https://planinfo.bluecrossma.com/customblue/2022/townofwilmington

Effective: 5/31/2022

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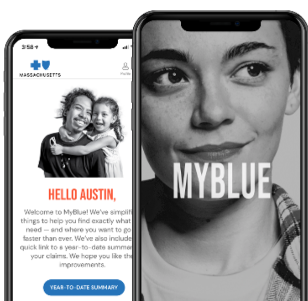

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SUMMARY OF BENEFITS

BLUE CARE ELECT PREFERRED

Town of Wilmington

UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:

COVERAGE AND BENEFITS

CLAIMS AND BALANCES

DIGITAL ID CARD

Sign in

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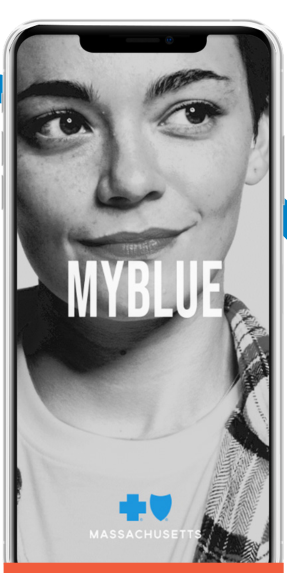

This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect January 1, 2014, as part of the Massachusetts Health Care Reform Law.

YOUR CHOICE

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

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

How to Find a Preferred Provider
To find a preferred provider:

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

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

You must pay a plan-year deductible before you can receive coverage for most out-of-network 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).

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 **$2,000** per member (or **$4,000** per family) for in-network and out-of-network services combined. Your out-of-pocket maximum for prescription drug benefits is **$4,450** per member (or **$8,900** 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 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: • 10 visits during the first year of life • Three visits during the second year of life (age 1 to age 2) • Two visits for age 2 • One visit per calendar year for age 3 and older	Nothing	20% coinsurance after deductible
Routine adult physical exams, including related tests (one per calendar year)	Nothing	20% coinsurance after deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing	20% coinsurance after deductible
Routine hearing exams, including routine tests	Nothing	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	20% coinsurance after deductible and all charges beyond the maximum
Routine vision exams (one every 24 months)	Nothing	20% coinsurance after deductible
Family planning services—office visits	Nothing	20% coinsurance after deductible
Outpatient Care		
Emergency room visits	$125 per visit (waived if admitted or for observation stay)	$125 per visit, no deductible (waived if admitted or for observation stay)
Office or health center visits	$25 per visit	20% coinsurance after deductible
Mental health or substance use treatment	$25 per visit	20% coinsurance after deductible
Outpatient telehealth services with a covered provider	Same as in-person visit	Same as in-person visit
Chiropractors' office visits	$25 per visit	20% coinsurance after deductible
Short-term rehabilitation therapy—physical and occupational (up to 100 visits per calendar year*)	$25 per visit	20% coinsurance after deductible
Speech, hearing, and language disorder treatment—speech therapy	$25 per visit	20% coinsurance after deductible
Diagnostic X-rays and lab tests, including CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	Nothing	20% coinsurance after deductible
Home health care and hospice services	Nothing	20% coinsurance after deductible
Oxygen and equipment for its administration	Nothing	20% coinsurance after deductible
Durable medical equipment—such as wheelchairs, crutches, hospital beds	20% coinsurance**	40% coinsurance after deductible**
Prosthetic devices	Nothing	20% coinsurance after deductible
Surgery and related anesthesia • Office or health center services • Ambulatory surgical facility, hospital outpatient department, or surgical day care unit	 $25 per visit*** $150 per admission	 20% coinsurance after deductible 20% coinsurance after deductible
Inpatient Care (including maternity care)		
General or chronic disease hospital care (as many days as medically necessary)	$250 per admission	20% coinsurance after deductible
Mental hospital or substance use facility care (as many days as medically necessary)	$250 per admission	20% coinsurance after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing	20% coinsurance after deductible
Skilled nursing facility care (up to 100 days per calendar year)	Nothing	20% coinsurance after deductible

* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or for the treatment of autism spectrum disorders.
** In-network cost share waived for one breast pump per birth (20% coinsurance after deductible out-of-network).
*** Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.

Covered Services	Your Cost In-Network	Your Cost Out-of-Network
Prescription Drug Benefits*		
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)**	$15 for Tier 1 $25 for Tier 2 $40 for Tier 3	Not covered
Through the designated mail order or designated retail pharmacy (up to a 90-day formulary supply for each prescription or refill)**	$15 for Tier 1*** $25 for Tier 2 $40 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 for certain covered drugs and supplies.
*** Certain generic medications are available through the mail order pharmacy at $9. For more information, go to bluecrossma.org/mail-order-pharmacy.

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

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: acupuncture visits; 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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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?	$0 in-network; $250 member / $500 family out-of-network.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Emergency room and emergency transportation.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For medical benefits, $2,000 member / $4,000 family; and for prescription drug benefits, $4,450 member / $8,900 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit 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 network provider?	Yes. See bluecrossma.com/findadoctor or call the Member Service number on your ID card for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 / visit	20% coinsurance	Deductible applies first for out-of-network; a telehealth cost share may be applicable
	Specialist visit	$25 / visit; $25 / chiropractor visit; Not covered / acupuncture visit	20% coinsurance; 20% coinsurance / chiropractor visit; Not covered / acupuncture visit	Deductible applies first for out-of-network; a telehealth cost share may be applicable
	Preventive care/screening/immunization	No charge	20% coinsurance	Deductible applies first for out-of-network; limited to age-based schedule and / or frequency; a telehealth cost share may be applicable. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization may be required
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization may be required

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **bluecrossma.org/medication**	Generic drugs	$15 / retail or mail order supply	Not covered	Up to 30-day retail (90-day designated retail or mail order) supply; cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain drugs
	Preferred brand drugs	$25 / retail or mail order supply	Not covered	
	Non-preferred brand drugs	$40 / retail or mail order supply	Not covered	
	Specialty drugs	Applicable cost share (generic, preferred, non-preferred)	Not covered	When obtained from a designated specialty pharmacy; pre-authorization required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 / admission	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required for certain services
	Physician/surgeon fees	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required for certain services
If you need immediate medical attention	Emergency room care	$125 / visit	$125 / visit; deductible does not apply	Copayment waived if admitted or for observation stay
	Emergency medical transportation	No charge	No charge	None
	Urgent care	$25 / visit	20% coinsurance	Deductible applies first for out-of-network; a telehealth cost share may be applicable

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 / admission	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required
	Physician/surgeon fees	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 / visit	20% coinsurance	Deductible applies first for out-of-network; a telehealth cost share may be applicable; pre-authorization required for certain services
	Inpatient services	$250 / admission	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required for certain services
If you are pregnant	Office visits	No charge	20% coinsurance	Deductible applies first for out-of-network; cost sharing does not apply for in-network preventive services; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); a telehealth cost share may be applicable
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	$250 / admission	20% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required
	Rehabilitation services	$25 / visit for outpatient services; No charge for inpatient services	20% coinsurance for outpatient services; 20% coinsurance for inpatient services	Deductible applies first for out-of-network; limited to 100 outpatient visits per calendar year (other than for autism, home health care, and speech therapy); limited to 60 days per calendar year for inpatient admissions; a telehealth cost share may be applicable; pre-authorization required for certain services
	Habilitation services	$25 / visit	20% coinsurance	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 for out-of-network; limited to 100 days per calendar year; pre-authorization required
	Durable medical equipment	20% coinsurance	40% coinsurance	Deductible applies first for out-of-network; in-network cost share waived for one breast pump per birth (20% coinsurance for out-of-network)
	Hospice services	No charge	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required for certain services

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

- Acupuncture
- 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.)

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

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Your state insurance department might also be able to help. If you are a Massachusetts resident, you can contact the Massachusetts Division of Insurance at 1-877-563-4467 or www.mass.gov/doi. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. For more information about possibly buying individual coverage through a state exchange, you can contact your state's marketplace, if applicable. If you are a Massachusetts resident, contact the Massachusetts Health Connector by visiting www.mahealthconnector.org. For more information on your rights to continue your employer coverage, contact your plan sponsor. (A 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 plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, call 1-800-782-3675 or contact your plan sponsor. (A plan 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 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 plan. It is not a policy. It is a general overview only. It does not provide all the details of this coverage, including benefits, exclusions and policy limitations. In the event there are discrepancies between this document and the policy, the terms and conditions of the policy will govern.

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

About these Coverage Examples:

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

Peg is Having a Baby
(9 months of in-network prenatal care and a hospital delivery)

- **The plan's overall deductible** **$0**
- **Delivery fee copay** **$0**
- **Facility fee copay** **$250**
- **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	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$360**

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

- **The plan's overall deductible** **$0**
- **Specialist visit copay** **$25**
- **Primary care visit copay** **$25**
- **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:

Cost Sharing	
Deductibles	$0
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,120**

Mia's Simple Fracture
(in-network emergency room visit and follow-up care)

- **The plan's overall deductible** **$0**
- **Specialist visit copay** **$25**
- **Emergency room copay** **$125**
- **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:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$300**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

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MCC COMPLIANCE

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PREFERRED PROVIDER ORGANIZATION (PPO)

IMPORTANT INFORMATION ABOUT YOUR PLAN

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

HOW TO ACCESS IMPORTANT RESOURCES

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

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

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

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

Need to Find a Doctor?

1. Go to **bluecrossma.org** 2. Click **Find a Doctor** under **Find Care**
3. Enter a provider or type of care, then select either the **PPO** or **EPO** network

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ACCESSING CARE

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

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

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

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

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

UNDERSTANDING PRIOR AUTHORIZATION

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

ABOUT YOUR ID CARD

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

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

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

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

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SUMMARY OF BENEFITS

NETWORK BLUE® NEW ENGLAND

Town of Wilmington

UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:

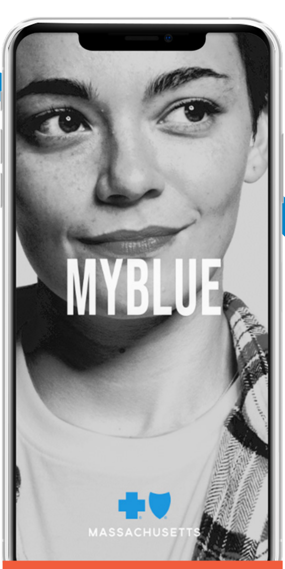
COVERAGE AND BENEFITS

CLAIMS AND BALANCES

DIGITAL ID CARD

Sign in

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



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.

An Association of Independent Blue Cross and Blue Shield Plans

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 Out-of-Pocket Maximum
Your out-of-pocket maximum is the most that you could pay during a plan year for copayments and coinsurance for covered services. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your out-of-pocket maximum for medical benefits is **$2,000** per member (or **$4,000** per family). Your out-of-pocket maximum for prescription drug benefits is **$4,450** per member (or **$8,900** 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're admitted to the hospital or for an observation stay. See the chart for your cost share.

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

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

When Outside the Service Area
If you're traveling outside the service area and you need urgent or emergency care, you should go to the nearest appropriate health care facility. You are covered for the urgent or emergency care visit and one follow-up visit while outside the service area. Any additional follow-up care must be arranged by your PCP. See your 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
Routine adult physical exams, including related tests	Nothing
Routine GYN exams, including related lab tests (one per calendar year)	Nothing
Routine hearing exams, including routine tests	Nothing
Hearing aids (up to $2,000 per ear every 36 months for a member age 21 or younger)	All charges beyond the maximum
Routine vision exams (one every 24 months)	Nothing
Family planning services—office visits	Nothing
Outpatient Care	
Emergency room visits	$125 per visit (waived if admitted or for observation stay)
Office or health center visits, when performed by: • Your PCP, OB/GYN physician, nurse midwife, limited services clinic, or by a physician assistant or nurse practitioner designated as primary care • Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	 $20 per visit $35 per visit
Mental health or substance use treatment	$20 per visit
Outpatient telehealth services with a covered provider	Same as in-person visit
Chiropractors' office visits	$35 per visit
Short-term rehabilitation therapy—physical and occupational (up to 60 visits per calendar year*)	$35 per visit
Speech, hearing, and language disorder treatment—speech therapy	$35 per visit
Diagnostic X-rays and lab tests, including CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	Nothing
Home health care and hospice services	Nothing
Oxygen and equipment for its administration	Nothing
Durable medical equipment—such as wheelchairs, crutches, hospital beds	20% coinsurance**
Prosthetic devices	Nothing
Surgery and related anesthesia in an office or health center, when performed by: • Your PCP, OB/GYN physician, nurse midwife, or by a physician assistant or nurse practitioner designated as primary care • Other covered providers, including a physician assistant or nurse practitioner designated as specialty care	 $20 per visit*** $35 per visit***
Surgery and related anesthesia in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	$150 per admission
Inpatient Care (including maternity care)	
General or chronic disease hospital care (as many days as medically necessary)	$250 per admission
Mental hospital or substance use facility care (as many days as medically necessary)	$250 per admission
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing
Skilled nursing facility care (up to 100 days per calendar year)	Nothing

* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or for the treatment of autism spectrum disorders.
** Cost share waived for one breast pump per birth.
*** Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.

Covered Services	Your Cost
Prescription Drug Benefits*	
At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)**	$15 for Tier 1 $25 for Tier 2 $40 for Tier 3
Through the designated mail order or designated retail pharmacy (up to a 90-day formulary supply for each prescription or refill)**	$15 for Tier 1*** $25 for Tier 2 $40 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.
** Cost share may be waived for certain covered drugs and supplies.
*** Certain generic medications are available through the mail order pharmacy at $9. For more information, go to bluecrossma.org/mail-order-pharmacy.

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

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: acupuncture visits; 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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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?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No.	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For medical benefits, $2,000 member / $4,000 family; and for prescription drug benefits, $4,450 member / $8,900 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit 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 network provider?	Yes. See bluecrossma.com/findadoctor or call the Member Service number on your ID card for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 / visit	Not covered	A telehealth cost share may be applicable
	Specialist visit	$35 / visit; $35 / chiropractor visit; Not covered / acupuncture visit	Not covered	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 cost share may be applicable. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	Pre-authorization required for certain services
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Pre-authorization required for certain services
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **bluecrossma.org/medication**	Generic drugs	$15 / retail or mail order supply	Not covered	Up to 30-day retail (90-day designated retail or mail order) supply; cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain drugs
	Preferred brand drugs	$25 / retail or mail order supply	Not covered	
	Non-preferred brand drugs	$40 / retail or mail order supply	Not covered	
	Specialty drugs	Applicable cost share (generic, preferred, non-preferred)	Not covered	When obtained from a designated specialty pharmacy; pre-authorization required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 / admission	Not covered	Pre-authorization required for certain services
	Physician/surgeon fees	No charge	Not covered	Pre-authorization required for certain services

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need immediate medical attention	Emergency room care	$125 / visit	$125 / visit	Copayment waived if admitted or for observation stay
	Emergency medical transportation	No charge	No charge	None
	Urgent care	$35 / visit	$35 / visit	Out-of-network coverage limited to out of service area; a telehealth cost share may be applicable
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 / admission	Not covered	Pre-authorization required
	Physician/surgeon fees	No charge	Not covered	Pre-authorization required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 / visit	Not covered	A telehealth cost share may be applicable; pre-authorization required for certain services
	Inpatient services	$250 / admission	Not covered	Pre-authorization required for certain services
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply for preventive services; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound); a telehealth cost share may be applicable
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	$250 / admission	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Pre-authorization required
	Rehabilitation services	$35 / visit for outpatient services; No charge for inpatient services	Not covered	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; pre-authorization required for certain services
	Habilitation services	$35 / 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	Limited to 100 days per calendar year; pre-authorization required
	Durable medical equipment	20% coinsurance	Not covered	Cost share waived for one breast pump per birth
	Hospice services	No charge	Not covered	Pre-authorization 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 for members with a cleft palate / cleft lip condition	Not covered	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.)

- Acupuncture
- 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.)

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

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Your state insurance department might also be able to help. If you are a Massachusetts resident, you can contact the Massachusetts Division of Insurance at 1-877-563-4467 or www.mass.gov/doi. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. For more information about possibly buying individual coverage through a state exchange, you can contact your state's marketplace, if applicable. If you are a Massachusetts resident, contact the Massachusetts Health Connector by visiting www.mahealthconnector.org. For more information on your rights to continue your employer coverage, contact your plan sponsor. (A 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 plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, call 1-800-782-3675 or contact your plan sponsor. (A plan 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 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 plan. It is not a policy. It is a general overview only. It does not provide all the details of this coverage, including benefits, exclusions and policy limitations. In the event there are discrepancies between this document and the policy, the terms and conditions of the policy will govern.

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

About these Coverage Examples:

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

Peg is Having a Baby
(9 months of in-network prenatal care and a hospital delivery)

- **The plan's overall deductible** **$0**
- **Delivery fee copay** **$0**
- **Facility fee copay** **$250**
- **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	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$360**

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

- **The plan's overall deductible** **$0**
- **Specialist visit copay** **$35**
- **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:

Cost Sharing	
Deductibles	$0
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,120**

Mia's Simple Fracture
(in-network emergency room visit and follow-up care)

- **The plan's overall deductible** **$0**
- **Specialist visit copay** **$35**
- **Emergency room copay** **$125**
- **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:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$300**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

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MCC COMPLIANCE

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HMO BLUE

IMPORTANT INFORMATION ABOUT YOUR PLAN

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

HOW TO ACCESS IMPORTANT RESOURCES

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

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

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

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

Need to Find a Doctor?

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

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ACCESSING CARE

The Importance of a PCP: Routine annual 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 & Estimate Costs** 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)**.

