOGUE43
WELLBUTRIN XL	XPOVIO PAK (40 MG	ZEJULA16
see bupropion hcl23	ONCE WEEKLY)15	ZELBORAF16
wera42	XPOVIO PAK (40 MG	ZEMAIRA58
WESTAB PLUS TAB 27-	TWICE WEEKLY)15	ZEMPLAR
1MG54	XPOVIO PAK (60 MG	see paricalcitol44
wixela inhub59	ONCE WEEKLY)15	zenatane60
X	XPOVIO PAK (60 MG	ZENPEP CAP 10000UNT
XALATAN	TWICE WEEKLY)16	47
see latanoprost55	XPOVIO PAK (80 MG	ZENPEP CAP 15000UNT
XALKORI15	ONCE WEEKLY)16	47
XANAX	XPOVIO PAK (80 MG	ZENPEP CAP 20000UNT
see alprazolam22	TWICE WEEKLY)16	47
XARELTO48	XTANDI10	

ZENPEP CAP 25000UNT	see <i>ezetimibe</i> 19	see <i>everolimus</i>
47	ZIAGEN	(immunosuppressant)
ZENPEP CAP 3000UNIT46	see abacavir sulfate5	<u>.</u> 51
ZENPEP CAP 40000UNT	zidovudine6	zovia 1/3542
47	ziprasidone hcl27	ZTALMY32
ZENPEP CAP 5000UNIT46	ziprasidone mesylate28	zumandimine42
ZENPEP CAP 60000UNT	ZIRGAN55	ZURZUVAE24
47	ZITHROMAX	ZYDELIG16
ZESTORETIC	see azithromycin8	ZYKADIA16
see lisinopril &	ZOCOR	ZYLET SUS 0.5-0.3%54
hydrochlorothiazide tab	see simvastatin19	ZYPREXA
10-12.5 mg16	zoledronic acid39	see olanzapine26
see lisinopril &	ZOLINZA16	ZYPREXA RELPREVV28
hydrochlorothiazide tab	ZOLOFT	ZYPREXA ZYDIS
20-12.5 mg16	see sertraline hcl24	see olanzapine27
see lisinopril &	zolpidem tartrate33	ZYTIGA
hydrochlorothiazide tab	ZONEGRAN	see abiraterone acetate
<i>20-25 mg</i> 17	see zonisamide32	10
ZESTRIL	ZONISADE32	ZYVOX
see lisinopril17	zonisamide32	see linezolid3
ZETIA	ZORTRESS	



P.O. Box 30011, Pittsburgh, PA 15222-0330

This formulary was updated on 09/20/2024. 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 the Document Portal (rxmedicareplans.memberdoc.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. Enrollment in an automatic refill program may not transfer between plans. You may be required to re-enroll your prescriptions in the new plan's automatic refill program.

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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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 MedicareRx<sup>sм</sup> (PDP)

# 2025 SUMMARY OF BENEFITS

2025 Summary of Benefits

Blue MedicareRx (PDP)

Employer Group Medicare Prescription Drug Plan with Supplemental Coverage:

\$0 / 20%

**Option 32** 



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

# **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, 2025 - December 31, 2025

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 our Document Portal: rxmedicareplans.memberdoc.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 https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf 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.

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: rxmedicareplans.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 2 "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-of-pocket 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: Deductible, Initial Coverage 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: rxmedicareplans.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: **rxmedicareplans**. **memberdoc.com**. Or, call us and we will send you a copy of the pharmacy directory.

# ADDITIONAL BENEFIT INFORMATION FOR BLUE MEDICARERX

# Important message about what you pay for vaccines

Our plan covers most Part D vaccines at no cost to you. Call Customer Care for more information.

# Important message about what you pay for insulin

You won't pay more than \$35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

# **SUMMARY OF BENEFITS**

**January 1, 2025 – December 31, 2025** 

# 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.

Initio	al Coverage	After you pay your yearly deductible, you pay the following until your total yearly drug costs reach \$2,0001:		
Deductible		\$50		
Standard Retail Cost-Sharing		One-month supply Three-month supply		
Tier 1	Generic	\$0	\$0	
Tier 2	Brand	20% 20%		
		Specialty drugs are limited to a one-month supply per fill. <sup>3</sup>		
Mail Order Cost-Sharing One-month supply Three		Three-month supply		
Tier 1	Generic	\$2	\$2	
Tier 2	Brand	\$15	\$15	
	Specialty drugs are limited to a one-month supply per fill.			

# Catastrophic Coverage

During this payment stage, you pay nothing for your Part D covered drugs.

- 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.
- 3. Tier 1 Specialty Generic drugs are covered at a flat \$0 copayment and Tier 2 Specialty Brand drugs are covered at a flat \$25 copayment.