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ABOUT YOUR ID CARD

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

Lost your ID card?
No problem, you can order another one through MyBlue.

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

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

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

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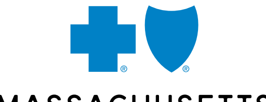

SUMMARY OF BENEFITS

DENTAL BLUE® SELECT

Town of Wilmington

A Dental Blue PPO Option

UNLOCK THE POWER OF YOUR PLAN

MyBlue gives you an instant snapshot of your plan:

COVERAGE AND BENEFITS

CLAIMS AND BALANCES

DIGITAL ID CARD

Sign in

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

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DENTAL BLUE SELECT

Preventive Benefit Group		Basic Benefit Group		Major Benefit Group	
In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Full Coverage	Full Coverage (after a $25 Per Member/$75 Per Family Calendar-Year Deductible)	Full Coverage	80% Coverage	60% Coverage	50% Coverage
$1,000 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
- Emergency dental care to treat acute pain or to prevent permanent harm to a member*
- General anesthesia when administered in conjunction with covered surgical services

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

* 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 SELECT,

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

Your Dentist

Dental Blue Select offers a large network of dentists, including dentists in Massachusetts and Rhode Island who participate with Blue Cross Blue Shield of Massachusetts. Dental Blue Select members also have access to participating dentists nationwide. When searching for a participating dentist, Dental Blue Select members can choose from the Dental Blue PPO network. Using a Dental Blue PPO 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

The dental benefits your plan covers are subject to the calendar-year deductible and coinsurance (if applicable), and benefit maximum amounts shown in the chart. The calendar year begins on January 1 and ends on December 31 of each year. The chart also shows the percentage of costs your plan will pay for covered dental services. Payments are based on whether or not you receive services from a network or out-of-network dentist. 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 network 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

Payments are based on the allowed charge for covered services. Network dentists agree to accept the allowed charge as payment in full. You pay only your deductible and coinsurance (if applicable), and any allowed charges beyond your calendar-year benefit maximum. In certain situations, you will have to pay the difference between the claim payment and the provider’s actual billed charge. Refer to your plan description for information about these situations.

How Out-of-Network Dentists Are Paid

Benefits for covered services by an out-of-network 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 allowed charge or the dentist’s actual charge, whichever is less. You are also responsible for your deductible and coinsurance (if applicable), and charges beyond your calendar-year benefit maximum.

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

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

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

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

If You Have to File a Claim
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 800-262-2583, or visit us online at bluecrossma.org.

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

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March 2022

DENTAL BLUE® ACCUMULATED MAXIMUM ROLLOVER

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

HOW MAXIMUM ROLLOVER WORKS

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

There is no cost to you. You don't need to do anything. To figure out the amount of benefit dollars that are eligible to roll over, just use the chart below. Start by searching for your benefit period maximum in the first column. If Blue Cross doesn't pay out more claims dollars on your behalf than the amount in the second column, your benefit maximum for the next year will increase by the amount in the third column.

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

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

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

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

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

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

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

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BLUE 20/20 EXAM-PLUS VISION PLAN: INSIGHT NETWORK

$130 – 24/12/24 Frequency

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

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

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

ADDITIONAL IN-NETWORK SAVINGS AND DISCOUNTS

40%
OFF A COMPLETE SECOND PAIR OF GLASSES

20%
OFF NON-PRESCRIPTION SUNGLASSES

15%
OFF RETAIL PRICE OR 5% OFF PROMOTIONAL PRICE FOR LASER VISION CORRECTION THROUGH U.S. LASER NETWORK

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

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

BENEFITS YOU CAN SEE—FROM A COMPANY YOU TRUST

ACCESS TO ONE OF NATIONS LARGEST VISION NETWORKS

THOUSANDS OF INDEPENDENT PROVIDERS

AWARD WINNING CUSTOMER SERVICE

FAVORITE NATIONAL RETAILERS

LENSCRAFTERS®

PEARLE VISION℠

and many regional retailers.

ON-LINE SHOPPING OPTIONS

- Glasses.com
- Contactsdirect.com
- Ray-Ban.com
- Targetoptical.com
- Lenscrafters.com

SPECIAL OFFERS FOR ADDITIONAL SAVINGS

Find them on the **blue2020ma.com**.

SAVE ON HEARING EXAMS AND HEARING AIDS

Offered by Amplifon Hearing, an independent company. To learn more about the savings available, visit **amplifonusa.com/blue2020**. Call **1-866-921-5367** to get started.

Questions?

Call customer service at **1-855-875-6948**.
To locate an in-network provider, visit **blue2020ma.com**.*

*Registration not required to search for providers.

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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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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SUMMARY OF BENEFITS

MEDEX® 2

Town of Wilmington

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

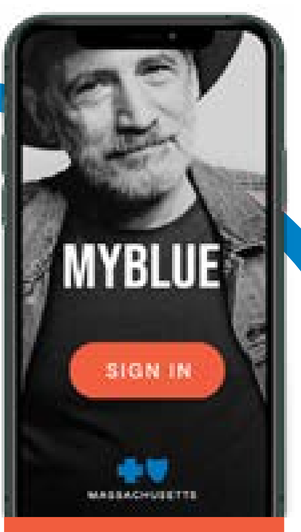
MyBlue gives you an instant snapshot of your plan:

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.

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YOUR MEDICAL BENEFITS

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

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

† The additional days are a combination of days in a general or mental hospital.
* A combined maximum of 365 days per benefit period in a Medicare participating and non-participating skilled nursing facility.
** Treatment of rape-related mental or emotional disorders for victims of an assault with intent to rape is covered to the same extent as biologically based conditions.

Preventive Services Approved by Medicare and Medex

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

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

Important Information

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

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.
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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November 2021

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Mail Order Pharmacy

The Mail Order Pharmacy Saves You Time and Money

You can get 90-day prescriptions for certain maintenance medications delivered right to your door, and for a fraction of the cost, when you order them through the mail order pharmacy. Maintenance medications, also known as long-term medications, are prescribed to treat chronic or ongoing conditions, such as high blood pressure or diabetes.

Advantages of Using the Mail Order Pharmacy

- You'll pay less for a 90-day supply than you would for three 30-day supplies of your maintenance medications
- Medications are shipped to you at no additional cost for standard shipping
- With fewer refills and no trips to the pharmacy, you'll be less likely to miss a dose
- Get your prescriptions on time, every time with automatic refills

How to Order Prescriptions

Express Scripts®´, an independent company that administers your pharmacy benefits on behalf of Blue Cross Blue Shield of Massachusetts, will deliver your prescriptions straight to your door. To order prescriptions, choose one of the following options. In most cases, Express Scripts will contact your doctor directly to arrange 90-day prescriptions, plus refills.

- Visit Express Scripts at **express-scripts.com /starthd**, and select **Register**
- Download the Express Scripts mobile app and select **Register**
- Call Express Scripts at **1-800-892-5119** (TTY: **1-800-305-5376**)
- Ask your doctor to e-prescribe a new, 90-day prescription to Express Scripts, or fax it to **1-800-837-0959**
- Fill out the order form* and mail it to:
  Home Delivery Service
  PO Box 66566
  St Louis, MO 63166-9967

How to Order Refills

- Log in to Express Scripts at **express-scripts.com**, select the medications to be filled, then click **Add to Cart**
- Call Express Scripts at **1-800-892-5119** (TTY: **1-800-305-5376**), 24 hours a day

Have Your Prescriptions Refilled Automatically

Worry Free Fills®´ are available for qualifying maintenance medications. When enrolled, Express Scripts will calculate when you'll need your prescriptions and deliver them on time. They'll contact you before processing each fill to confirm delivery, and the delivery date. Enroll in Worry Free Fills by choosing one of the following methods:

- Visit Express Scripts at **express-scripts.com**, and select **Automatic Refills**
- When refilling a prescription, answer yes when asked to enroll in Worry Free Fills
- Call Express Scripts at **1-800-892-5119** (TTY: **1-800-305-5376**)

Save up to 33%

When you use the mail order pharmacy.**

*You can download and print a copy of the mail order form at **express-scripts.com.**
**Compared to three 30-day prescriptions purchased at a retail pharmacy.

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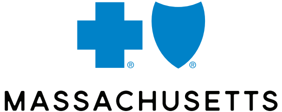

Blue Cross Blue Shield of Massachusetts Formulary: Value-Based Benefit Medication List

Last Updated: January 1, 2022

The following list includes medications that are covered by plans with the Blue Cross Blue Shield of Massachusetts formulary. These medications are covered under the value-based pharmacy benefit.

You may be eligible to pay less for the following medications when purchased through the mail order pharmacy managed by Express Scripts®, an independent company that administers your pharmacy benefits on behalf of Blue Cross Blue Shield of Massachusetts. If you have an HSA-qualified "Saver" plan,[1] the deductible is waived when you purchase these medications through mail order.[2]

Learn More About Your Coverage

For more information about these medications, look them up using the **Medication Lookup** tool at **bluecrossma.org/medication**.

1. Blue Cross Blue Shield of Massachusetts plans that are HSA-qualified include the term "Saver" in the plan name. For example, Blue Care® Elect Saver or HMO Blue New England Saver $2,000.
2. Some employers may also exempt the copayment or co-insurance. Check your benefit materials for details.

Anti-Asthmatic Medications

Medication Name			
ALBUTEROL INHALATION SOLUTION	FLOVENT / DISKUS	MONTELUKAST	QVAR
AMINOPHYLLINE	FLOVENT HFA	PROAIR HFA	THEOCHRON
BUDESONIDE NEBULIZER SOLUTION	IPRATROPIUM NEBULIZER SOLUTION	PROAIR RESPICLICK	THEOPHYLLINE
CROMOLYN NEBULIZER SOLUTION	IPRATROPIUM-ALBUTEROL	PULMICORT	ZAFIRLUKAST

Anti-Depressant Medications

You're eligible to pay the reduced cost for these medications below through the mail order pharmacy, if you're also taking one of the medications listed in this document to treat asthma or diabetes, **OR:** one of the medications listed in this document to treat high blood pressure **AND** one of the medications listed in this document to treat cholesterol.

Medication Name			
CITALOPRAM	FLUOXETINE	PAROXETINE HCL	SERTRALINE
ESCITALOPRAM	FLUVOXAMINE	PAROXETINE-CR	

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Cardiovascular Maintenance Medications

You're eligible to pay the reduced cost for these medications below through the mail order pharmacy, if you're taking one of the medications on this list to treat high blood pressure **AND** one of the medications on this list to treat high cholesterol.

Medication Name (High Blood Pressure)			
AMILORIDE / HCTZ	DILTIAZEM HCL	HYDRALAZINE	NIFEDIPINE CR
AMLODIPINE	DILTIAZEM HCL ER CAP	HYDROCHLOROTHIAZIDE	NIFEDIPINE ER
AMLODIPINE / BENAZEPRIL	DILTIAZEM HCL SR CAP	IRBESARTAN	NIFEDIPINE XL
ATENOLOL	DILTIAZEM HCL TAB	IRBESARTAN / HCTZ	PROPRANOLOL
ATENOLOL / CHLORTHALIDONE	DILTIAZEM HCL XR CAP	LISINOPRIL	RAMIPRIL
BENAZEPRIL	DILTIAZEM HCL XT CAP	LISINOPRIL / HCTZ	SPIRONOLACTONE
BENAZEPRIL / HCTZ	DILTIAZEM XR CAP	LOSARTAN POTASSIUM	TERAZOSIN
BISOPROLOL / HCTZ	DOXAZOSIN	LOSARTAN POTASSIUM / HCTZ	TRIAMTERENE / HCTZ
CAPTOPRIL	ENALAPRIL	METHAZOLAMIDE	VALSARTAN
CARVEDILOL	ENALAPRIL / HCTZ	METOPROLOL	VALSARTAN / HCTZ
CHLORTHALIDONE	EPLERENONE	METOPROLOL SUCCINATE ER	VERAPAMIL
CLONIDINE	FELODIPINE ER	NADOLOL	VERAPAMIL ER
DILTIAZEM CD	FUROSEMIDE	NICARDIPINE	

Medication Name (High Cholesterol)—Generics			
ATORVASTATIN	COLESTIPOL	GEMFIBROZIL	PREVALITE
CHOLESTYRAMINE / LIGHT	FENOFIBRATE	PRAVASTATIN	SIMVASTATIN

Diabetes Medications

Medication Name			
ACARBOSE	GLIPIZIDE / METFORMIN HCL	JANUVIA	SYMLIN
BYDUREON	GLYBURIDE	JARDIANCE	SYNJARDY
BYETTA	GLYBURIDE / METFORMIN HCL	KOMBIGLYZE XR	SYNJARDY XR
CHLORPROPAMIDE	GLYBURIDE-MICRO	LANTUS	TOLAZAMIDE
FARXIGA	GLYXAMBI	METFORMIN	TOLBUTAMIDE
GLIMEPIRIDE	HUMALOG	METFORMIN ER (GENERIC VERSION OF GLUCOPHAGE)	TRULICITY
GLIPIZIDE	HUMULIN	NATEGLINIDE	XIGDUO XR
GLIPIZIDE ER	JANUMET	ONETOUCH TEST STRIPS	
GLIPIZIDE XL	JANUMET XR	ONGLYZA	

Smoking-Cessation Medications

You have access to the following medications at no additional cost through the mail order pharmacy and at retail pharmacies.

Medication Name			
BUPROBAN	COMMIT	NICOTINE[4]	NICOTROL
BUPROPION HCL ER[3]	NICODERM CQ	NICOTINE GUM[4]	NICOTROL NS
BUPROPION HCL SR[3]	NICORELIEF	NICOTINE LOZENGE[4]	NTS
CHANTIX	NICORETTE	NICOTINE PATCH[4]	

3. Generics of Zyban only
4. Also includes various store brands

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

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

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

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

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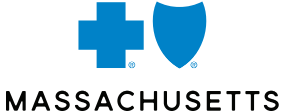

Blue Cross Blue Shield of Massachusetts Formulary: Maintenance Medication List

Last Updated: January 1, 2022

The following list includes maintenance medications that are covered by plans with the Blue Cross Blue Shield of Massachusetts formulary. These maintenance medications, also known as long-term medications, are included in our Smart90®´, Select Home Delivery, and Exclusive Home Delivery programs.

This isn't a complete list of covered medications, and inclusion on the 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.

Maintenance Medications Included in the National Preferred Formulary (NPF)

The maintenance medications listed in this document are also included in the National Preferred Formulary (NPF), which is available through Express Scripts®', an independent company that administers your pharmacy benefits on behalf of Blue Cross Blue Shield of Massachusetts. Pharmacy management program requirements apply to maintenance medications included in the NPF.

Where to Fill Your Maintenance Medications

Members of our pharmacy plans that use the Blue Cross formulary or NPF must fill their maintenance medications at an in-network pharmacy. If your plan includes Smart90, Select Home Delivery, or Exclusive Home Delivery, you may be required to fill your maintenance medication in designated quantities from a participating retail pharmacy or through the mail order pharmacy managed by Express Scripts.

NOTE: Some maintenance medications on this list may be considered non-covered, including new medications under review. Your doctor may request an exception for a non-covered medication when medically necessary.[2]

Learn More About Your Coverage

For more information about your pharmacy benefits, including the NPF and the medications listed in this document, sign in to your MyBlue account at **bluecrossma.org/myblue**.

1. Not all medications listed are covered by all prescription plans. Check your benefit materials for details.
2. If approved, you'd pay the highest-tier cost.