# **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-ofnetwork pharmacies in special circumstances as long as the pharmacy is located within the United States and its territories. 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 or Brand drug. When using an out of network pharmacy, you may be responsible for any cost differential between the amount charged and the allowed charge.

Medicare considers drugs which cost more than \$950 for a one month supply to be specialty drugs.

## 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 CD, data CD, accessible electronic formats, and 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, sex, sexual orientation, or gender identity, 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.jsf, 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, TTY: 1-800-537-7697 Complaint forms are available at hhs.gov/ocr/office/file/index.html.

You can file a complaint if you feel that you received inaccurate, misleading, or inappropriate information. Please call Customer Care at the number listed on the back page of this booklet (TTY users call: 711). If your complaint involves a broker or agent, be sure to include the name of the broker/agent when filing your complaint.

# **NOTES**



# 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 rxmedicareplans.memberdoc.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.



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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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SB-8582-20PT32-25



# **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).



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).



# MIND AND BODY REIMBURSEMENT

Great holistic health shouldn't be a stretch. Get reimbursed for qualified services and apps.

Save up to

\$300

per family per calendar year.





## Qualified for Mind and Body Reimbursement:\*

- Massage therapy
- Hypnosis therapy
- Meditation therapy
- Tai chi
- Qi (chi) gong
- Breathing and meditation apps



## Not Qualified for Mind and Body Reimbursement:

- Visits to nutrition providers or other services included in the Fitness or Weight-Loss Reimbursement programs
- Apps not focused on breathing or meditation, such as those focused on sleep

## Find a Qualified Provider and Save

You can get up to 30 percent off standard rates when you use an alternative health practitioner in our network. You'll also have peace of mind knowing that your practitioner is accredited in their field and meets specific requirements for education, training, and facilities. To search for a practitioner, go to **bluecrossma.org**.

Be sure to check with your doctor before receiving alternative medicine services.

# **GET REIMBURSED IN THREE EASY STEPS**

1

## Choose

Start by selecting a qualified mind and body service or app.

2

## Complete

After you pay for the service or app, fill out the attached form.

8

### Mail

Send the completed form to the address listed.

# **Questions?**

To learn more about your alternative health care benefits, sign in to MyBlue at **bluecrossma.com/myblue** or call Member Service at the number on the front of your ID card.

# MIND AND BODY REIMBURSEMENT REQUEST

Please print all information clearly. All 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 Stree	et	City	State	ZIP Code
Employer's Name				
	Claim Ir	nformation		
Member's Last Name	First Name Middle Initial Date of Birth//			
Claim is for (choose one and color in the entire box):	and Name, Address, and Phone Number for Qualified Expense (Service or App)			
□ Subscriber (policyholder) □ Spouse (of policyholder) □ Ex-Spouse □ Dependent (up to age 26) □ Other (specify):  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 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://				

## Important Information:

- Keep copies of proof of payment in case we request them from you.
- Mind and Body reimbursement can be granted for any single member or combination of members enrolled under the same Blue Cross health plan. Blue Cross will make a reimbursement decision within 30 days of receiving a complete request.
- Reimbursement requests must be submitted by March 31 of the following year.
- Reimbursement may be considered taxable income, so you should 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).



## 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 Inform	nation (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 Ir	formation										
Member's Last Name	Fi	irst Name	Middle Initial	Date of Birth//								
Claim is for (choose one and color in the entire box):  Subscriber (policyholder)	Name, Address,	and Phone Number of Quali	fied Fitness Expense									
☐ Spouse (of policyholder)												
□ Ex-Spouse												
Dependent (up to age 26)	Total Dollars requ	uested for Qualified Fitness	alified Fitness Expense: \$									
☐ Other (specify):	at 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://												
	•	orm and mail it to: eld of Massachusetts,										
	Local Claims	Department,	Local Claims Department,									

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 tarj ta 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).

PO Box 986030, Boston, MA 02298



# LOSE WEIGHT, GAIN SAVINGS

Stay motivated and get up to \$150 annually for participating in a qualified weight-loss program.<sup>1</sup>





### Qualifies for weight-loss reimbursement

- 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



### Doesn't qualify 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, complete the attached form.

3

### Mail

Send the completed form to the address listed.

You can also sign in to MyBlue to submit the form at member.bluecrossma.com/login.

Be sure to check with your primary care provider before starting any weight-loss program.

### **Questions?**

Call Team Blue Member Service at the number on your ID card.

<sup>1.</sup> To verify this reimbursement is offered for your plan, or for more information, sign in to MyBlue at bluecrossma.com/myblue or call the Team Blue Member Service at the 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 clearly.

To verify this reimbursement is offered within your plan, or for more information, sign in to MyBlue at **bluecrossma.org** or call Team Blue Member Service at the number on your ID card. All weight-loss 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 na	me		Middle initial				
Address – number and street			City		State	ZIP code				
Employer's name										
		Claim i	nformation							
Member's last name	Member's last name First name N									
Claim is for (choose one and color in the ent	ire box):									
☐ Subscriber (policyholder) ☐ Ex-spouse ☐ Spouse (of policyholder) ☐ Depender		,								
Name, address, and phone number of qualifi	ed weight-	loss program	n:							
Total dollars requested: \$					Year fees p	aid:				
Monthly program participation fee: \$										
Blue Cross Blue Shield of Massachusetts will make a reimbursement decision within thirty 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 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 weight-loss program to Blue Cross Blue Shield of Massachusetts.										
Subscriber signature:		Date (MM/DD/YY)								
Complete this form and mail it to: Blue Cross Blue Shield of Massachusetts Local Claims Department P.O. Box 986030 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).



# YOUR ONLINE WELLNESS PROGRAM, IN A NUTSHELL

With ahealthyme®´Rewards from Personify Health™, an independent company, it's easy to make your healthy choices pay off. Track your healthy habits, earn points, and rake in the rewards.\*



### **BRING ON THE REWARDS**

Here's a quick look at how to make the most of ahealthyme Rewards:



### Create an Account

Sign up at **ahealthymerewards.com**, and download the Personify Health app.



### **Earn Points**

Track your healthy habits, join challenges, and complete daily tasks to start earning.



### Claim Your Rewards

Use your points to shop exclusive deals, get gift cards, donate to charity, or add to your savings.

### Get Started

Ready to start earning? Sign up at <u>ahealthymerewards.com</u>, then download the Personify Health app.

### Earn up to \$400 in rewards annually.

### SO MANY WAYS TO LEARN AND EARN

ahealthyme Rewards makes it easy to earn rewards annually, just for making healthier choices.



### **Devices and Apps**

Connect your device to earn points and rewards. Under **Tracking**, you can connect all compatible devices and apps.



### My Interests

Choose your interests and we'll create a program experience around your life and goals.



### Your To-dos

Visit the home page and see all the ways you can earn points and trophies.



### **Daily Cards**

Complete easy quizzes and pick up fun facts—your daily cards offer an easy way to earn points.



### **Friends**

Invite co-workers to join in. Make it more fun by creating groups around common interests, like walking or sharing recipes. Earn points when you add friends.



### **My Stats**

Keep tabs on your progress, from steps taken to calories consumed.



### **Your Rewards**

To redeem, navigate to the **Rewards** tab, click **Spend** and choose how to spend your earnings.



### **Journeys**

Improving your health and wellness begins with adopting new habits. Now you have the digital coaching you need—to commit to goals that fit your life, to reinforce good habits, and to achieve real results.

### **HEALTHY HABITS**

From sleeping more to laughing more, you can practice three healthy habits every day, then track them to receive rewards.

### Themes include:

- Getting Active
- Eating Healthy
- Sleeping Well
- Reducing Stress
- Being Productive
- Learning New Things
- Contributing to My Community
- Building Relationships
- Managing My Finances

### **CHALLENGES**

### Team Challenges

Team up with co-workers and use the Personify Health app to take on fun, four- week virtual challenges across a variety of terrains.

### Personal Challenges

Think about how you'd like to get healthier, then choose a personal challenge that fits your goals.

### **NUTRITION GUIDE**

Personify Health's Nutrition Guide integrates with MyFitnessPal, the world's leading on-the-go nutrition tracker. Now you have the personalized nutrition plan you need to track your diet, get recipes, and make positive changes every day.

### **SLEEP GUIDE**

A good night's sleep can work wonders for your mind and body—but getting enough Zs is tough for many adults. Use the Sleep Guide to set goals, track your sleep, and take steps to sleep more soundly.

To make the most of ahealthyme Rewards, download the mobile app.