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Maintenance Medications

Drug Class	Medication Name	
5-Lipoxygenase Inhibitors	ZILEUTON	ZYFLO CR
ACE Inhibitor-Calcium Channel Blocker Combination	AMLODIPINE BESYLATE-BENAZEPRIL	TRANDOLAPRIL-VERAPAMIL
	PRESTALIA	
ACE Inhibitor-Thiazide or Thiazide-Like Diuretic	BENAZEPRIL-HYDROCHLOROTHIAZIDE	FOSINOPRIL-HYDROCHLOROTHIAZIDE
	CAPTOPRIL-HYDROCHLOROTHIAZIDE	LISINOPRIL-HYDROCHLOROTHIAZIDE
	ENALAPRIL MALEATE-HYDROCHLOROTHIAZIDE	QUINAPRIL-HYDROCHLOROTHIAZIDE
Agents to Treat Hypoglycemia (Hyperglycemics)	BAQSIMI	PROGLYCEM
	DIAZOXIDE	ZEGALOGUE
	GVOKE	
Alpha-Adrenergic Blocking Agents	DOXAZOSIN MESYLATE	TERAZOSIN
	PRAZOSIN	
Alpha/Beta-Adrenergic Blocking Agents	CARVEDILOL	LABETALOL
	CARVEDILOL ER	
Alzheimer's Therapy, NMDA Receptor Antagonists	MEMANTINE	NAMENDA
	MEMANTINE ER	NAMENDA XR
Analgesic/Antipyretics, Salicylates	DIFLUNISAL	
Angiotensin Receptor Antag-Calcium Channel Blocker-Thiazide	AMLODIPINE-VALSARTAN-HCTZ	OLMESARTAN-AMLODIPINE-HCTZ
	EXFORGE HCT	TRIBENZOR
Angiotensin Receptor Antag-Neprilysin Inhibitor Combination (ARNI)	ENTRESTO	
Angiotensin Receptor Antag-Thiazide Diuretic Combination	CANDESARTAN-HYDROCHLOROTHIAZIDE	MICARDIS HCT
	EDARBYCLOR	OLMESARTAN-HYDROCHLOROTHIAZIDE
	IRBESARTAN-HYDROCHLOROTHIAZIDE	TELMISARTAN-HYDROCHLOROTHIAZIDE
	LOSARTAN-HYDROCHLOROTHIAZIDE	VALSARTAN-HYDROCHLOROTHIAZIDE
Angiotensin Receptor Blocker-Calcium Channel Blocker	AMLODIPINE-OLMESARTAN	TELMISARTAN-AMLODIPINE
	AMLODIPINE-VALSARTAN	TWYNSTA
Angiotensin II Receptor Blocker-Beta Blocker Combination	BYVALSON	
Antianginal, Anti-Ischemic Agents, Non-Hemodynamic	RANEXA	RANOLAZINE ER
Anti-Anxiety Drugs	BUSPIRONE	
Antiarrhythmics	AMIODARONE	NORPACE
	DISOPYRAMIDE PHOSPHATE	NORPACE CR
	FLECAINIDE ACETATE	PACERONE
	MEXILETINE	PROPAFENONE
	MULTAQ	PROPAFENONE ER

Drug Class	Medication Name	
Antiarrhythmics (Cont.)	QUINIDINE GLUCONATE	RYTHMOL SR
	QUINIDINE SULFATE	
Anti-Arthritic and Chelating Agents	CUPRIMINE	D-PENAMINE
	DEPEN	
Anticholinergics, Orally Inhaled Long Acting	INCRUSE ELLIPTA	SPIRIVA RESPIMAT
	LONHALA MAGNAIR REFILL	TUDORZA PRESSAIR
	LONHALA MAGNAIR STARTER	YUPELRI
	SPIRIVA	
Anticholinergics, Orally Inhaled Short Acting	ATROVENT HFA	IPRATROPIUM BROMIDE
Anticonvulsants	DIACOMIT	
Antidiuretic and Vasopressor Hormones	DDAVP	VASOPRESSIN-0.9% NACL
	DESMOPRESSIN ACETATE	VASOPRESSIN-D5W
	NOCDURNA	VASOPRESSIN-NS
	NOCTIVA	VASOSTRICT
	STIMATE	
Antihyperglycemic, Alpha-Glucosidase Inhibitors	ACARBOSE	MIGLITOL
	GLYSET	PRECOSE
Antihyperglycemic, Amylin Analog	SYMLINPEN 60	SYMLINPEN 120
Antihyperglycemic, Biguanide Type	DM2	METFORMIN
	FORTAMET	METFORMIN ER
	GLUCOPHAGE	METFORMIN ER FILM TAB
	GLUCOPHAGE XR	RIOMET
	GLUMETZA	
Antihyperglycemic, DPP-4 Enzyme Inhibitor-Thiazolidinedione	ALOGLIPTIN-PIOGLITAZONE	OSENI
Antihyperglycemic, Incretin Mimetic (GLP-1 Receptor Agonist)	ADLYXIN	RYBELSUS
	BYDUREON	TRULICITY
	BYDUREON BCISE	VICTOZA
	BYETTA	XULTOPHY 100-3.6
	OZEMPIC	
Antihyperglycemic–Sod/Gluc Cotransport-2 (SGLT2) Inhibitors	FARXIGA	JARDIANCE
	INVOKANA	STEGLATRO
Antihyperglycemic–Dopamine Receptor Agonists	CYCLOSET	

Drug Class	Medication Name	
Antihyperglycemic, DPP-4 Inhibitors	ALOGLIPTIN	ONGLYZA
	JANUVIA	TRADJENTA
	NESINA	
Antihyperglycemic, DPP-4 Inhibitor-Biguanide Combination	ALOGLIPTIN-METFORMIN	JENTADUETO XR
	JANUMET	KAZANO
	JANUMET XR	KOMBIGLYZE XR
	JENTADUETO	
Antihyperglycemic, Insulin-Release Stimulant Type	CHLORPROPAMIDE	GLYBURIDE
	GLIMEPIRIDE	GLYBURIDE MICRONIZED
	GLIPIZIDE	GLYNASE
	GLIPIZIDE ER	NATEGLINIDE
	GLIPIZIDE XL	REPAGLINIDE
	GLUCOTROL	TOLAZAMIDE
	GLUCOTROL XL	TOLBUTAMIDE
Antihyperglycemic, Insulin-Release Stimulant-Biguanide	GLIPIZIDE-METFORMIN	REPAGLINIDE-METFORMIN HCL
	GLYBURIDE-METFORMIN HCL	
Antihyperglycemic, SGLT-2 and DPP-4 Inhibitor Combination	GLYXAMBI	STEGLUJAN
	QTERN	
Antihyperglycemic, Thiazolidinedione (PPARG Agonist)	ACTOS	PIOGLITAZONE
	AVANDIA	
Antihyperglycemic, Thiazolidinedione and Biguanide	ACTOPLUS MET	PIOGLITAZONE-METFORMIN
	ACTOPLUS MET XR	
Antihyperglycemic, Thiazolidinedione-Sulfonylurea	DUETACT	PIOGLITAZONE-GLIMEPIRIDE
Antihyperglycemic-SGLT2 Inhibitor-Biguanide Combination	INVOKAMET	SYNJARDY
	INVOKAMET XR	SYNJARDY XR
	SEGLUROMET	XIGDUO XR
Antihyperlipidemic	NEXLETOL	NEXLIZET
Antihyperlipidemic HMG COA Reductase Inhibitor-Cholesterol Inhibitor	EZETIMIBE-SIMVASTATIN	ROSUVASTATIN-EZETIMIBE
Antihyperlipidemic HMG COA Reductase Inhibitors	ALTOPREV	LIVALO
	ATORVASTATIN CALCIUM	LOVASTATIN
	EZALLOR SPRINKLE	PRAVASTATIN SODIUM
	FLOLIPID	ROSUVASTATIN CALCIUM
	FLUVASTATIN ER	SIMVASTATIN
	FLUVASTATIN SODIUM	ZYPITAMAG

Drug Class	Medication Name	
Antihyperlipidemic HMG COA Reductase Inhibitor-Niacin	ADVICOR	SIMCOR
Antihyperlipidemic HMG COA Ri-Calcium Channel Blocker	AMLODIPINE-ATORVASTATIN	CADUET
Antihypertensives, ACE Inhibitors	BENAZEPRIL	MOEXIPRIL
	CAPTOPRIL	PERINDOPRIL ERBUMINE
	ENALAPRIL MALEATE	QUINAPRIL
	EPANED	RAMIPRIL
	FOSINOPRIL SODIUM	TRANDOLAPRIL
	LISINOPRIL	
Antihypertensives, Angiotensin Receptor Antagonists	CANDESARTAN CILEXETIL	LOSARTAN POTASSIUM
	EDARBI	OLMESARTAN MEDOXOMIL
	EPROSARTAN MESYLATE	TELMISARTAN
	IRBESARTAN	VALSARTAN
Antihypertensives, Sympatholytic	CATAPRES-TTS	METHYLDOPA
	CLONIDINE	METHYLDOPA-HYDROCHLOROTHIAZIDE
	GUANFACINE	
Antihypertensives, Vasodilators	HYDRALAZINE HCL	MINOXIDIL
Antileprotics	DAPSONE	
Antimalarial Drugs	HYDROXYCHLOROQUINE SULFATE	PRIMAQUINE
	PLAQUENIL	
Antiparkinson Drugs	AMANTADINE HCL	PRAMIPEXOLE DIHYDROCHLORIDE
	AZILECT	PRAMIPEXOLE ER
	CARBIDOPA-LEVODOPA	RASAGILINE MESYLATE
	CARBIDOPA-LEVODOPA ER	ROPINIROLE HCL
	CARBIDOPA-LEVODOPA-ENTACAPONE	RYTARY
	COMTAN	SELEGILINE HCL
	ENTACAPONE	SINEMET
	GOCOVRI ER	STALEVO
	INBRIJA	TASMAR
	NEUPRO	TOLCAPONE
	NOURIANZ	XADAGO
	ONGENTYS	ZELAPAR
	OSMOLEX ER	
Antithyroid Preparations	METHIMAZOLE	TAPAZOLE
	PROPYLTHIOURACIL	

Drug Class	Medication Name	
Anti-Ulcer Preparations	CARAFATE	MISOPROSTOL
	CYTOTEC	SUCRALFATE
Benign Prostatic Hypertrophy/ Micturition Agents	ALFUZOSIN ER	RAPAFLO
	AVODART	SILODOSIN
	DUTASTERIDE	TAMSULOSIN
	FINASTERIDE	UROXATRAL
Beta-Adrenergic Agents	ALBUTEROL SULFATE SYRUP	METAPROTERENOL SULFATE
	ALBUTEROL SULFATE TABLETS	TERBUTALINE SULFATE
Beta-Adrenergic Agents, Inhaled, Ultra-Long Acting	STRIVERDI RESPIMAT	
Beta-Adrenergic Agents, Orally Inhaled, Long Acting	ARFORMOTEROL TARTRATE	PERFOROMIST
	BROVANA	SEREVENT DISKUS
	FORMOTEROL FUMARATE	
Beta-Adrenergic and Anticholinergic Combo, Inhaled	ANORO ELLIPTA	STIOLTO RESPIMAT
	BEVESPI AEROSPHERE	UTIBRON NEOHALER
	DUAKLIR PRESSAIR	
Beta-Adrenergic and Glucocorticoid Combo, Inhaled	ADVAIR DISKUS	DULERA
	ADVAIR HFA	FLUTICASONE-SALMETEROL
	AIRDUO	SYMBICORT
	BREO ELLIPTA	WIXELLA INHUB
	BUDESONIDE-FORMOTEROL FUMARATE	
Beta-Adrenergic Blocking Agents	ACEBUTOLOL	NADOLOL
	ATENOLOL	NEBIVOLOL
	BETAPACE	PINDOLOL
	BETAPACE AF	PROPRANOLOL
	BETAXOLOL	PROPRANOLOL ER
	BISOPROLOL FUMARATE	SORINE
	BYSTOLIC	SOTALOL
	INNOPRAN XL	SOTALOL AF
	KAPSPARGO SPRINKLE	SOTYLIZE
	METOPROLOL SUCCINATE	TIMOLOL MALEATE
	METOPROLOL TARTRATE	TOPROL XL
Beta-Adrenergic-Anticholinergic-Glucocorticoid, Inhaled	BREZTRI AEROSPHERE	TRELEGY ELLIPTA

Drug Class	Medication Name	
Beta-Blockers and Thiazide, Thiazide-Like Diuretics	ATENOLOL/CHLORTHALIDONE	NADOLOL/BENDROFLUMETHIAZIDE
	BISOPROLOL FUMARATE-HCTZ	PROPRANOLOL HCL-HCTZ
	DUTOPROL	TENORETIC
	METOPROLOL SUCCINATE-HCTZ ER	ZIAC
	METOPROLOL-HYDROCHLOROTHIAZIDE	
Bile Salts	ACTIGALL	URSO FORTE
	URSO	URSODIOL
Bile Salt Sequestrants	CHOLESTYRAMINE	COLESTID
	CHOLESTYRAMINE LIGHT	COLESTIPOL HCL
	COLESEVELAM HCL	
Blood Sugar Diagnostics	ACCU-CHEK AVIVA PLUS	FREESTYLE INSULINX TEST STRIPS
	ACCU-CHEK COMPACT	FREESTYLE LITE TEST STRIPS
	ACCU-CHEK COMPACT PLUS	FREESTYLE PRECISION NEO
	ACCU-CHEK GUIDE TEST STRIP	FREESTYLE TEST STRIPS
	ACCU-CHEK SMARTVIEW	GOJJI TEST STRIP
	ACCUTREND GLUCOSE	HARMONY GLUCOSE TEST STRIP
	ADVOCATE TEST STRIP	IGLUCOSE TEST STRIP
	ASCENSIA BREEZE 2	INFINITY VOICE TEST STRIP
	ASSURE PLATINUM	LIBERTY TEST STRIP
	CARETOUCH TEST STRIP	MICRODOT XTRA
	CLEVER CHOICE TALK	ONE TOUCH ULTRA BLUE TEST STRIPS
	CONTOUR	ONE TOUCH ULTRA TEST STRIPS
	CONTOUR NEXT EZ	ONE TOUCH VERIO TEST STRIPS
	EASY TOUCH TEST STRIP	OPTIUM
	EASY TRACK II TEST STRIP	OPTIUM EZ
	EMBRACE	PRECISION PCX
	EMBRACE EVO	PRECISION PCX PLUS
	EMBRACE PRO	PRECISION POINT OF CARE
	EMBRACE TALK TEST STRIP	PRECISION Q-I-D
	EVENCARE TEST STRIP	PRECISION XTRA
	FORA 6 CONNECT GLUCOSE STRIP	PREMIER TEST STRIP
	FORA GTEL GLUCOSE TEST STRIP	UNISTRIP1
	FORA V10-V12-D10-D20	VERASENS TEST STRIP
	FREESTYLE INSULINX	VIVAGUARD INO TEST STRIP

Drug Class	Medication Name	
Bone Resorption Inhibitors	ALENDRONATE SODIUM	FORTICAL
	ATELVIA	IBANDRONATE SODIUM
	BINOSTO	RISEDRONATE SODIUM
	ETIDRONATE DISODIUM	RISEDRONATE SODIUM DR
Bone Resorption Inhibitor and Vitamin D Combinations	FOSAMAX PLUS D	
BPH 5-Alpha-Reductase Inhib-Alpha1-Adrenocep Antagonist	DUTASTERIDE-TAMSULOSIN	JALYN
Calcium Channel Blocking Agents	AMLODIPINE BESYLATE	NICARDIPINE HCL
	CALAN	NIFEDICAL XL
	CALAN SR	NIFEDIPINE
	CARTIA XT	NIFEDIPINE ER
	DILTIAZEM 12HR ER	NISOLDIPINE
	DILTIAZEM 24HR ER	TAZTIA XT
	DILTIAZEM 24HR ER (CD)	TIADYLT ER
	DILTIAZEM 24HR ER (LA)	TIAZAC
	DILTIAZEM 24HR ER (XR)	VERAPAMIL ER
	DILTIAZEM HCL	VERAPAMIL ER PM
	DILT-XR	VERAPAMIL HCL
	FELODIPINE ER	VERELAN
	ISRADIPINE	VERELAN PM
	MATZIM LA	
Carbonic Anhydrase Inhibitors	ACETAZOLAMIDE	METHAZOLAMIDE
Cholinesterase Inhibitors	ARICEPT	MESTINON
	DONEPEZIL	PYRIDOSTIGMINE BROMIDE
	DONEPEZIL ODT	PYRIDOSTIGMINE BROMIDE ER
	EXELON	RAZADYNE
	GALANTAMINE	RAZADYNE ER
	GALANTAMINE ER	RIVASTIGMINE
Chronic Inflammatory Colon DX, 5-Aminosalicylate Drug Treatment	APRISO	MESALAMINE
	ASACOL HD	MESALAMINE DR
	AZULFIDINE	PENTASA
	DELZICOL	SULFASALAZINE
	DIPENTUM	SULFASALAZINE DR
	LIALDA	SULFAZINE
Contraceptives, Intravaginal, Systemic	ANNOVERA	

Drug Class	Medication Name	
Contraceptives, Oral	BALCOLTRA	MINASTRIN 24 FE
	BEYAZ	MIRCETTE
	BREVICON	NATAZIA
	CYCLESSA	NORETHINDRONE/ETHINYL ESTRADIOL/ FERROUS FUMARATE
	DESOGEN	NORINYL
	DROSPIRENONE/ETHINYL ESTRADIOL/ LEVOMEFOLATE	NOR-Q-D
	ESTROSTEP FE	ORTHO-NOVUM
	FAYOSIM	QUARTETTE
	FEMCON FE	RIVELSA
	LEVONORGESTREL/ETHINYL ESTRADIOL/ ETHINYL ESTRADIOL	SAFYRAL
	LO LOESTRIN FE	SEASONIQUE
	LOESTRIN	SLYND
	LOESTRIN FE	TAYTULLA
	LOSEASONIQUE	TYBLUME
	MELODETTA 24 FE	TYDEMY
	MIBELAS 24 FE	YASMIN
	MICROGESTIN 24 FE	YAZ
Contraceptives, Transdermal	TWIRLA	
Decarboxylase Inhibitors	CARBIDOPA	LODOSYN
Digitalis Glycosides	DIGITEK	DIGOXIN
	DIGOX	LANOXIN
Erectile Dysfunction Drugs	STENDRA	
Estrogenic Agents	ACTIVELLA	ESTRADIOL/NORETHINDRONE ACETATE
	ALORA	ESTROGEL
	AMABELZ	ESTROPIPATE
	CLIMARA	FEMHRT
	CLIMARA PRO	FYAVOLV
	COMBIPATCH	JINTELI
	DIVIGEL	LYLLANA
	DOTTI	MENEST
	ELESTRIN	MENOSTAR
	ESTRACE	MIMVEY
	ESTRADIOL	MINIVELLE