### HERE'S HOW TO EARN POINTS

What You Do		How Often	Requirements	Points			
Preventive Hea		Annually	Set a well-being goal Get a flu shot Preventive cancer screening (e.g., mammography, cervical cancer screening, colonoscopy) Routine health checkup Tobacco free agreement	500 250 500 500 250			
			Complete your Health Pulse Check Biometric screening (on-site or remote)	1,000 100			
Interests		Quarterly	Set interests	250			
Physical Activity Sync your steps.		Daily	Per 1,000 steps (validated, 14,000 steps max) 15 or more active minutes 30 or more active minutes 45 or more active minutes *Maximum of 140 points per day	10** 70 100 140			
		Monthly	Take 7,000 steps 20 days a month Take 10,000 steps 20 days a month	400 500			
		Daily	Healthy Habit tracking (up to three a day)	10			
Self-Tracking Track healthy hak	Self-Tracking Track healthy habits and activities.		Enter your weight or blood pressure Track healthy habits 10 days in a month Track healthy habits 20 days in a month	50 200 300			
			Track healthy habits five days in one month for the first time	100			
Cards		Daily	Complete cards (up to two per day)	20			
Complete, learn,	Complete, learn, and earn.		Monthly  Complete 10 daily cards in a month Complete 20 daily cards in a month				
	Personal Challenges	Monthly	Create a personal challenge Join a personal challenge	50 100			
Challenges	Healthy Habit Challenges	Monthly	Win the promoted healthy habit challenge	200			
Set and achieve goals.	Destination-Based Steps Challenges	Quarterly	Join the company challenge Post a chat comment at least once a week during the challenge period Track steps at least once a week during the challenge period Create and fill a team in the company challenge Unlock a destination Complete the final destination of a challenge	100 100 100 250 100 250			

<sup>\*\*</sup>Maximum of 140 points per day.

### HERE'S HOW TO EARN POINTS (Cont.)

What You Do	How Often	Requirements	Points
	Daily	Daily calorie tracking using MyFitnessPal Browse healthy recipes	20 10
	Weekly	Add a recipe to grocery list Favorite a recipe	10 10
<b>Nutrition</b> See how healthy choices add up.	Quarterly	Select your eating type	250
	Monthly	Track calories 10 days in a month Track calories 20 days in a month	200 300
	One-time	Connect calorie tracker to MyFitnessPal	100
	Daily	Track sleep manually Track sleep nightly (validated) Sleep more than seven hours a night (validated)	10 20 50
Sleep† Connect more sleep to better health.	Monthly	Track sleep 10 days in a month Track sleep 20 days in a month Sleep more than seven hours, 20 days a month	100 200 300
	Quarterly	Choose your sleep profile	250
Journeys	Daily	Complete a Journey step	20
Build healthy habits through self-guided courses.	Quarterly	Complete a Journey	250
More Ways to Earn Do the little things.	One-time	Registration Connect first activity device Add profile picture Add your first five friends Add a friend outside of your company Invite five colleagues (200 points each) Initial sign-in on your mobile app	100 200 250 250 100 1000 250

†Validated sleep data is required to earn points.

### Questions?

Chat live at <u>app.personifyhealth.com</u>, email <u>bcbsma@personifyhealth.com</u>, or call (toll-free) 1-844-854-7285.

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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 D (TTY: 711).

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### **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

Primary Care Provider's Name:

Doctor's Phone:

Doctor's Hospital Affiliation:

Your Blue Cross Blue Shield Member ID:

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).

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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 of treatment, payment, and health care operations or that

that would be reported to you is our disclosure of your

information in response to a court order.

you authorized (among others). An example of a disclosure

 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.

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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

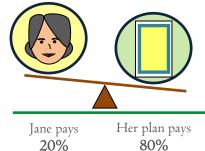
When a <u>provider</u> bills you for the balance remaining on the bill that your <u>plan</u> doesn't cover. This amount is the difference between the actual billed amount and the <u>allowed amount</u>. For example, if the provider's charge is \$200 and the allowed amount is \$110, the provider may bill 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 deductibles 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

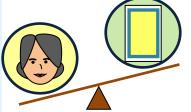
Your share of costs for services that a <u>plan</u> covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are <u>copayments</u>, <u>deductibles</u>, and <u>coinsurance</u>. Family cost sharing is the share of cost for <u>deductibles</u> 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 <u>health insurance</u> where individuals, families and small businesses can learn about their <u>plan</u> options; compare plans based on costs, benefits and other important features; apply for and receive financial help with <u>premiums</u> and <u>cost sharing</u> based on income; and choose a <u>plan</u> 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

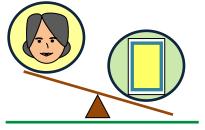
A fixed amount (for example, \$30) you pay for covered health care services from <u>providers</u> who do **not** contract with your <u>health insurance</u> or <u>plan</u>. Out-of-network copayments usually are more than <u>in-network</u> <u>copayments</u>.

# 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 <u>plan</u> 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</u> amount.

### **Urgent Care**

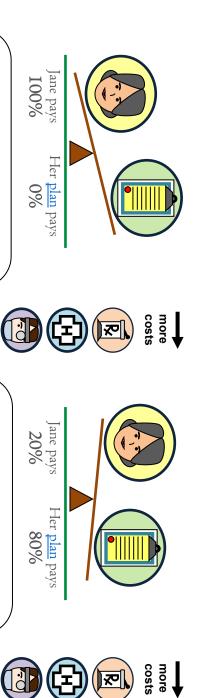
Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require <u>emergency room care</u>.