Drug Class	Medication Name	
Estrogenic Agents (Cont.)	NORETHINDRONE/ETHINYL ESTRADIOL	PREMPHASE
	PREFEST	PREMPRO
	PREMARIN	VIVELLE-DOT
Estrogen-Progestin with Antimineralocorticoid Combinations	ANGELIQ	
Fibromyalgia Agents, Serotonin–Norepinephrine Reuptake Inhibitors	SAVELLA	
Fluoride Preparations	CLINPRO 5000	PREVIDENT PLUS
	DENTA 5000 PLUS	SF
	DENTAGEL	SF 5000 PLUS
	FLUORIDEX	SODIUM FLUORIDE
	PREVIDENT	SODIUM FLUORIDE 5000 PLUS
	PREVIDENT 5000 ENAMEL PROTECT	SODIUM FLUORIDE ENAMEL PROTECT
	PREVIDENT 5000 ORTHO DEFENSE	SODIUM FLUORIDE SENSITIVE
	PREVIDENT 5000 SENSITIVE	
Glucocorticoids	ALKINDI SPRINKLE	HYDROCORTISONE
	BETALOAN SUIK	MEDROLOAN SUIK
	CORTEF	MEDROLOAN II SUIK
	DEXONTO	TRILOAN SUIK
	DMT SUIK	TRILOAN II SUIK
	EMFLAZA	ZILRETTA
Glucocorticoids, Orally Inhaled	ALVESCO	FLOVENT DISKUS
	ARMONAIR	FLOVENT HFA
	ARNUITY ELLIPTA	PULMICORT
	ASMANEX	PULMICORT FLEXHALER
	ASMANEX HFA	QVAR
	BUDESONIDE	QVAR REDIHALER
Gold Salts	RIDAURA	
Heart Rate Reducing, Selective Current Inhibitors	CORLANOR	
Hemorrheologic Agents	PENTOXIFYLLINE	
Histamine H2-Receptor Inhibitors	CIMETIDINE	PEPCID
	FAMOTIDINE	RANITIDINE HCL
	NIZATIDINE	ZANTAC RX
Hyperparathyroid TX Agents–Vitamin D Analog-Type	DOXERCALCIFEROL	HECTOROL

Drug Class	Medication Name	
Hyperparathyroid TX Agents–Vitamin D Analog-Type (Cont.)	PARICALCITOL	ZEMPLAR
	RAYALDEE	
Hyperuricemia TX–Xanthine Oxidase Inhibitors	ALLOPURINOL	ULORIC
	FEBUXOSTAT	ZYLOPRIM
Insulins	ADMELOG	INSULIN LISPRO
	ADMELOG SOLOSTAR	LANTUS
	AFREZZA	LANTUS SOLOSTAR
	APIDRA	LEVEMIR
	APIDRA SOLOSTAR	LEVEMIR FLEXTOUCH
	BASAGLAR KWIKPEN U-100	LYUMJEV
	FIASP	MYXREDLIN
	FIASP FLEXTOUCH	NOVOLIN 70-30
	HUMALOG	NOVOLIN 70-30 FLEXPEN
	HUMALOG JUNIOR KWIKPEN	NOVOLIN N
	HUMALOG MIX 50-50	NOVOLIN R
	HUMALOG MIX 75-25	NOVOLOG
	HUMULIN 70-30	NOVOLOG FLEXPEN
	HUMULIN 70/30 KWIKPEN	NOVOLOG MIX 70-30
	HUMULIN N	SEMGLEE
	HUMULIN N KWIKPEN	TOUJEO MAX SOLOSTAR
	HUMULIN R	TOUJEO SOLOSTAR
	HUMULIN R U-500 KWIKPEN	TRESIBA FLEXTOUCH U-100
	INSULIN ASPART	TRESIBA FLEXTOUCH U-200
	INSULIN GLARGINE	
Iodine-Containing Agents	POTASSIUM IODIDE	SSKI
Laxatives and Cathartics	KRISTALOSE	LACTULOSE
Leukotriene Receptor Antagonists	ACCOLATE	SINGULAIR
	MONTELUKAST SODIUM	ZAFIRLUKAST
Lipotropics	ANTARA	GEMFIBROZIL
	EZETIMIBE	ICOSAPENT ETHYL
	FENOFIBRATE	LIPOFEN
	FENOFIBRIC ACID	NIACIN ER
	FENOGLIDE	NIASPAN
	FIBRICOR	OMEGA-3 ACID ETHYL ESTERS

Drug Class	Medication Name	
Loop Diuretics	BUMETANIDE	FUROSEMIDE
	EDECRIN	LASIX
	ETHACRYNIC ACID	TORSEMIDE
MAOIs, Non-Selective, Irreversible Antidepressants	MARPLAN	PHENELZINE SULFATE
	NARDIL	TRANYLCYPROMINE SULFATE
	PARNATE	
Mast Cell Stabilizers, Orally Inhaled	CROMOLYN SODIUM	
Menopausal Symptoms Suppressant–SSRIs	BRISDELLE	PAROXETINE MESYLATE
Metabolic Deficiency Agents	CARNITOR	LEVOCARNITINE
	CARNITOR SF	
Mineralocorticoids	FLUDROCORTISONE ACETATE	
Miotics and Other Intraocular Pressure Reducers	ALPHAGAN P	LEVOBUNOLOL
	APRACLONIDINE	LUMIGAN
	BETAXOLOL	PILOCARPINE
	BIMATOPROST	RHOPRESSA
	BRIMONIDINE TARTRATE	ROCKLATAN
	BRINZOLAMIDE	SIMBRINZA
	CARTEOLOL	TIMOLOL MALEATE
	COMBIGAN	TIMOPTIC-XE
	COSOPT	TRAVATAN Z
	COSOPT PF	TRAVOPROST
	DORZOLAMIDE	TRUSOPT
	DORZOLAMIDE-TIMOLOL	VYZULTA
	IOPIDINE	XALATAN
	ISOPTO CARPINE	XELPROS
	ISTALOL	ZIOPTAN
	LATANOPROST	
Monoamine Oxidase (MAO) Inhibitor Antidepressants	EMSAM	
Multivitamin Preparations	CONCEPT DHA	FOLIVANE-OB
	CONCEPT OB	NEEVODHA
	ELITE-OB	NESTABS ONE
	ENBRACE HR	OB COMPLETE

Drug Class	Medication Name	
Multivitamin Preparations (Cont.)	OBSTETRIX ONE	PUREFE OB PLUS
	PNV-DHA	TARON PRENATAL
	PNV-OMEGA	TARON-C DHA
	PRENATAL-U	VIRT-C DHA
	PRENATE	VIRT-PN DHA
	PRENATE AM	VIRT-PN PLUS
	PRENATE DHA	ZATEAN-PN DHA
	PRENATE ESSENTIAL	ZATEAN-PN PLUS
Mydriatics	ATROPINE SULFATE	ISOPTO ATROPINE
	ATROPINE SULFATE-NS	LIDOCAINE-PHENYLEPHRINE-BSS
	CYCLOGYL	LIDOCAINE-PHENYLEPHRINE-WATER
	CYCLOMYDRIL	MYDRIACYL
	CYCLOPENTOLATE	MYDRIATIC 3 (TROP-CYCLOPENT-PE)
	EPINEPHRINE-LIDOCAINE HCL-BSS	TROPICAMIDE
	HOMATROPINE	TROPICAMIDE-CYCLOPENTOLATE-PE
Needles/Needleless Devices	B-D ECLIPSE	FLOW-EZE
	B-D INSULIN PEN NEEDLE UF MINI	HYPODERMIC NEEDLE
	B-D INTEGRA NEEDLE	INTEGRA PRECISIONGLIDE NEEDLE
	B-D NEEDLES	LIFESHIELD BLUNT CANNULA
	B-D PRECISIONGLIDE NEEDLE	MONOJECT BLOOD COLLECTION
	B-D SAFETYGLIDE	NOKOR ADMIX NEEDLE
	BLUNT NEEDLE	NOKOR NEEDLE
	EASY TOUCH FLIPLOCK NEEDLE	PEN-NEEDLE
	EASY TOUCH HYPODERMIC NEEDLE	PHASEAL PROTECTOR
	EASYPOINT NEEDLE	POLY HUB NEEDLE
	ECLIPSE NEEDLE	PRECISIONGLIDE
	EXEL HUBER NEEDLE	TERUMO SURGUARD
	EXEL HYPODERMIC NEEDLE	TRANSFER NEEDLE
	EXEL MULTI DRAWING NEEDLE	YALE NEEDLE
	FILTER NEEDLE	
Norepinephrine and Dopamine Reuptake Inhibitors (NDRIs)	APLENZIN	BUPROPION SR
	BUPROPION	BUPROPION XL
	BUPROPION ER	FORFIVO XL

Drug Class	Medication Name	
NSAID and Histamine H2 Receptor Antagonist Combination	DUEXIS	
NSAID, Cox Inhibitor-Type and Proton Pump Inhibitor	VIMOVO	
NSAID, Cox Non-Spec. Inhibitor and Prostaglandin Analog	DICLOFENAC/MISOPROTAL	
NSAIDs, Cyclooxygenase Inhibitor-Type Analgesics	DICLOFENAC SODIUM	MELOXICAM
	EC-NAPROSYN	MOBIC
	ETODOLAC	NABUMETONE
	ETODOLAC ER	NAPROXEN
	FELDENE	NAPROXEN SODIUM
	FENOPROFEN CALCIUM	NAPROXEN SODIUM ER
	FENORTHO	OXAPROZIN
	FLURBIPROFEN	PIROXICAM
	IBU	PROFENO
	IBUPROFEN	TIVORBEX
	KETOPROFEN	TOLMETIN SODIUM
	LODINE	VIVLODEX
	MECLOFENAMATE SODIUM	ZORVOLEX
NSAIDs, Cyclooxygenase-2 (COX-2) Selective Inhibitor	CELEBREX	CELECOXIB
Ophthalmic Antibiotics	NEOMYCIN/BACITRACIN/POLYMYXIN	NEO-POLYCIN
Ophthalmic Anti-Inflammatory Immunomodulator-Type	CEQUA	RESTASIS MULTIDOSE
	CYCLOSPORINE IN KLARITY	XIIDRA
	RESTASIS	
Overactive Bladder Agents, Beta-3 Adrenergic Receptor Agonist	MYRBETRIQ	
Parasympathetic Agents	CEVIMELINE HCL	EVOXAC
Pediatric Vitamin Preparations	ESCAVITE D	MULTIVITAMINS
	ESCAVITE LQ	POLY-VI-FLOR FS
	FLORIVA	QUFLORA
	FLORIVA PLUS	QUFLORA FE
	MULTIVITAMIN WITH FLUORIDE	TEXAVITE LQ
Pituitary Suppressive Agents	CABERGOLINE	

Drug Class	Medication Name	
Platelet Aggregation Inhibitors	ASPIRIN-DIPYRIDAMOLE ER	LOW DOSE ASPIRIN
	BRILINTA	PERSANTINE
	CHILDREN'S ASPIRIN	PLAVIX
	CILOSTAZOL	PLETAL
	CLOPIDOGREL	PRASUGREL HCL
	DIPYRIDAMOLE	YOSPRALA
	DURLAZA	ZONTIVITY
	EFFIENT	
Platelet Reducing Agents	AGRYLIN	ANAGRELIDE HYDROCHLORIDE
Potassium Replacement	EFFER-K	KLOR-CON-EF
	K-TAB	POTASSIUM CHLORIDE
	KLOR-CON	POTASSIUM CITRATE ER
	KLOR-CON M	
Potassium Sparing Diuretics	ALDACTONE	EPLERENONE
	AMILORIDE	INSPRA
	CAROSPIR	KERENDIA
	DYRENIUM	SPIRONOLACTONE
Potassium Sparing Diuretics in Combination	AMILORIDE HCL/HCTZ	TRIAMTERENE/HCTZ
	SPIRONOLACTONE/HCTZ	
Progestational Agents	AYGESTIN	PROGESTERONE
	MEDROXYPROGESTERONE ACETATE	PROMETRIUM
	NORETHINDRONE ACETATE	PROVERA
Pulmonary Anti-Hypertension	AMBRISENTAN	BOSENTAN
Renin Inhibitor, Direct	ALISKIREN	TEKTURNA
Renin Inhibitor, Direct and Thiazide Diuretic Combination	TEKTURNA HCT	
Selective Serotonin Reuptake Inhibitor (SSRIs)	CITALOPRAM HBR	PAROXETINE ER
	ESCITALOPRAM OXALATE	PAROXETINE HCL
	FLUOXETINE DR	SARAFEM
	FLUOXETINE HCL	SERTRALINE HCL
	FLUVOXAMINE MALEATE	
Serotonin-2 Antagonist/Reuptake Inhibitors (SARIs)	NEFAZODONE HCL	

Drug Class	Medication Name	
Serotonin-Norepinephrine Reuptake-Inhibitor (SNRIs)	DESVENLAFAXINE ER	FETZIMA
	DESVENLAFAXINE FUMARATE ER	PRISTIQ
	DESVENLAFAXINE SUCCINATE ER	VENLAFAXINE HCL
	DRIZALMA SPRINKLE	VENLAFAXINE HCL ER
	DULOXETINE HCL	
Skeletal Muscle Relaxants	BACLOFEN	DANTROLENE SODIUM
	DANTRIUM	
Smoking Deterrent Agents (Ganglionic Stimulants, Others)	NICODERM CQ	
Soluble Guanylate Cyclase (SGC) Stimulator	VERQUVO	
SSRI and 5HT1A Partial Agonist Antidepressants	VIIBRYD	
Syringes and Accessories	ADVOCATE SYRINGES	MAGELLAN INSULIN SAFETY SYRINGE
	B-D INSULIN SYRINGE	MAGELLAN INSULIN SYRINGE
	B-D SAFETYGLIDE	MAXICOMFORT
	B-D SAFETYGLIDE SYRINGE	MAXICOMFORT INSULIN SYRINGE
	CARETOUCH INSULIN SYRINGE	MINIMED RESERVOIR
	COMFORT EZ	MONOJECT
	DROPLET INSULIN SYRINGE	MONOJECT INSULIN SYRINGE
	EASY COMFORT INSULIN SYRINGE	MONOJECT MAGELLAN SYRINGE
	EASY GLIDE INSULIN SYRINGE	PARADIGM
	EASY TOUCH	PRO COMFORT INSULIN SYRINGE
	EASY TOUCH FLIPLOCK INSULIN	PRODIGY INSULIN SYRINGE
	EASY TOUCH INSULIN SAFETY	SAFESNAP INSULIN SYRINGE
	EASY TOUCH LUER LOCK INSULIN	SURE COMFORT
	EASY TOUCH SHEATHLOCK INSULIN	SURE COMFORT INSULIN SYRINGE
	EASY TOUCH UNI-SLIP	SURE-JECT INSULIN SYRINGE
	FREESTYLE PRECISION	TECHLITE INSULIN SYRINGE
	HEALTHWISE INSULIN SYRINGE	TERUMO INSULIN SYRINGE
	INSULIN CARTRIDGE	THINPRO INSULIN SYRINGE
	INSULIN SYRINGE	TOPCARE ULTRA COMFORT
	LITE TOUCH	TRUE COMFORT INSULIN SYRINGE
	LUER-LOK SYRINGE	TRUE COMFORT PRO INSULIN SYRINGE

Drug Class	Medication Name	
Syringes and Accessories (Cont.)	TRUEPLUS INSULIN SYRINGE	ULTRA FLO INSULIN SYRINGE
	ULTICARE	ULTRACARE INSULIN SYRINGE
	ULTICARE INSULIN SYRINGE	ULTRA-THIN II
	ULTIGUARD SAFEPACK-INSULIN SYRINGE	VANISHPOINT
	ULTILET INSULIN SYRINGE	VANISHPOINT SYRINGE
	ULTRA COMFORT	
Thiazide and Related Diuretics	CHLOROTHIAZIDE	METHYCLOTHIAZIDE
	CHLORTHALIDONE	METOLAZONE
	DIURIL	MICROZIDE
	HYDROCHLOROTHIAZIDE	THALITONE
	INDAPAMIDE	
Thrombin Inhibitors, Selective, Direct, Reversible	PRADAXA	
Thyroid Hormones	ARMOUR THYROID	SYNTHROID
	CYTOMEL	THYQUIDITY
	EUTHYROX	THYROLAR
	LEVO-T	TIROSINT
	LEVOTHYROXINE SODIUM	UNITHROID
	LEVOXYL	WESTHROID
	LIOTHYRONINE SODIUM	WP THYROID
	NP THYROID	
Topical Anti-Inflammatory, NSAIDs	CAPSFENAC PAK	DICLOTREX
	CAPSINAC	DICLOVIX M
	DERMACINRX LEXITRAL	DICLOZOR
	DICLO GEL	DIMENTHO
	DICLO GEL/XRYLIX SHEET	DITHOL
	DICLOFENAC SODIUM	FROTEK
	DICLOFEX DC	INFLAMMA-K
	DICLOFONO	KAPZIN DC
	DICLOHEAL-60	LEXIXRYL
	DICLOPAK	NUDICLO
	DICLOPR	PENNSAICIN
	DICLOTRAL	PENNSAID

Drug Class	Medication Name	
Topical Anti-Inflammatory, NSAIDs (Cont.)	ROAOXIA	XELITRAL
	VAROPHEN	XRYLIX
	VENNGEL ONE	ZICLOPRO
Uricosuric Agents	PROBENECID	ZURAMPIC
	PROBENECID W/COLCHICINE	
Uricosuric and Xanthine Oxidase Inhibitor Combination	DUZALLO	
Urinary PH Modifiers	POTASSIUM CITRATE ER	UROCIT-K
Urinary Tract Antispasmodic, M(3) Selective Antagonist	DARIFENACIN ER	VESICARE
	SOLIFENACIN SUCCINATE	
Urinary Tract Antispasmodic/ Anti-Incontinence Agent	FLAVOXATE	TOLTERODINE TARTRATE
	GELNIQUE	TOLTERODINE TARTRATE ER
	OXYBUTYNIN CHLORIDE	TOVIAZ
	OXYBUTYNIN CHLORIDE ER	TROSPIUM CHLORIDE
	OXYTROL	
Vaginal Estrogen Preparations	ESTRACE	PREMARIN
	ESTRADIOL	VAGIFEM
	ESTRING	YUVAFEM
	FEMRING	
Vasodilators, Combination	BIDIL	
Vasodilators, Coronary	DILATRATE-SR	NITRO-BID
	ISORDIL	NITROGLYCERIN
	ISOSORBIDE DINITRATE	NITRO-TIME
	ISOSORBIDE MONONITRATE	
Vasodilators, Peripheral	ERGOLOID MESYLATES	ISOXSUPRINE HCL
Vitamin B Preparations	POTABA	VB7 MAX
Vitamin B12 Preparations	NASCOBAL	
Vitamin D Preparations	CALCITRIOL	ROCALTROL
Xanthines	ELIXOPHYLLIN	THEOCHRON
	THEO-24	THEOPHYLLINE ANHYDROUS

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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).