# How You and Your Insurer Share Costs - Example

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

**January 1**50
Beginning of Coverage Period

**December 31**st
End of Coverage Period



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

Jane hasn't reached her \$1,500 <u>deductible</u> yet

Her plan doesn't pay any of the costs.

Office visit costs: \$125

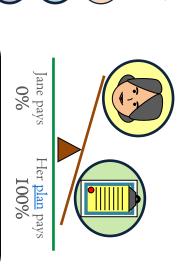
Her plan pays: \$0

Jane pays: \$125

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

Office visit costs: \$125

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



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

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

Office visit costs: \$125

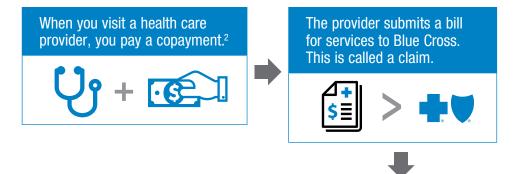
Jane pays: \$0 Her plan pays: \$125

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

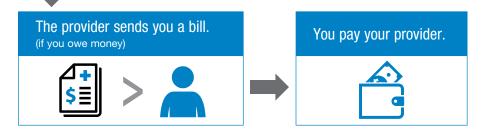
### A Guide to Your Summary of Health Plan Payments<sup>1</sup>

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 provider<sup>2</sup> 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.

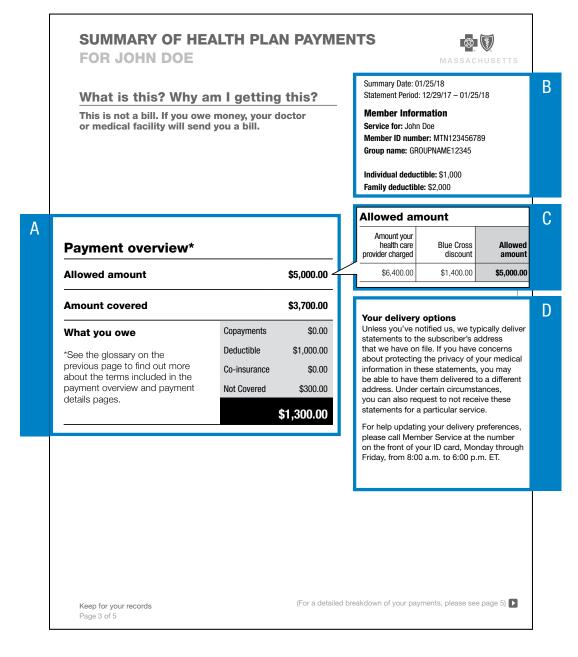
### Financial accounts can help cover costs.

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**

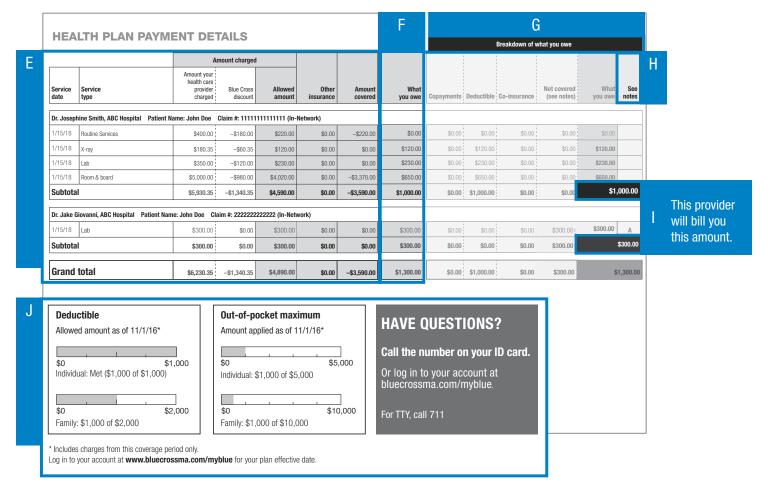
### **Payment Overview Page**



- 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**

Read the instructions below carefully.

For members of HMO Blue®, Network Blue®, Blue Choice®, HMO Blue New England<sup>SM</sup>, or Blue Choice New England<sup>SM</sup>: You're required to choose a primary care provider (PCP) when you enroll. Choose a PCP from your plan's provider directory. Be sure to read the "PCP ID #" in Section 2. List your PCP choice on your enrollment form. You can also find the PCP ID number by visiting bluecrossma.org and selecting Find a Doctor.