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Blue Cross Blue Shield of Massachusetts Formulary: $9 Generic Medication List

Last Updated: January 1, 2022
Valid Until: July 1, 2022

The following list includes generic medications covered by plans with the Blue Cross Blue Shield of Massachusetts Formulary. Members can get these medications in 90–day supplies for $9[1] when they order them through the mail order pharmacy available through Express Scripts®', an independent company that administers your pharmacy benefits on behalf of Blue Cross Blue Shield of Massachusetts.

Normal prescription guidelines apply, which in some cases result in prescription supplies for less than 90 days. If your copayment for a 90–day supply through the mail order pharmacy is less than $9, you'll pay the lesser amount. The $9–or–less price is based only on a 90–day supply of each generic medication.[2] The price of the medication may differ if the quantity purchased is different.

This isn't a complete list of covered medications, and inclusion on the list doesn't guarantee coverage.[3] 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.

$9 Generic Medications Included in the National Preferred Formulary (NPF)

The generic medications listed in this document are also included in the National Preferred Formulary (NPF), which is available through Express Scripts. Pharmacy management program requirements apply to generic medications included in the NPF.

Learn More About Your Coverage

For more information about your pharmacy benefits, including the NPF and the medications listed in this document, sign in to your MyBlue account at **bluecrossma.org**.

1. Medications and pricing are subject to change without notice, so you should always confirm your cost prior to filling a prescription. A processing fee may apply. In applicable states, sales tax may be added to the cost of your prescriptions. Cost of standard shipping is included as part of your prescription plan. The coverage and prices of certain medications are also subject to the specific terms of your plan. Changes are made available to your Plan Sponsor.
2. Pre–packaged medications are only available for $9 in the package sizes specified.
3. Not all medications listed are covered by all prescription plans. Check your benefit materials for details.

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Drug Class	Medication Name	Strength	Form	$9 Quantity
Antibiotics/Antifungals/ Antivirals	ACYCLOVIR	200 MG	CAPSULE	180
	AMOXICILLIN	500 MG	TABLET	180
	AMOXICILLIN TR/POTASSIUM CLAVULANATE	200 MG–28.5 MG	CHEW TABLET	60
	AMOXICILLIN TR/POTASSIUM CLAVULANATE	400 MG–57 MG	CHEW TABLET	60
	AMOXICILLIN TR/POTASSIUM CLAVULANATE	250 MG–125 MG	TABLET	30
	AMOXICILLIN TR/POTASSIUM CLAVULANATE	500 MG–125 MG	TABLET	60
	AMOXICILLIN TR/POTASSIUM CLAVULANATE	875 MG–125 MG	TABLET	60
	AMOXICILLIN TRIHYDRATE	250 MG	CAPSULE	180
	AMOXICILLIN TRIHYDRATE	500 MG	CAPSULE	180
	AMOXICILLIN TRIHYDRATE	125 MG/5 ML	SUSPENSION, RECONSTITUTED, ORAL	300
	AMOXICILLIN TRIHYDRATE	200 MG/5 ML	SUSPENSION, RECONSTITUTED, ORAL	300
	AMOXICILLIN TRIHYDRATE	250 MG/5 ML	SUSPENSION, RECONSTITUTED, ORAL	240
	AMOXICILLIN TRIHYDRATE	250 MG/5 ML	SUSPENSION, RECONSTITUTED, ORAL	300
	AMOXICILLIN TRIHYDRATE	250 MG/5 ML	SUSPENSION, RECONSTITUTED, ORAL	450
	AMOXICILLIN TRIHYDRATE	400 MG/5 ML	SUSPENSION, RECONSTITUTED, ORAL	300
	CEPHALEXIN MONOHYDRATE	250 MG	CAPSULE	90
	CEPHALEXIN MONOHYDRATE	500 MG	CAPSULE	180
	CIPROFLOXACIN HCL	250 MG	TABLET	90
	CIPROFLOXACIN HCL	500 MG	TABLET	180
	FLUCONAZOLE	150 MG	TABLET	3
	METRONIDAZOLE	250 MG	TABLET	270
	METRONIDAZOLE	500 MG	TABLET	42
	PENICILLIN V POTASSIUM	250 MG/5 ML	SUSPENSION, RECONSTITUTED	400
	PENICILLIN V POTASSIUM	250 MG/5 ML	SUSPENSION, RECONSTITUTED	900
	PENICILLIN V POTASSIUM	250 MG	TABLET	180

Drug Class	Medication Name	Strength	Form	$9 Quantity
Antibiotics/Antifungals/ Antivirals (Cont.)	PENICILLIN V POTASSIUM	500 MG	TABLET	180
	SULFAMETHOXAZOLE/TRIMETHOPRIM	400 MG–80 MG	TABLET	90
	SULFAMETHOXAZOLE/TRIMETHOPRIM	800 MG–160 MG	TABLET	180
	TERBINAFINE	250 MG	TABLET	90
Antiseizure Medications	ZONISAMIDE	25 MG	CAPSULE	180
Arthritis/Pain	DICLOFENAC SODIUM	50 MG	TABLET DR	180
	DICLOFENAC SODIUM	75 MG	TABLET DR	180
	IBUPROFEN	400 MG	TABLET	270
	IBUPROFEN	600 MG	TABLET	270
	IBUPROFEN	800 MG	TABLET	270
	INDOMETHACIN	25 MG	CAPSULE	270
	MELOXICAM	7.5 MG	TABLET	90
	MELOXICAM	15 MG	TABLET	90
	NAPROXEN	250 MG	TABLET	180
	NAPROXEN	375 MG	TABLET	180
	NAPROXEN	500 MG	TABLET	180
	NAPROXEN SODIUM	220 MG	TABLET	72
	NAPROXEN SODIUM	275 MG	TABLET	180
Asthma/Respiratory	ALBUTEROL SULFATE	0.83 MG/ML	SOLUTION	225
Behavioral Health	BENZTROPINE MESYLATE	0.5 MG	TABLET	180
	BENZTROPINE MESYLATE	2 MG	TABLET	180
	BUSPIRONE HCL	5 MG	TABLET	180
	BUSPIRONE HCL	10 MG	TABLET	180
	BUSPIRONE HCL	15 MG	TABLET	180
	CHLORDIAZEPOXIDE HCL	5 MG	CAPSULE	180
	CHLORDIAZEPOXIDE HCL	10 MG	CAPSULE	180
	CHLORDIAZEPOXIDE HCL	25 MG	CAPSULE	180
	CITALOPRAM HYDROBROMIDE	10 MG	TABLET	90
	CITALOPRAM HYDROBROMIDE	20 MG	TABLET	90
	CITALOPRAM HYDROBROMIDE	40 MG	TABLET	90
	CLONIDINE HCL	0.3 MG	TABLET	90
	DONEPEZIL HCL	5 MG	TABLET	90
	DONEPEZIL HCL	10 MG	TABLET	90
	DONEPEZIL HCL	5 MG	TABLET ODT	90

Drug Class	Medication Name	Strength	Form	$9 Quantity
Behavioral Health (Cont.)	DONEPEZIL HCL	10 MG	TABLET ODT	90
	DOXEPIN HCL	10 MG	CAPSULE	90
	DOXEPIN HCL	25 MG	CAPSULE	90
	FLUOXETINE HCL	10 MG	CAPSULE	90
	FLUOXETINE HCL	20 MG	CAPSULE	90
	FLUOXETINE HCL	40 MG	CAPSULE	90
	HYDROXYZINE PAMOATE	25 MG	CAPSULE	180
	IMIPRAMINE HCL	10 MG	TABLET	90
	IMIPRAMINE HCL	25 MG	TABLET	90
	IMIPRAMINE HCL	50 MG	TABLET	90
	LITHIUM CARBONATE	150 MG	CAPSULE	90
	LITHIUM CARBONATE	300 MG	CAPSULE	180
	LITHIUM CARBONATE	600 MG	CAPSULE	180
	LITHIUM CARBONATE	300 MG	TABLET SA	180
	MIRTAZAPINE	15 MG	TABLET	90
	MIRTAZAPINE	30 MG	TABLET	90
	MIRTAZAPINE	45 MG	TABLET	90
	NORTRIPTYLINE HCL	10 MG	CAPSULE	90
	NORTRIPTYLINE HCL	25 MG	CAPSULE	90
	PAROXETINE HCL	10 MG	TABLET	90
	PAROXETINE HCL	20 MG	TABLET	90
	PAROXETINE HCL	30 MG	TABLET	90
	PAROXETINE HCL	40 MG	TABLET	90
	SERTRALINE HCL	25 MG	TABLET	90
	TRAZODONE HCL	50 MG	TABLET	90
	TRAZODONE HCL	100 MG	TABLET	90
	TRAZODONE HCL	150 MG	TABLET	90
	TRIHEXYPHENIDYL HCL	2 MG	TABLET	180
	TRIHEXYPHENIDYL HCL	5 MG	TABLET	180
Blood Pressure/Heart Health	AMILORIDE-HYDROCHLOROTHIAZIDE	5 MG–50 MG	TABLET	90
	AMIODARONE HCL	200 MG	TABLET	90
	ATENOLOL	25 MG	TABLET	90
	ATENOLOL	50 MG	TABLET	90
	ATENOLOL	100 MG	TABLET	90
	BENAZEPRIL HCL	5 MG	TABLET	90
	BENAZEPRIL HCL	10 MG	TABLET	90

Drug Class	Medication Name	Strength	Form	$9 Quantity
Blood Pressure/Heart Health (Cont.)	BENAZEPRIL HCL	20 MG	TABLET	90
	BENAZEPRIL HCL	40 MG	TABLET	90
	BISOPROL-HYDROCHLOROTHIAZIDE	2.5 MG–6.25 MG	TABLET	90
	BISOPROL-HYDROCHLOROTHIAZIDE	5 MG–6.25 MG	TABLET	90
	BISOPROL-HYDROCHLOROTHIAZIDE	10 MG–6.25 MG	TABLET	90
	BISOPROLOL FUMARATE	5 MG	TABLET	90
	BISOPROLOL FUMARATE	10 MG	TABLET	90
	CARVEDILOL	3.125 MG	TABLET	180
	CARVEDILOL	6.25 MG	TABLET	180
	CARVEDILOL	12.5 MG	TABLET	180
	CARVEDILOL	25 MG	TABLET	180
	CLONIDINE HCL	0.1 MG	TABLET	90
	CLONIDINE HCL	0.2 MG	TABLET	90
	DILTIAZEM HCL	120 MG	CAPSULE SR	90
	DILTIAZEM HCL	30 MG	TABLET	180
	DILTIAZEM HCL	60 MG	TABLET	180
	DOXAZOSIN MESYLATE	1 MG	TABLET	90
	DOXAZOSIN MESYLATE	2 MG	TABLET	90
	DOXAZOSIN MESYLATE	4 MG	TABLET	90
	DOXAZOSIN MESYLATE	8 MG	TABLET	90
	ENALAPRIL MALEATE	2.5 MG	TABLET	90
	ENALAPRIL MALEATE	5 MG	TABLET	90
	ENALAPRIL MALEATE	10 MG	TABLET	90
	ENALAPRIL MALEATE	20 MG	TABLET	90
	ENALAPRIL-HYDROCHLOROTHIAZIDE	5 MG–12.5 MG	TABLET	90
	ENALAPRIL-HYDROCHLOROTHIAZIDE	10 MG–25 MG	TABLET	90
	FELODIPINE	2.5 MG	TABLET SR	90
	FELODIPINE	5 MG	TABLET SR	90
	FELODIPINE	10 MG	TABLET SR	90
	FUROSEMIDE	20 MG	TABLET	90
	FUROSEMIDE	40 MG	TABLET	90
	FUROSEMIDE	80 MG	TABLET	90
	HYDRALAZINE HCL	10 MG	TABLET	270
	HYDRALAZINE HCL	25 MG	TABLET	270

Drug Class	Medication Name	Strength	Form	$9 Quantity
Blood Pressure/Heart Health (Cont.)	HYDRALAZINE HCL	50 MG	TABLET	270
	HYDRALAZINE HCL	100 MG	TABLET	270
	HYDROCHLOROTHIAZIDE	12.5 MG	CAPSULE	90
	HYDROCHLOROTHIAZIDE	25 MG	TABLET	90
	HYDROCHLOROTHIAZIDE	50 MG	TABLET	90
	INDAPAMIDE	1.25 MG	TABLET	90
	INDAPAMIDE	2.5 MG	TABLET	90
	ISOSORBIDE MONONITRATE	30 MG	TABLET SR 24H	90
	ISOSORBIDE MONONITRATE	60 MG	TABLET SR 24H	90
	LABETALOL HCL	100 MG	TABLET	180
	LABETALOL HCL	200 MG	TABLET	180
	LABETALOL HCL	300 MG	TABLET	180
	LISINOPRIL	2.5 MG	TABLET	90
	LISINOPRIL	5 MG	TABLET	90
	LISINOPRIL	10 MG	TABLET	90
	LISINOPRIL	20 MG	TABLET	90
	LISINOPRIL	30 MG	TABLET	90
	LISINOPRIL	40 MG	TABLET	90
	LISINOPRIL-HYDROCHLOROTHIAZIDE	10 MG–12.5 MG	TABLET	90
	LISINOPRIL-HYDROCHLOROTHIAZIDE	20 MG–12.5 MG	TABLET	90
	LISINOPRIL-HYDROCHLOROTHIAZIDE	20 MG–25 MG	TABLET	90
	METHYLDOPA	250 MG	TABLET	180
	METOPROLOL TARTRATE	50 MG	TABLET	180
	METOPROLOL TARTRATE	100 MG	TABLET	180
	MINOXIDIL	2.5 MG	TABLET	180
	MINOXIDIL	10 MG	TABLET	90
	PRAZOSIN HCL	1 MG	CAPSULE	90
	PROPRANOLOL HCL	10 MG	TABLET	180
	PROPRANOLOL HCL	20 MG	TABLET	180
	PROPRANOLOL HCL	40 MG	TABLET	180
	PROPRANOLOL HCL	60 MG	TABLET	180
	PROPRANOLOL HCL	80 MG	TABLET	180
	QUINAPRIL HCL	5 MG	TABLET	90
	QUINAPRIL HCL	10 MG	TABLET	90
	QUINAPRIL HCL	20 MG	TABLET	90
	QUINAPRIL HCL	40 MG	TABLET	90
	QUINAPRIL-HYDROCHLOROTHIAZIDE	10 MG–12.5 MG	TABLET	90

Drug Class	Medication Name	Strength	Form	$9 Quantity
Blood Pressure/Heart Health (Cont.)	QUINAPRIL-HYDROCHLOROTHIAZIDE	20 MG–12.5 MG	TABLET	90
	QUINAPRIL-HYDROCHLOROTHIAZIDE	20 MG–25 MG	TABLET	90
	RAMIPRIL	1.25 MG	CAPSULE	90
	RAMIPRIL	2.5 MG	CAPSULE	90
	RAMIPRIL	5 MG	CAPSULE	90
	RAMIPRIL	10 MG	CAPSULE	90
	SOTALOL HCL	80 MG	TABLET	180
	SOTALOL HCL	240 MG	TABLET	180
	SPIRONOLACTONE	25 MG	TABLET	90
	TERAZOSIN HCL	1 MG	CAPSULE	90
	TERAZOSIN HCL	2 MG	CAPSULE	90
	TERAZOSIN HCL	5 MG	CAPSULE	90
	TERAZOSIN HCL	10 MG	CAPSULE	90
	TORSEMIDE	5 MG	TABLET	90
	TORSEMIDE	10 MG	TABLET	90
	TORSEMIDE	20 MG	TABLET	90
	TORSEMIDE	100 MG	TABLET	90
	TRANDOLAPRIL	1 MG	TABLET	90
	TRANDOLAPRIL	2 MG	TABLET	90
	TRANDOLAPRIL	4 MG	TABLET	90
	TRIAMTERENE-HYDROCHLOROTHIAZIDE	37.5 MG–25 MG	CAPSULE	90
	TRIAMTERENE-HYDROCHLOROTHIAZIDE	37.5 MG–25 MG	TABLET	90
	TRIAMTERENE-HYDROCHLOROTHIAZIDE	75 MG–50 MG	TABLET	90
	VERAPAMIL HCL	80 MG	TABLET	270
	VERAPAMIL HCL	120 MG	TABLET	90
	VERAPAMIL HCL	120 MG	TABLET SA	90
	VERAPAMIL HCL	180 MG	TABLET SA	90
	VERAPAMIL HCL	240 MG	TABLET SA	90
	WARFARIN SODIUM	1 MG	TABLET	90
	WARFARIN SODIUM	2 MG	TABLET	90
	WARFARIN SODIUM	2.5 MG	TABLET	90
	WARFARIN SODIUM	3 MG	TABLET	90
	WARFARIN SODIUM	4 MG	TABLET	90
	WARFARIN SODIUM	5 MG	TABLET	90

Drug Class	Medication Name	Strength	Form	$9 Quantity
Blood Pressure/Heart Health (Cont.)	WARFARIN SODIUM	6 MG	TABLET	90
	WARFARIN SODIUM	7.5 MG	TABLET	90
	WARFARIN SODIUM	10 MG	TABLET	90
Cold and Allergy Therapy	BENZONATATE	100 MG	CAPSULE	270
	CYPROHEPTADINE HCL	4 MG	TABLET	90
	DEXTROMETHORPHAN HBR/ PROMETHAZINE HCL	15 MG– 6.25 MG/5 ML	SYRUP	360
	PROMETHAZINE HCL	6.25 MG/5 ML	SYRUP	360
	PROMETHAZINE HCL	12.5 MG	TABLET	90
	PROMETHAZINE HCL	25 MG	TABLET	90
	PROMETHAZINE HCL	50 MG	TABLET	270
Diabetes	GLIMEPIRIDE	1 MG	TABLET	90
	GLIMEPIRIDE	2 MG	TABLET	90
	GLIMEPIRIDE	4 MG	TABLET	180
	GLIPIZIDE	5 MG	TABLET	180
	GLIPIZIDE	10 MG	TABLET	180
	GLIPIZIDE	5 MG	TABLET OSM 24HR	90
	GLYBURIDE	1.25 MG	TABLET	90
	GLYBURIDE	2.5 MG	TABLET	90
	GLYBURIDE	5 MG	TABLET	180
	GLYBURIDE/METFORMIN HCL	5 MG–500 MG	TABLET	360
	METFORMIN HCL	500 MG	TABLET	180
	METFORMIN HCL	850 MG	TABLET	180
	METFORMIN HCL	1000 MG	TABLET	180
	METFORMIN HCL	500 MG	TABLET SR 24H	180
	METOPROLOL TARTRATE	25 MG	TABLET	180
Eye Health	BACITRACIN-POLYMYXIN B SULFATE	500–10KU/G	OINTMENT	10.5
	ERYTHROMYCIN BASE	5 MG/G	OINTMENT	10.5
	GENTAMICIN SULFATE	0.3%	DROPS	15
	NEOMYCIN POLYMYXIN B SULFATE DEXAMETHASONE	3.5–10 K–0.1	OINTMENT	10.5
	POLYMYXIN B SULFATE/TMP	10 K U–0.1%	DROPS	30
GI Drugs	HYOSCYAMINE SULFATE	0.125 MG	TABLET	270
	METOCLOPRAMIDE HCL	5 MG	TABLET	360
	METOCLOPRAMIDE HCL	10 MG	TABLET	360

Drug Class	Medication Name	Strength	Form	$9 Quantity
Heartburn/Ulcer	FAMOTIDINE	40 MG	TABLET	90
	RANITIDINE HCL	300 MG	TABLET	90
High Cholesterol	LOVASTATIN	10 MG	TABLET	90
	LOVASTATIN	20 MG	TABLET	90
	LOVASTATIN	40 MG	TABLET	90
	PRAVASTATIN SODIUM	10 MG	TABLET	90
	PRAVASTATIN SODIUM	20 MG	TABLET	90
	PRAVASTATIN SODIUM	40 MG	TABLET	90
Muscle Relaxants	BACLOFEN	10 MG	TABLET	270
	CYCLOBENZAPRINE HCL	5 MG	TABLET	90
	CYCLOBENZAPRINE HCL	10 MG	TABLET	90
	ORPHENADRINE CITRATE	100 MG	TABLET SA	180
	TIZANIDINE HCL	2 MG	TABLET	270
	TIZANIDINE HCL	4 MG	TABLET	270
Parkinson's Disease	BENZTROPINE MESYLATE	1 MG	TABLET	180
Skin Conditions	HYDROCORTISONE	2.5%	CREAM	90
	TRIAMCINOLONE ACETONIDE	0.5%	CREAM	180
Thyroid Therapy	LEVOTHYROXINE SODIUM	25 MCG	TABLET	90
	LEVOTHYROXINE SODIUM	50 MCG	TABLET	90
	LEVOTHYROXINE SODIUM	75 MCG	TABLET	90
	LEVOTHYROXINE SODIUM	88 MCG	TABLET	90
	LEVOTHYROXINE SODIUM	100 MCG	TABLET	90
	LEVOTHYROXINE SODIUM	112 MCG	TABLET	90
	LEVOTHYROXINE SODIUM	125 MCG	TABLET	90
	LEVOTHYROXINE SODIUM	137 MCG	TABLET	90
	LEVOTHYROXINE SODIUM	150 MCG	TABLET	90
	LEVOTHYROXINE SODIUM	175 MCG	TABLET	90
	LEVOTHYROXINE SODIUM	200 MCG	TABLET	90
	METHIMAZOLE	5 MG	TABLET	90
	METHIMAZOLE	10 MG	TABLET	90
Vitamins and Electrolytes	FOLIC ACID	1 MG	TABLET	90
	POTASSIUM CHLORIDE	10 MEQ	TABLET SR	90
Women's Health	ESTRADIOL	0.5 MG	TABLET	90
	ESTRADIOL	1 MG	TABLET	90
	ESTRADIOL	2 MG	TABLET	90

Drug Class	Medication Name	Strength	Form	$9 Quantity
Women's Health (Cont.)	LEVONORGESTREL-ETHINYL ESTRADIOL	0.15 MG– 0.03 MG	TABLET	84
	MEDROXYPROGESTERONE ACETATE	2.5 MG	TABLET	90
	MEDROXYPROGESTERONE ACETATE	5 MG	TABLET	90
	MEDROXYPROGESTERONE ACETATE	10 MG	TABLET	90
	NORGESTIMATE-ETHINYL ESTRADIOL	7 DAYS X 3 28	TABLET	84
Other Medications	ALENDRONATE SODIUM	5 MG	TABLET	90
	ALENDRONATE SODIUM	10 MG	TABLET	90
	ALENDRONATE SODIUM	35 MG	TABLET	12
	ALENDRONATE SODIUM	70 MG	TABLET	12
	ALLOPURINOL	100 MG	TABLET	90
	ALLOPURINOL	300 MG	TABLET	90
	CHLORHEXIDINE GLUCONATE	0.12%	MOUTHWASH	1,419
	DEXAMETHASONE	0.5 MG	TABLET	90
	DEXAMETHASONE	0.75 MG	TABLET	90
	FLUDROCORTISONE ACETATE	0.1 MG	TABLET	90
	ISONIAZID	300 MG	TABLET	90
	LIDOCAINE HCL	20 MG/ML	SOLUTION	300
	MEGESTROL ACETATE	20 MG	TABLET	90
	METHYLPREDNISOLONE	4 MG	TABLET DS PK	63
	OXYBUTYNIN CHLORIDE	5 MG	TABLET	180
	PREDNISONE	1 MG	TABLET	360
	PREDNISONE	2.5 MG	TABLET	90
	PREDNISONE	5 MG	TABLET	90
	PREDNISONE	10 MG	TABLET	90
	PREDNISONE	20 MG	TABLET	90

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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**).

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GET TO KNOW THE MEDICATION LOOKUP TOOL

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

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

KEY FEATURES

Using the tool, you can:

SEARCH FOR ANY MEDICATION

See if it's covered by your plan

GET DETAILED INFORMATION

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

VIEW ADDITIONAL COVERAGE REQUIREMENTS

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

SEE COVERED ALTERNATIVES

For non-covered medications

Start Searching

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

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GETTING COVERAGE INFORMATION, SIMPLIFIED

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

PERSONALIZED SEARCH

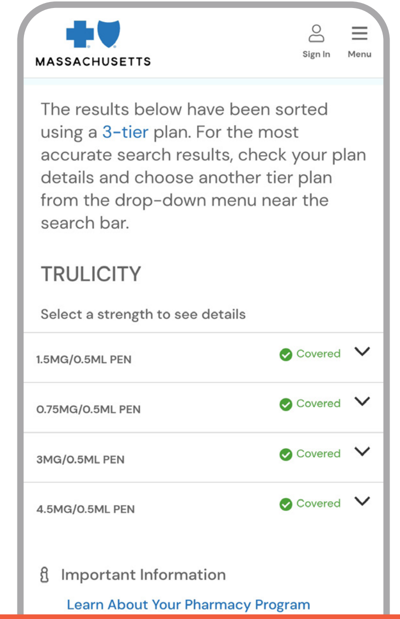
When you're signed in to your MyBlue account, your plan's formulary and tier structure will be automatically displayed in the tool. That way, you'll know you're getting the most accurate search results for your plan.

ANYONE CAN USE IT

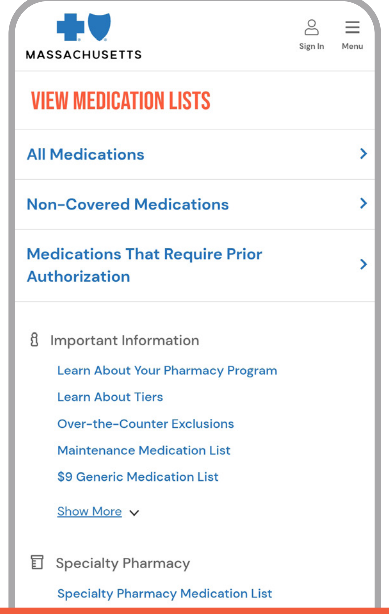
The **Medication Lookup** tool is available to everyone, even if you aren't a member yet. You can easily find out if your medication is covered, or see covered alternatives, before you enroll.

HOW TO USE THE TOOL

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



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



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

Learn More

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

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MASSACHUSETTS

Covered Medications (Formulary)

Learn About Your Pharmacy Program

Effective January 1, 2022

This guide provides an overview of your pharmacy program, lists some of the medications covered under your plan, lists medications not covered under your plan, and includes other important information about your pharmacy coverage.

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Pharmacy Program Overview

Your pharmacy program is designed to provide you and your doctor with access to a wide variety of safe, clinically effective medications. We've carefully developed a substantial covered medications list, also known as a formulary, that includes many medications that are available at affordable out-of-pocket costs.

About This Guide

This guide is up to date as of January 1, 2022, and is subject to change. Use it as a reference whenever you need coverage information about your pharmacy program. For the most current and complete information about covered medications, use our **Medication Lookup** tool at **bluecrossma.org/medication**.

Mail Order Pharmacy

You can have certain prescriptions delivered right to your door when you order them through Express Scripts®´, an independent company that administers your pharmacy benefits on behalf of Blue Cross Blue Shield of Massachusetts. With Mail Order Pharmacy, most maintenance medications (also known as long-term medications) can be automatically refilled and shipped every 90 days at a lower cost. No more running out of medicine or last-minute trips to the pharmacy.

To get started with the Mail Order Pharmacy, sign in to MyBlue, then select **90-Day Mail Order Pharmacy** in the drop-down menu under **My Medications**. You can also call Express Scripts at **1-800-892-5119**.

Unlock the Power of Your Plan

MyBlue is your key to more features and savings. Sign in to your account at **bluecrossma.org** or open the MyBlue app to review claims, track medications, look up plan information, and get easy access to these online resources:

Medication Lookup Tool

Use this tool to search, quickly and easily, for prescription medications, and find out how they're covered. To start, go to **Medication Lookup Tool** under **My Medications**.

Express Scripts

Go to **Express Scripts®** under **My Medications** to get detailed information about your pharmacy coverage, including the cost of medications. You can also search for a local pharmacy, or sign up for the Mail Order Pharmacy and have your prescriptions shipped directly to you.

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 the tier your medication is in and your benefits. The amount you pay may also include your copayment, co-insurance, and deductibles. The pharmacist will tell you how much you owe. To find your out-of-pocket costs for specific prescriptions, sign in to **MyBlue,** then select **Express Scripts®** under **My Medications** on your MyBlue home page.

How Covered Medications Are Placed in Tiers

Medications are placed in 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 below. Check your plan materials to see which tier structure your plan uses, and learn more about how medications are covered.*

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 and Drug Administration (FDA) requirements.
Tier 2: Brands	Brand-name medications cost more than generic medications, so you'll **pay more** 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 **pay more** 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 **pay more** 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 **pay more** if you use them instead of any generics or preferred brands.

*Exceptions may apply. For example, the brands and preferred-brands tiers could include some generic medications in addition to brand-name medications.

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 **pay more** 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 medications cost more than preferred brands, so you'll **pay more** if you use them instead of any generics or preferred-brand 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 **pay more** 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 **pay more** 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 medications cost more than preferred-brands, so you'll **pay more** if you use them instead of any generics or preferred-brands specialty medications.

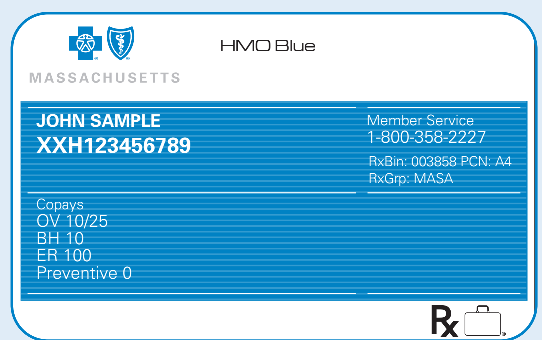
For more information about your pharmacy benefit, sign in to your MyBlue account at **bluecrossma.org**.

Compounded Medications

Covered compounded medications that require a prescription will be processed at your highest pharmacy benefit tier, regardless of the ingredients in the medication. Compounded medications are made to order by a pharmacist when existing, commercially available medications don't meet your specific needs as determined by your doctor. Some compounded medications may need Prior Authorization, have Quality Care Dosing guidelines, or require an exception.

Covered Medications List Changes

Our covered medications list may change from time to time. This may include changing medications to a non-covered status, changing medication tier status, applying Quality Care Dosing limitations, and/or moving medications to a specialty pharmacy. We notify any affected members of these changes via direct mail at least 30 days in advance of the change.



Sample ID card for illustrative purposes only.

Your ID Card

Your ID card contains important information about your pharmacy benefits. Be sure to bring the card with you and give it to your pharmacist when you fill a prescription.

Over-the-Counter Medications

For non-grandfathered health plans under the Affordable Care Act (ACA), the following list includes over-the-counter medications that are covered at no cost to you when they're prescribed by your doctor. This list is up to date as of January 1, 2022, and may change from time to time.

- Generic Aspirin (81mg)
- Generic Contraceptives (such as female condoms, sponges, and spermicide) are covered
- Generic Folic Acid is covered for people up to age 50
- Generic Iron is covered for infants up to 12 months old
- Generic Smoking Cessation (such as nicotine gum, lozenges, and patches) is covered for up to two 90-day supplies per calendar year
- Generic Vitamin D is covered for people aged 65 and older

Benefit Exclusions

The following are considered benefit exclusions under your policy. This means these medications and other health products aren't covered, and exceptions aren't available. Some medications within these categories have over-the-counter alternatives available.

- Anorexiants
- Cough and cold products that contain one or more of the following ingredients in equivalent over-the-counter doses: guaifenesin, chlorpheniramine, pseudoephedrine, phenylephrine, clemastine, dextromethorphan, and pyrilamine
- Non-sedating antihistamines
- Ophthalmic drug solutions to treat allergies
- Inhaled nasal steroids
- Proton pump inhibitors (PPIs), except for prescription PPIs that are prescribed for members under age 18 or prescribed as part of a combination drug used to treat helicobacter pylori
- Topical acne medications (benzoyl peroxide products in 10% strength or less, and some combinations)
- Pharmaceuticals that you can buy without a prescription, except as described in this Pharmacy Program booklet
- Medical supplies such as dressings and antiseptics
- Combination vitamins that require a prescription, except for prescription prenatal vitamins and pediatric vitamins with fluoride

This list is up to date as of January 1, 2022. See your subscriber certificate for additional exclusions.

Quality Care Dosing

Our Quality Care Dosing program helps to ensure that the quantity and dosage of the medications you receive meet the Food and Drug Administration (FDA)'s regulations, clinical standards, and manufacturer's guidelines. When you fill a prescription for one of the following medications, it's checked electronically in two ways:

Dose Consolidation
Checks to see whether you're taking two or more pills a day that can be replaced with one pill providing the same daily dosage

Recommended Monthly Dosing Level
Checks to see that your monthly dosage is consistent with the FDA's and manufacturer's monthly dosing recommendations and clinical information

You may fill a quantity up to the allowed limit, but quantities greater than the allowed limit will be denied.

Note: Your doctor may request an exception for medications that are subject to Quality Care Dosing when medically necessary. Some medications on this list may also be subject to Step Therapy and/or Prior Authorization requirements, be considered non-covered, or be considered a specialty medication. Please check the corresponding pages to determine coverage requirements.

This list of medications in our Quality Care Dosing program is up to date as of January 1, 2022, and may change from time to time.

For the most current list of medications subject to Quality Care Dosing, along with associated dosing limits, use our **Medication Lookup** tool at **bluecrossma.org/medication**.