### For members of Access Blue<sup>SM</sup>:

Although you aren't required to choose a PCP, we recommend that 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 has Medicare and/or other insurance in addition to your Blue Cross Blue Shield of Massachusetts plan. Be sure to check either **Y** (for yes) or **N** (for no) in the correct box. This information will help us coordinate your benefits accurately. Follow the instructions in Sections 2 and 3.

Print two copies of your completed application. Keep one for your records and send the other to your employer to sign and mail to Blue Cross Blue Shield of Massachusetts. Your employer must sign the application to complete your enrollment request.

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

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).

### Instructions

### Section 1

Your employer will fill out this section.

**Type of Transaction**—Check one or more boxes that apply.

Subscriber Cancellation Codes. If the subscriber won't be continuing any Blue Cross Blue Shield coverage, select one of the following carefully 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	65 or over, changing to Group Medex <sup>®</sup> plan. (Requires Medicare A and B)     65 or over, changing to direct-pay Medex plan. (Requires Medicare A and B)     65 or over, changing to Medicare supplement other than Medex plans.	
043	• Medicare (age = 65 or over)	

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, 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. Include the new Medical or Dental Group #. Cancellation date will be the first day of no coverage.

### Qualifying Events—Remarks:

To assist in the enrollment process, use check boxes or write the 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 by the company.
- COBRA—Check this box if person is continuing coverage under COBRA.
- Add Spouse—Check this box if spouse is being added. Ensure that 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. Include HIPAA Continuation 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. 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.

### Yourself (Member 1) Section 2

Fill in all information that applies to you. (REQUIRED)\*

PCP ID#—If your health plan requires you to choose a primary care provider (PCP), fill in this section. Write the PCP ID number (not the telephone number) of the doctor you've 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, call our Physician Selection Service at 1-800-821-1388. A representative will help you select a provider. You can find the PCP ID number at bluecrossma.org, select Find a Doctor.

Gender—Enter M for male, F for female, or NB for non-binary.

Other Insurance—Do you have other health insurance or Medicare in addition to your Blue Cross Blue Shield plan? Be sure to check either Y (for yes) or N (for no) in the correct box. If you have other insurance, 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, 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.

### Member 2 Section 3

If you choose a Family membership, 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? Be sure to check either Y (for yes) or N (for no) in the correct box. If your spouse or partner has other insurance, write the name of the other insurance company and the member identification number.

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

If you choose a Family membership, 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, use additional Enrollment Forms as needed. Indicate on the form that additional forms have been used and write in the total number of dependents you want to be enrolled.

### Personal Savings Account Section 5

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

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, see your employer.

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

### Signatures (Employee & Employer)

Employee: Sign and date the application and return it to your employer. Employer: Sign and date the application and return it to Blue Cross Blue Shield of Massachusetts.

Please mail to

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

\* Under the Affordable Care Act, we're required to collect the Social Security number for you and any dependent enrolling in your plan.

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Please TYPE OR PRINT CLEARLY, using blue or black ink, to avoid coverage delay.