Quality Care Dosing

Abilify Mycite
Abstral
AcipHex (excluded for 18 years and older)
AcipHex Sprinkle (excluded for 18 years and older)
Actemra
Actiq
Actonel
ACTOplus Met
ACTOplus Met XR
Actos
Acular
Acular LS
Acular PF
Acyclovir cream
Adderall XR
Adhansia XR
Adlyxin
Admelog
Admelog Solostar
Advair Diskus
Advair HFA
Adyphren
Adyphren II
Adyphren Amp
Adyphren Amp II
Adzenys XR
Aemcolo
Aerospan
Aimovig
AirDuo DigiHaler
AirDuo RespiClick
Ajovy
Akynzeo
Albuterol Sulfate HFA
Alendronate Sodium
Alinia
Almotriptan
Alora
Alosetron
Alrex
Alsuma
Altoprev
Alvesco
Ambien
Ambien CR
Amethia
Amethia Lo
Amerge
Amitiza
Amlodipine
Amlodipine-Atorvastatin
Ampyra
Anzemet
Apidra
Apidra Solostar
Aplenzin ER
Aprepitant
Aptenzio XR
Aranesp
Arava
Arcapta Neohaler
Arformoterol
Arikayce
ArmonAir DigiHaler
ArmonAir RespiClick
Arnuity Ellipta
Arixtra
Arymo ER
Ashlyna
Asmanex HFA
Asmanex Twisthaler
Aspirin/Omeprazole (excluded for 18 years and older)
Astepro
Atelvia DR
Atomoxetine
Atorvastatin
Atrovent (nasal spray)
Atrovent HFA
Auvi-Q
Avandia
Avinza
Avonex
Axert
Azelastine (nasal spray)
Azstarys
Baqsimi
Basaglar
Belbuca
Belsomra
Betaseron
Bevespi AeroSphere
Bevyxxa
Bijuva
Binosto
Boniva tablets
Breo Ellipta
Breztri Aerosphere
Brexafemme
Brisdelle
Bronchitol
Brovana
Brukinsa
Budeprion SR
Budeprion XL
Budesonide (nebules)
Budesonide/Formoterol
Bunavail
Buprenorphine
Buprenorphine-Naloxone
Buprenorphine film
Buprenorphine patch
Bupropion SR
Bupropion XL
Butorphanol NS
Butrans
Bydureon
Bydureon Bcise
Byetta
Cabergoline
Cabometyx
Caduet
Calcipotriene
Calcipotriene/Betamethasone
Calypta
Camrese
Camrese Lo
Cardura
Cardura XL
Catapres TTS
Celebrex
Celecoxib
Celexa
Cesamet
Cholbam
Ciclodin solution/kit
Ciclopirox cream
Ciclopirox gel
Ciclopirox nail lacquer
Ciclopirox shampoo
Ciclopirox topical suspension
Cimzia
Citalopram
Climara
Climara Pro
Clindamycin 1% gel
Clindamycin 1% solution
Clindamycin 1% lotion
Clindamycin 1% foam
Clindamycin 2% vaginal
Clonidine patch
Combivent
Combivent Respimat
Concerta
Conjupri
Cotempla XR ODT
Contrave ER
Copaxone
Cosentyx
Crestor
Cromolyn ophthalmic
Cymbalta
Daklinza
Dalfampridine
Daurismo
Daysee
Dayvigo
Denavir
Desvenlafaxine ER
Dexilant (excluded for 18 years and older)
Dexmethylphenidate ER
Dexmethylphenidate XR
Dextroamphetamine/Amphetamine ER
Diabetic Testing Strips (all)
Diclofenac 3% gel
Diclofenac solution
Diflorasone cream
Diflucan (150 mg only)

Quality Care Dosing

- Dihydroergotamine (nasal spray)
- DM 2 Kit
- Doptelet
- Dotti
- Dovonex
- Doxazosin
- Doxepin cream
- Doxepin tablets
- Drizalma Sprinkle
- Duaklir Pressair
- Dulera
- Duloxetine DR
- Duragesic
- Econazole cream
- Edluar
- Effexor XR
- Eletriptan
- Embeda
- Emend
- Emgality
- Emverm
- Enbrel
- Enoxaparin
- Epclusa
- Epinephrine injection
- Epinephrine Professional kit
- Epinephrine Professional EMS kit
- Epi-Pen Auto-Injector
- Epogen
- Escitalopram
- Esomep-EZS (excluded for 18 years and older)
- Esomeprazole (excluded for 18 years and older)
- Esomeprazole Strontium (excluded for 18 years and older)
- Estradiol patch
- Estrogel
- Eszopiclone
- Evamist
- Evenity
- Evzio
- Exalgo
- Exkivity
- Extavia
- Ezallor Sprinkle
- Ezetimibe
- Ezetimibe/Simvastatin
- Famciclovir
- Farydak
- Farxiga
- Fasenra
- Fayosim
- Fentanyl Citrate
- Fentanyl oral/mucosal
- Fentanyl patch
- Fentora
- Fetzima
- Fiasp
- Flovent Diskus
- Flovent HFA
- Fluconazole (150 mg only)
- Fluoxetine
- Fluoxetine DR
- Fluticasone/Salmeterol
- Fluvastatin
- Fluvastatin XR
- Fluvoxamine
- Fluvoxamine CR
- Focalin XR
- Fondaparinux
- Forfivo XL
- Formoterol
- Forteo
- Fosamax
- Fosamax Plus D
- Fotivda
- Fragmin
- Frova
- Frovatriptan
- Fulphila
- Gatifloxacin
- Gavreto
- Gemtesa
- Gentimicin cream
- Gentimicin ointment
- Glatiramer
- Glatopa
- Glucose testing strips (all)
- Glyxambi
- Granisetron
- Granix
- Grastek
- Halobetasol cream
- Halobetasol ointment
- Harvoni
- Hetlioz
- Humalog
- Humalog Jr.
- Humulin
- Humira
- Humira CF
- Hydrocodone ER
- Hydromorphone ER
- Hysingla ER
- Ibandronate
- Ibrance
- Ilumya
- Imitrex
- Impavido
- Incruse Ellipta
- Indomethacin 20mg
- Infergen
- Ingrezza
- Insulins (all)
- Insulins Lispro
- Intermezzo
- Introvale
- Invokamet
- Invokamet XR
- Invokana
- Iodoquinol/Hydrocortisone/Aloe
- Ipratropium NS
- Irenka DR
- Itraconazole
- Jakafi
- Jardiance
- Jolessa
- Jornay PM
- Jynarque
- Kadian
- Kalydeco
- Kenalog aerosol
- Kerendia
- Kerydin
- Ketoconazole 2%
- Ketorolac ophthalmic
- Keveyis
- Kevzara
- Khedezla
- Kineret
- Klisyri
- Kloxxado
- Krintafel
- Kynmobi
- Lamisil
- Lansoprazole (excluded for 18 years and older)
- Lansoprazole ODT (excluded for 18 years and older)
- Lansoprazole/Amoxicillin/Clarithromycin
- Lantus
- Lazanda
- Leflunomide
- Ledipasvir/Sofosbuvir
- Lescol
- Lescol XL
- Levalbuterol HFA
- Levemir
- Levonorgestrel/Ethinyl Estradiol
- Levonorgestrel/Ethinyl Estradiol/Ethinyl Estradiol
- Lexapro
- Lidociane 5% cream
- Lidocaine 5% ointment
- Lidocaine Patch
- Lidoderm
- Linzess
- Lipitor
- Livalo
- Lonhala Magnair
- LoSeasonique
- Lotronex
- Lovastatin
- Lovenox
- Lubriprotone
- Lucemyra

Quality Care Dosing

Lumakras
Lunesta
Lybalvi
Lyllana
Lyrica CR
Lysteda
Lyumjev
Mavyret
Maxalt
Maxalt-MLT
Meloxicam
Meloxicam submicronized
Menostar
Methylphenidate CD
Methylphenidate ER
Methylphenidate LA
Methylphenidate 72 mg
Migranal
Migranow Kit
Minivelle
Mirtazapine
Mirtazapine Rapid Dissolve
Mobic
Morphabond ER
Morphine Sulfate ER
Movantik
Moxifloxacin
Moxeza
MS Contin
Mupirocin
Mulpleta
Mydayis
Myfembree
Naloxone
Naratriptan
Narcan
NebuPent
Neulasta
Neupogen
Nexium (excluded for 18 years and older)
Nexletol
Nexlizet
Nitazoxanide
Nivestym
Nocdurna
Norvasc
Novolin
Novolog
Nucynta ER
Nuplazid
Nurtec ODT
Nyamyc powder
Nystatin powder
Nystop powder
Nyvepria
Ocaliva
Odomzo
Olanzepine-Fluoxetine
Olopatadine Nasal
Olumiant
Olysio
Omeprazole (excluded for 18 years and older)
Omeprazole-Sodium Bicarbonate (excluded for 18 years and older)
OmePPI (excluded for 18 years and older)
Omontys
Ondansetron
Ondansetron ODT
Onmel
Onsolis
Onzetra Xsail
Opana ER
Opzelura
Oralair
Oramorph SR
Orencia
Orkambi
Orladeyo
Otezla
Oxbryta
Oxiconazole Nitrate
Oxistat
Oxycodone ER
OxyContin
Oxymorphone ER
Ozempic
Pantoprazole (excluded for 18 years and older)
Paroxetine
Paroxetine CR
Patanase
Paxil
Paxil CR
Pegasys
PEG-Intron
Penlac
Pennsaid
Perforomist
Pexeva
Pimecrolimus cream
Plegridy
Pomalyst
Ponvory
Praluent
Pravachol
Pravastatin
Pregabalin CR
Prevacid (excluded for 18 years and older)
PrevPac
Prilosec (excluded for 18 years and older)
Pristiq
Pristiq ER
ProAir DigiHaler
ProAir HFA
ProAir RespiClick
Procrit
Protonix (excluded for 18 years and older)
Proventil HFA
Prozac
Prozac Weekly
Prudoxin
Pulmicort Flexhaler
Pulmicort Respules
Qbrexxa
Qelbree
Qinlock
Qmiiz ODT
Qtern
Qualaquin
Quartette
Quasense
Qulipta
Quillichew
Quinine Sulfate
Qutenza
QVAR
Rabeprazole (excluded for 18 years and older)
Ramelteon
Ragwitek
Rebif
RediTrex
Relexxii ER
Relpax
Remeron
Remeron Soltab
Repatha
Restasis
Retacrit
Rexulti
Reyvow
Rezurock
Rhopressa
Rinvoq ER
Risedronate
Ritalin LA
Rivelsa
Rizatriptan
Rizatriptan ODT
Rocklatan
Rosuvastatin
Rosuvastatin/Ezetimibe
Roszet
Rozerem
Rybelsus
Sancuso
Sarafem
Saxenda
Seasonique
Secuado
Seebri Neohaler
Segluromet
Semglee
Serevent Diskus

Quality Care Dosing

Sertraline
Setlakin
Silenor
Siliq
Simponi
Simvastatin
Skyrizi
Sofosbuvir/Velpatasvir
Soliqua
Solosec
Sonata
Sovaldi
Spiriva HandiHaler
Spiriva RespiMat
Sporanox
Stelara
Steglatro
Steglujan
Stiolto Respimat
Strattera
Striverdi Respimat
Suboxone
Subsys
Sumatriptan
Sumavel Dosepro
Symbicort
Symbyax
Symdeko
Symjepi
Symproic
Synjardy
Synjardy XR
Tagrisso
Talicia DR
Taltz
Tanzeum
Tavaborole
Tazverik
Technivie
Tegsedi
Tepmetko
Teriparatide
Terazosin
Terbinafine
Tivorbex
Tolsura
Tosymra
Toujeo Solostar
Toujeo Max Solostar
Tranexamic Acid
Trelegy Ellipta
Tremfya
Tresiba
Treximet
Triamcinolone spray
Trijardy XR
Trikafta
Trintellix
Triptodur
Trudhesa
Trulance
Trulicity
Truseltiq
Tudorza
Tukysa
Tymlos
Ubrelvy
Undenyca
Ukoniq
Utibron Neohaler
Valacylovir
Valtrex
Varubi
Venlafaxine ER capsule
Venlafaxine ER tablet
Ventolin HFA
Verquvo
Verzenio
Viberzi
Victoza
Viekira PAK
Viekira XR
Vigamox
Viibryd
Vitrakvi
Vivelle
Vivelle-Dot
Vivitrol
Vivlodex
Voltaren 1%
Vosevi
Vumerity DR
Vyleesi
Vyndaqel
Vyndamax
Vytorin
Vyvanse
Wakix
Wegovy
Wellbutrin SR
Wellbutrin XL
Wixela Inhub
Xartemis XR
Xeljanz
Xeljanz XR
Xenleta
Xermelo
Xiidra
Xifaxan
Xigduo
Xigduo XR
Xopenex HFA
Xospata
Xtampza ER
Xultophy
Xuriden
Yupelri
Yosprala
Zaleplon
Zarxio
Zegerid (excluded for 18 years and older)
Zembrace Symtouch
Zepatier
Zeposia
Zetia
Ziextenzo
Zinbryta
Zocor
Zofran
Zofran ODT
Zohydro ER
Zoladex
Zolmitriptan
Zolmitriptan nasal
Zolmitriptan ODT
Zoloft
Zolpidem
Zolpidem CR
Zolpidem SL
Zolpimist
Zomig
Zomig nasal
Zomig ZMT
Zonalon
Zovirax cream
Zubsolv
Zuplenz
Zydelig
Zymaxid
Zypitamag

Prior Authorization

Your doctor is required to obtain Prior Authorization before prescribing specific medications. This ensures that your doctor has determined that this medication is necessary to treat you, based on specific medical standards.

Our Prior Authorization program includes Step Therapy. Please refer to the Step Therapy section in this booklet for more information.

Note: Some medications on this list may also be subject to Step Therapy and/or Quality Care Dosing requirements, be considered non-covered, or be considered a specialty medication. Please check the corresponding pages to determine coverage requirements.

This list of medications that require Prior Authorization is up to date as of January 1, 2022, and may change from time to time.

For the most current list of medications that require Prior Authorization, use our **Medication Lookup** tool at **bluecrossma.org/medication**.

Prior Authorization

- Abstral
- AcipHex (excluded for 18 years and older)
- Actemra
- Acthar
- Actimmune
- Actiq
- Adakveo
- Adcirca
- Addyi
- Advair Diskus
- Advair HFA
- Air Duo
- Aimovig
- Ajovy
- Alecensa
- Alfenta
- Alunbrig
- Alyq
- Amondys 45
- Amphetamines (e.g Amphetamine, Methamphetamine, Liquadd, Procentra)
- Ampyra
- Apadaz
- Aralast
- Armodafinil
- Aranesp
- Arikayce
- Arymo ER
- Aspirin/Omeprazole (excluded for 18 years and older)
- Astramorph/PF
- Avinza
- Avsola
- Ayvakit
- Balversa
- Belbuca
- Benzhydrocodone/APAP
- Berinert
- Boniva syringe
- Botox/Botulinum Toxin
- Braftovi
- Breo Ellipta
- Breztri
- Budesonide/Formoterol
- Buprenorphine film
- Buprenorphine patch
- Butrans
- Bylvay
- Capital and Codeine
- Cequa
- Cerezyme
- Cimzia
- Cinqair
- Cinryze
- Cocet/Plus
- Co-gesic
- Copkitra
- Contrave
- Cotellic
- Cosentyx
- Daklinza
- Dalfampridine
- Demerol
- Desoxyn
- Dexilant (excluded for 18 years and older)
- Dexedrine
- Dextroamphetamines
- Dificid
- Dilaudid
- Diskets
- Dolophine
- Dujolvi
- Dulera
- Dupixent
- Duragesic
- Doramorph
- Durolane
- Dvorah
- Dysport
- Egrifta
- Elidel
- Embeda
- Emgality
- Empaveli
- Enbrel
- Enspryng
- Enteral formula
- Entyvio
- Epclusa
- Epogen
- Erlotinib
- Esomeprazole (excluded for 18 years and older)
- Esomeprazole Strontium (excluded for 18 years and older)
- Esomep-EZS (excluded for 18 years and older)
- Euflexxa
- Evekeo
- Evenity
- Evkeeza
- Evrysdi
- Exalgo
- Exondys 51
- Eysuvis
- Factor VIII, VIIIa, IX, XIII (medical benefit only)
- Farydak
- Fasenra
- Fentanyl Citrate
- Fentanyl patch
- Fentanyl oral/mucosal
- Fentora
- Firazyr
- Firdapse
- Fluticasone/Salmeterol
- Forteo
- Fulphila
- Galafold
- Gamifant
- Gavreto
- Gel-One
- Gelsyn-3
- Genotropin
- Genvisc
- Gilotrif
- Givlaari
- Granix
- Grastek
- Harvoni
- Haegarda
- Hetlioz
- Humatrope
- Humira
- Hyalgan
- Hycet
- Hydrocodone ER
- Hydrogesic
- Hydromorphone ER
- Hydroxyprogesterone
- Hymovis
- Hysingla ER
- Ibandronate injection/syringe
- Ibrance
- Ibudone
- Idhifa
- Ilaris
- Ilumya
- Imcivree
- Increlex
- Incruse Ellipta
- Inflectra
- Infumorph
- Inrebic
- Interferons (alpha, gamma)
- Iressa
- Isturisa
- IV Immunoglobulin
- Juxtapid
- Kadian
- Kalbitor
- Kalydeco
- Kanuma
- Kevzara
- Kineret
- Kisqali
- Kisqali Femara
- Kynamro
- Lazanda
- Ledipasvir/Sofosbuvir
- Lemtrada
- Lenvima
- Liquadd
- Lorbrena
- Lorcet
- Lumakras
- Lynparza