### **Enrollment and Change Form**

1. To Be Filled O	ut by You	ır Employ	er																	
Company Name	•	,					Current Medical Group #:						Medical Group # Transferring To:							
Current BCBS ID #, if any: Requested Effective Date:				Date of Hire:			Curr	Current Dental Group #:					Dental Group # Transferring to:			p # Transferring to:				
MM DD YYYY				MM	DD 1.c.		YYYY													
Type of Transaction				Ren	Remarks (e.g., qualifying event for a new add, change to family or other instruction):															
☐ ADD ☐ CANCEL ☐ CHANGE Three-digit ☐ ☐ ☐ ☐				Open Enrollment							ss of Coverag	ge (HIP	AA Contini	uation of	f Coveri	age Le	tter required)			
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Street Address/ P.O. Box #						Apt. #		City/ Town		,						State		ZIP	Code	
Home Phone ( )					Cell Phone	( )							Email							
Social Security # (REQUIRED) <sup>1</sup>						nsurance?	Oth	her In:	surance Con	pany Na	те		Λ	Member	r Identificat	ation Number				
PCP ID # (See instructions)					Name o								City / Stat	te					his your current PCP?	
Are you covered	Part A Effe	ective Date		Part B	Effective	e Date		Par	t D Effective	Date			 Medicare #	:				+ 🗆	Disabled  ESRD	
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Name						171.1.		Nam	e							Genuci	·	Dun	of Birai	
Social Security # Phone (REQUIRED) <sup>1</sup> ( )			)		Other Insurance? Other Insurance Company Name Member Identification $Y \square / N \square$					ntification Number										
PCP ID # (see instructions)		_			Name o	of							City / Stat	te		Is this your current PCP? $Y \square / N \square$				
Are you covered by Medicare? <sup>2</sup>	Part A Effe	ctive Date		Part B	Effective	Part D Effective Date			-	Medicare #				☐ 65+ ☐ Disabled ☐ ESRD						
$Y \square / N \square$	MM	DD	YYYY	MM		DD.	$Actively Working? Y \square / N \square$ If Retired, Date													
4. Your Eligible D	)epende	nts (Meml	bers 3, 4	, and	5)															
Dependent's First Nam 3.)	ie					M.I. Last Name			e						Gende	r	Date	e of Birth		
Social Security # (REQUIRED) <sup>1</sup>				PCP II	) # (See	instructions	)			ame of CP										
Is this your current PCI	P? Y□ / N	v 🗖	Full-tin	ıe stude	nt and a	and aged 19 or older 🗖 🏻 Disa			sabled and aged 26 or older 🗖					Plan Type:	□Ме	dical [	<b>□</b> Det	ntal		
Dependent's First Nam 4.)	ie					M.I.	Last Name								Gender Date		Date	e of Birth		
Social Security # (REQUIRED) <sup>1</sup>				PCP II	) # (See	instructions	)			ame of CP										
Is this your current PCI	P? Y□ / N	<sub>V</sub> $\square$	Full-tin	ıe stude	nt and a	nd aged 19 or older 🗖 🛮 Disabled and a				ged 26 or older 🗖 Pl					Plan Type:			ntal		
Dependent's First Nam 5.)	ie								Last Name			Ge		Gende	Gender Date of Birth		e of Birth			
Social Security # PCP ID # (St. (REQUIRED) <sup>1</sup>				) # (See	e instructions) Name PCP					e of										
Is this your current PCI	P? Y□ / N	√ 🗖	Full-tin	ıe stude	nt and a	ged 19 or old	ler 🗖 🛚	Disab	led and age	d 26 or ol	lder 🗆	J			Plan Type:	□ме	dical [	<b>D</b> Dei	ntal	
Check if you're using	g separate j	forms for ad	ditional de	epende	nt child	lren 🔲					To	otal#	of depende	ents: _						
5. Personal Savi	ngs Acc	ount																		
HSA: Health Savings Account						Start D	ate End Date							al Amount cructions for limits): \$						
						Start D				+	d Date				Health: \$					
DCFSA: Depend				unt			Start D	rate			End	d Date	: 			Depende	nt Care	e:\$		
6. Signatures (En	complete an	d true. I under	rstand that I	Blue Cro	ss and Bi	lue Shield wi	ll rely on	this in	nformation t	o enroll m	ie and	l my de	ependents or	to mak	te changes to	o my mei	mbersh	ip. I ui	nderstand that I should read ld may obtain personal and	
	out me to car	rry out its busi	ness, and th	at it may	use and	l disclose that	informa	ation i	in accordanc										collection, use, and disclosure	
Emnlovee's Signature						Date			Emnlo	ver's Sigr	natun	e							Date	



# GETTING MORE. NOW THERE'S A PLAN.

Your plan has more benefits than you probably realize. Tap into all of them, all in one place.

The MyBlue App is your key to more features and savings. Plus, up-to-date status for claims, your deductible, account balances, and more. It's like a free upgrade for the plan you already have.



### **UNLOCK THE POWER OF YOUR PLAN**

The MyBlue App gives you an instant snapshot of your plan, including:

FITNESS AND WEIGHT-

LOSS REIMBURSEMENT





**BALANCES** 





MEDICATION LOOKUP



VIDEO
DOCTOR VISITS USING
WELL CONNECTION

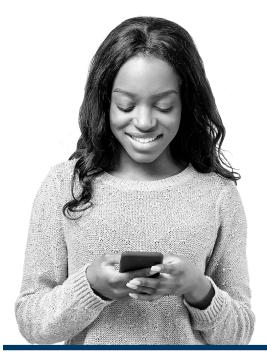
Get the App

Download the app from the App Store® or Google Play™.

### STAY ON TOP OF YOUR COVERAGE

It's never been easier, faster, or more convenient.

### YOUR PLAN IN YOUR HAND



Once you sign in or create a MyBlue App account, you can see all of your benefits, all in one place.

Track your claims, medications, account balances, and more from your device. And, you can easily keep track of reimbursements and savings.



Track claims and benefits Keep up to date on benefits and coverage.



Check deductible balances End the guesswork and know for sure every time.



Fitness and weight-loss reimbursement The online forms are here, along with other savings and offers.



Find a Doctor
Or a specialist,
dentist, or facility. On
your phone and on
the fly.



Your medications at a glance Their names, costs, and prescriptions at your fingertips.



Need your cards Access your ID cards without opening your wallet.



### **GET THE MYBLUE APP**

You can download the MyBlue App from the App Store® or Google Play™.

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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).



#### **CALL TEAM BLUE**

Let us know if you have more than one plan by calling us at 1-888-799-1888.

# COORDINATION OF BENEFITS ENSURES YOUR BEST COVERAGE

If you're covered by more than one medical or dental insurance plan, you must inform us which ones you have so we can coordinate your benefits. This will help us work with your other plans, to make sure you get the best coverage when you receive medical or dental services. It will also ensure that your claims are processed correctly.

## HOW TO KNOW WHEN COORDINATION OF BENEFITS IS NEEDED

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. Federal and state rules will usually determine which plan is primary. You may need coordination of benefits if:

- You and your spouse each have separate insurance plans through your employers
- Your child has one insurance plan through school and another 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 Medicare coverage

## WHAT TO DO IF YOU HAVE MORE THAN ONE MEDICAL OR DENTAL PLAN

- Call each insurer to let them know. Each insurer can tell you
  which plan is primary and which is secondary. When calling,
  be sure you have your member ID cards ready.
- When you visit a doctor, dentist, or hospital, present each insurance card to the office on the day of your visit.
   This information is needed to determine which company should be billed as a primary insurer, and which should be billed as a secondary insurer.
- If one of your insurance plans is canceled, you'll need to inform the other plan(s).

#### 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 for Medicare, call us at 1-888-799-1888 to submit your new plan information. If you don't call us, your claims could be delayed or processed incorrectly.

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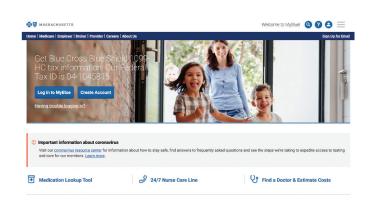
# HOW TO FIND YOUR PRIMARY CARE PROVIDER'S ID NUMBER

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?

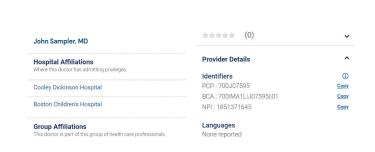
Call Member Service at **1-888-456-1351**. You can also find this number on the front of your ID card and in your Summary of Benefits.

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

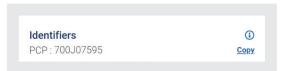
Enter your doctor's name, and your location.
Select Search to bring up your doctor's
profile page. When you sign in to MyBlue, your
network information will appear. Otherwise,
members with an HMO plan or Blue Choice®
should select HMO Blue as the network.

# Find a Doctor & Estimate Costs Enter all fields to see results Doctor, hospital, Specialty Q 02170 - Quincy, MA 17 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.





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## A WHOLE NEW WAY TO DO PRIMARY CARE

#### Your Virtual Care Team is here

An innovative way to do primary care that's convenient and comprehensive is here. You can now choose a virtual primary care provider (PCP) to lead your new Virtual Care Team.\*



### PRIMARY CARE THAT'S A PRIME EXPERIENCE

It's a new kind of primary care — one that comes with a team of experts committed to getting you the care you need.



With virtual visits, there's no need to travel to the doctor's office and no waiting room.



#### **COMPREHENSIVE**

Your team is here to make sure your physical and mental health needs are met.



#### **COORDINATED**

If you need in-person care, a care coordinator will help find in-network specialists who work for you.

### **LEARN MORE**

For more information, sign in to your MyBlue account at bluecrossma.org.

<sup>\*</sup>Coverage details may vary. Please check your 2023 plan benefits for more information.

### **HERE'S HOW IT WORKS**

START BY PICKING YOUR VIRTUAL PCP

+

ENJOY MORE
CONVENIENT CARE

+ GET THE BEST
OF BOTH WORLDS



To get started with your Virtual Care Team, the first step is selecting a virtual PCP. You'll also get access to a care coordinator, and your team may include other experts, such as a mental health specialist, picked based on your health needs. It's the care you need most, in the most convenient way.

Scheduling visits is as easy as hopping online, with appointments available in days, not weeks. Plus, you can reach out to your team with questions via talk, text, email, and chat. It's care that works on your terms, on your schedule, wherever you are, with a level of communication, technology, and access that will surprise you.

After your first visit, you'll receive a welcome kit which may include connected medical devices, like a blood pressure monitor, that make your virtual care as thorough as in-person visits. When you do need in-person care, your team will help find a specialist who works for you and follow up with you after the appointment.

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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/ةىر:

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 (TTY: **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).