Prior Authorization

- Lyrica
- Lyrica CR
- Magnacet
- Mavyret
- Maxidone
- Makena
- Margesic-H
- Mekinist
- Mektovi
- Meperitab
- Methadone
- Methadose
- Methamphetamine
- Modafinil
- Monovisc
- Morphabond ER
- Morphine Sulfate CR
- Morphine Sulfate ER
- MS Contin
- Myalept
- Myobloc
- Nalocet
- Natrecor
- Nexium (excluded for 18 years and older)
- Neulasta
- Neupogen
- Nexlitol
- Nexlizet
- Norco
- Norditropin
- Nucala
- Nucynta ER
- Nulibry
- Nutritional Supplements
- Nutropin
- Nuvigil
- Olumiant
- Olysio
- Omeprazole-Sodium Bicarbonate (excluded for 18 years and older)
- OmePPI (excluded for 18 years and older)
- Omnitrope
- Onpattro
- Onsolis
- Opana ER
- Oralair
- Oramorph SR
- Orencia
- Orkambi
- Orladeyo
- Orthovisc
- Otezla
- Oxbryta
- Oxecta
- Oxervate
- Oxlumo
- Oxycodone ER
- Oxycontin
- Oxymorphone ER
- Panlor SS
- Pemazyre
- Percocet
- Percodan
- Pimecrolimus
- Piqray
- Polygesic
- Praluent
- Pregabalin
- Pregabalin CR
- Prevacid (excluded for 18 years and older)
- Prilosec (excluded for 18 years and older)
- Primlev
- Procentra
- Procrit
- Prolate
- Proleukin
- Prolia
- Protonix (excluded for 18 years and older)
- Protopic
- Provigil
- Ragwitek
- Reblozyl
- Regranex
- Remicade
- Renflexis
- Repatha
- Respiratory SyncytialVirus IG/Synagis
- Retacrit
- Restasis
- Retevmo
- Revatio
- Rezurock
- Riabni
- Rinvoq ER
- Rituxan
- Roxybond
- Rozlytrek
- Ruconest
- Ruxience
- Rydapt
- Saizen
- SaizenPrep
- Sajazir
- Saxenda
- Serostim
- Sildenafil (antihypertensive)
- Siliq
- Simponi
- Simponi Aria
- Skyrizi
- Sodium Hyaluronate 1% Syringe
- Sofosbuvir/Velpatasvir
- Sovaldi
- Spinraza
- Stagesic
- Stelara
- Subsys
- Sunosi
- Supartz
- Symbicort
- Symdeko
- Synalgos-DC
- Synvisc
- Synvisc One
- Tabrecta
- Tacrolimus (topical)
- Tadalafil (antihypertensive)
- Tafinlar
- Takhzyro
- Tarceva
- Tagrisso
- Taltz
- Talzenna
- Technivie
- Tegsedi
- Tepezza
- Tepmetko
- Teriparatide
- Tev-Tropin
- Tibsovo
- Topical Retinoic Acid Derivatives and Combinations (e.g. Retin-A)
- TPN (total parenteral nutrition) (medical benefit only)
- Trelegy Ellipta
- Tremfya
- Trezix
- Trikafta
- Triluron
- Trivisc
- Truseltiq
- Truxima
- Tylenol with Codeine
- Tylox
- Tymlos
- Tysabri
- Udenyca
- Verdrocet
- Verzenio
- Vicodin
- Vicoprofen
- Viekira XR
- Viekira PAK
- Viltepso
- Visco-3
- Vitrakvi
- Vizimpro
- Vosevi
- Vyepti
- Vyleesi
- Vyndamax
- Vyndaqel
- Vyondys-53
- Wakix
- Wegovy

Prior Authorization

Wixela Inhub
Xalkori
Xartemis XR
Xeljanz
Xeljanz XR
Xeomin
Xgeva
Xiaflex
Xiidra
Xodol
Xolair
Xospata
Xtampza ER
Yosprala
Zamicet
Zarxio
Zegerid (excluded for 18 years and older)
Zelboraf
Zenzedi
Zepatier
Zeposia
Zerlor
Zohydro ER
Zokinvy
Zolvit
Zomacton
Zorbtive
Zydelig
Zydone
Zykadia

Step Therapy

Step Therapy is a key part of our Prior Authorization program, allowing us to help your doctor provide you with an appropriate and affordable medication treatment. Before coverage is allowed for certain costly “second-step” medications, we require that you first try an effective, but less expensive, “first-step” medication. Some medications may have multiple steps.

Note: Some medications on this list may also be subject to Quality Care Dosing requirements, be considered non-covered, or be considered a specialty medication. Please check the corresponding pages to determine coverage requirements.

This list of medications in our Step Therapy program is up to date as of January 1, 2022, and may change from time to time.

For the most current list of medications that require Step Therapy, use our **Medication Lookup** tool at **bluecrossma.org/medication**.

Step Therapy

Anti-Migraine

Almotriptan
Amerge
Axert
Dihydroergotamine
Eletriptan
Frova
Frovatriptan
Imitrex
Maxalt
Maxalt-MLT
Migranal
Nurtec
Onzetra Xsail
Replax
Sumatriptan/Naproxen
Tosymra
Treximet
Trudhesa
Ubrelvy
Zembrace Symtouch
Zolmitriptan
Zolmitriptan nasal
Zomig
Zomig Nasal
Zomig ZMT

Cardiovascular

Entresto
Farxiga
Jardiance
Verquvo

Diabetes Management

Adlyxin
Alogliptin
Alogliptin/Metformin
Alogliptin/Pioglitazone
ACTOplus Met
ACTOplus Met XR
Actos
Afrezza
Avandaryl
Avandia
Bydureon
Byetta
Duetact
Farxiga
Fortamet
Glucophage
Glucophage XR
Glumetza
Glyxambi
Invokana
Invokamet
Invokamet XR
Janumet
Janumet XR
Januvia
Jardiance
Jentadueto
Jentadueto XR
Kazano
Kerendia
Kombiglyze XR
Metformin Film Coated ER (generic for Glumetza)
Metformin ER (generic for Fortamet)
Nesina
Onglyza
Oseni
Ozempic
Pioglitazone
Pioglitazone-Glimepiride
Pioglitazone-Metformin
Prandin
Qtern
Riomet
Riomet ER
Rybelsus
Segluromet
Soliqua
Steglatro
Steglujan
Synjardy
Synjardy XR
Tanzeum
Tradjenta
Trijardy XR
Trulicity
Victoza
Xigduo
Xigduo XR
Xultophy

Glaucoma

Lumigan
Rescula
Rocklatan
Travatan
Travatan Z
Xalatan
Xelpros
Vyzulta
Zioptan

Methotrexate Auto-Injectors

Otrexup
Rasuvo

Multiple Sclerosis

Avonex
Bafiertam
Betaseron
Copaxone
Extavia
Gilenya
Kesimpta
Mavenclad
Mayzent
Plegridy
Ponvory
Rebif
Tecfidera
Vumerity DR
Zeposia

Osteoporosis Treatment (Oral)

Actonel
Atelvia DR
Binosto
Boniva tablets
Fosamax
Fosamax Plus D

Overactive Bladder Treatment

Detrol
Detrol LA
Ditropan XL
Enablex
Gelnique
Gemtesa
Myrbetriq
Oxytrol
Toviaz
Vesicare

Pain Relievers (Cox II Inhibitors)

Capxib
Celebrex
Celecoxib
Lidoxib

Parkinson's Disease Management

Inbrija
Nourianz
Ongentys

Prostate Treatment

Avodart
Jalyn
Proscar

Topical Antibiotics

Mupirocin cream

Topical Testosterone

Androgel
Axiron
Fortesta
Natesto Nasal
Testim
Testosterone gel (Fortesta Authorized product)
Testosterone gel (Testim Authorized product)
Testosterone gel (Vogelxo Authorized product)

Step Therapy

Testone CIK Kit
Testosterone CIK Kit
Vogelxo

Specialty Pharmacy Medications

In our formulary, some medications are classified as specialty medications. These medications are usually used to treat complex health conditions. We've developed a network of specialty pharmacies that are experienced in dispensing these medications. Members are required to fill most specialty medications through one of the pharmacies listed below. However, if a highly specialized medication isn't available at one of our specialty pharmacies, we'll cover the cost of the medication when it's filled at an in-network pharmacy. For a list of specialty medications, see the following pages.

Specialty Network Pharmacy Contact Information

AcariaHealth™
1-866-892-1202
Fax: 1-877-541-1503
acariahealth.com

Accredo®
1-877-988-0058
Fax: 1-800-391-9707
accredo.com

CVS Specialty™
1-866-846-3096
Fax: 1-800-323-2445
cvsspecialty.com

Specialty Network Pharmacy Contact Information for Fertility Medications

Freedom Fertility Pharmacy
1-866-297-9452
Fax: 1-888-660-4283
freedomfertility.com

Metro Drugs
1-888-258-0106
Fax: 1-201-253-1101
metrodrugs.com/fertility

Village Fertility Pharmacy
1-877-334-1610
Fax: 1-866-935-0719
vfppharmacygroup.com

Note: Some medications on this list may also be subject to Step Therapy, Prior Authorization, and/or Quality Care Dosing requirements, or be considered non-covered. Please check the corresponding pages to determine coverage requirements.

This list of Specialty Medications is up to date as of January 1, 2022, and may change from time to time.

For the most current specialty medication and specialty pharmacy network information, use our **Medication Lookup** tool at **bluecrossma.org/medication**.

Specialty Pharmacy Medications

Injectable Medications Required to Be Filled at an In-Network Specialty Pharmacy

Actemra
Acthar
Actimmune
Adakveo
Adriamycin
Adrucil
Alferon-N
Alkeran
Apokyn
Aranesp
Arcalyst
Asceniv
Aveed
Avonex
Avsola
Beleodaq
Berinert
Besponsa
Betaseron
BiCNu
Bivigam
Bleomycin Sulfate
Blincyto
Boniva
Bortezomib
Botox
Busulfex
Bynfezia
Calcium Folinate
Camptosar
Carboplatin
Carimune
Carmustine
Cerezyme
Cimzia
Cinqair
Cinryze
Cisplatin
Cladribine
Copaxone
Cosentyx
Cosmegen
Crysvita
Cuvitru
Cyclophosphamide
Cytarabine
Cytogam
Dacarbazine
Dactinomycin
Daunorubicin HCL
DDAVP
Desmopressin Acetate
Dexrazoxane
Docefrez
Docetaxel
Dupixent
Dysport
Egrifta
Eligard
Ellence
Enbrel
Enspryng
Entyvio
Epirubicin
Epogen
Ethyol
Etopophos
Etoposide
Evenity
Extavia
Fasenra
Faslodex
Fensolvi
Firazyr
Firmagon
Flebogamma
Floxuridine
Fludarabine phosphate
Fluorouracil
Forteo
Fulphila
Fulvestrant
Fuzeon
GamaSTAN
Gammagard
Gammagard Liquid
Gammaked
Gammaplex
Gamunex
Gattex
Gemcitabine
Gemzar
Genotropin
Givlaari
Glatiramer
Glatopa
Granix
Haegarda
Hizentra
Humatrope
Humira
Hycamtin
Hydroxyprogesterone
HyQvia
Ibandronate injection/syringe
Icatibant
Idamycin PFS
Idarubicin
Ifex
Ifosfamide
Ifosfamide/Mesna
Ilaris
Ilumya
Increlex
Inflectra
Intron A
Irinotecan
Istodax
Kalbitor
Kenalog
Kesimpta
Kevzara
Kynamro
Lartruvo
Lemtrada
Leucovorin Calcium
Leukine
Leuprolide Acetate
Levoleucovorin
Lumoxiti
Lupaneta Pack
Lupron Depot
Lupron Depot-Ped
Makena
Mepsevii
Mesna
Mesnex
Methotrexate
Mitomycin
Mitoxantrone
Mozobil
Mustargen
Mylotarg
Myobloc
Naptara
Navelbine
Neulasta
Neupogen
Nexviazyme
Nipent
Nivestym
Norditropin
Norditropin Flexpro
Norditropin Nordiflex
Nplate
Nucala
Nutropin AQ Nuspin
Nyvepria
Ocrevus
Octagam
Octreotide injection
Omnitrope
Oncaspar
Orencia
Otrexup
Oxaliplatin
Paclitaxel
Palynziq
Pamidronate
Pamidronate disodium
Panzyga
Pegasys
Pegasys Proclick
Peg-Intron
Photofrin

Specialty Pharmacy Medications

Plegridy
Privigen
Procrit
Prolia
Radicava
Rebif
RediTrex
Remicade
Renflexis
Retacrit
Revatio
Riabni
Rituxan
Ruconest
Ruxience
Saizen
SaizenPrep
Sandostatin
Sandostatin-LAR
Serostim
Signafor
Signafor LAR
Siliq
Simponi
Simponi Aria
Skyrizi
Somatuline
Somavert
Spinraza
Stelara
Sublocade
Sylatron
Sylvant
Synagis
Takhzyro
Taltz
Taxotere
Tegsedi
Temodar
Teniposide
Tepadina
Tepezza
Teriparatide
Tev-Tropin
TheraCys
Thiotepa
Thyrogen
Toposar
Totect
Trelstar
Trelstar Depot
Trelstar LA
Tremfya
Truxima
Tymlos
Tysabri
Udenyca
Valrubicin
Valstar
Velcade
Vimizim
Vinblastine
Vincristine
Vinorelbine
Vivitrol
Xembify
Xeomin
Xgeva
Xolair
Zaltrap
Zanosar
Zarxio
Ziextenzo
Zilretta
Zinecard
Zoladex
Zomacton
Zorbtive

Injectable Medications That Can Be Filled at Other In-Network Pharmacies

Acetadote
Amondys 45
Arikayce
Benlysta Autoinject/syringe
Bicillin
Bleo 15
Cablivi
Ceftazadime
Cutaquig
Cuvposa
Delestrogen
Depo-Estradiol
Desferal
Desferoxamine
Empaveli
Evkeeza
Evomela
Exondys
Fintepla
Fortaz
Gamifant
Imcivree
Kanuma
Kineret
Libtayo
Marqibo
Nabi-HB
Neulasta Onpro
Nulibry
Onpattro
Oxlumo
Portrazza
Revcovi
Rimso-50
Rocephin
Romidepsin
Sajazir
Saphnelo
Sandimmune
Sildenafil antihypertensive
Strensiq
Synribo
Tazicef
Testosterone Enanthate
Triptodur
Unituxin
Uptravi
Viltepso
Vyepti
Vyleesi
Vyondys-53
Vyxeos
Xiaflex
Yondelis

Oral Medications Required to Be Filled at an In-Network Specialty Pharmacy

Abiraterone
Adcirca
Adempas
Afinitor
Afinitor Disperz
Alecensa
Alkeran
Alunbrig
Alyq
Ambrisentan
Ampyra
Aubagio
Bafiertam
Bethkis
Bosentan
Bosulif
Bronchitol
Bylvay
Cabometyx
Capecitabine
Carbaglu
Cayston
Cerdelga
Copegus
Cotellic
Cyclophosphamide
Cystagon
Daklinza
Dalfampridine
Daurismo
Deferasirox
Dimethyl Fumarate
Dojolvi
Doptelet
Droxidopa
Duopa
Epclusa
Erivedge
Erleada

Specialty Pharmacy Medications

- Erlotinib
- Esbriet
- Etoposide
- Everolimus
- Evrysdi
- Exjade
- Farydak
- Galafold
- Gilenya
- Gilotrif
- Gleevec
- Harvoni
- Hetlioz
- Hetlioz LQ
- Hycamtin
- Ibrance
- Idhifa
- Imatinib
- Inlyta
- Inqovi
- Inrebic
- Iressa
- Jadenu
- Jakafi
- Juxtapid
- Kalydeco
- Kisqali
- Kisqali Femara
- Kitabis PAK
- Kuvan
- Lapatinib
- Ledipasvir/Sofosbuvir
- Lenvima
- Letairis
- Lonsurf
- Lorbrena
- Lumakras
- Mavenclad
- Mavyret
- Mayzent
- Mekinist
- Mesnex
- Miglustat
- Moderiba
- Mulpleta
- Mycapssa DR
- Nerlynx
- Nexavar
- Ninlaro
- Northera
- Nourianz
- Nubeqa
- Nuplazid
- Ocaliva
- Odomzo
- Ofev
- Olumiant
- Olysio
- Onureg
- Opsumit
- Orenitram
- Orkambi
- Otezla
- Otezla Starter Pack
- Oxbryta
- Palforzia
- Piqray
- Pomalyst
- Ponvory
- Procysbi
- Promacta
- Pulmozyme
- Pyrimethamine
- Ravicti
- Rebetol
- Retevmo
- Revatio
- Revlimid
- Ribasphere
- Ribasphere Ribapak
- Ribavirin
- Rilutek
- Riluzole
- Rinvoq ER
- Rozlytrek
- Rubraca
- Rydapt
- Sabril
- Samsca
- Sapropterin
- Sildenafil antihypertensive
- Sofosbuvir/Velpatasvir
- Sovaldi
- Sprycel
- Stivarga
- Sunitinib
- Sutent
- Symdeko
- Tabrecta
- Tadalafil antihypertensive
- Tafinlar
- Tagrisso
- Talzenna
- Tarceva
- Tasigna
- Tecfidera
- Technivie
- Temodar
- Temozolamide
- Tetrabenazine
- Thalomid
- TOBI ampules
- TOBI-Podhaler
- Tobramycin ampules
- Tolvaptan
- Tracleer
- Trikafta
- Tykerb
- Tyvaso
- Uptravi
- Veltassa
- Verzenio
- Viekira PAK
- Viekira XR
- Vigabatrin
- Vitrakvi
- Vizimpro
- Vosevi
- Votrient
- Vumerity DR
- Vyndamax
- Vyndaqel
- Wakix
- Xalkori
- Xeljanz
- Xeljanz XR
- Xeloda
- Xenazine
- Xtandi
- Xyrem
- Zavesca
- Zelboraf
- Zepatier
- Zeposia
- Zolinza
- Zykadia
- Zytiga

Oral Medications That Can Be Filled at Other In-Network Pharmacies

- 8-Mop
- Austedo
- Ayvakit
- Balversa
- Boniva 150mg
- Calquence
- Chenodal
- Cholbam
- Cometriq
- Copiktra
- Daraprim
- DDAVP
- Diacomit
- Emflaza
- Exkivity
- Exservan
- Firdapse
- Fotivda
- Gavreto
- Gocovri ER
- Iclusig
- Imbruvica
- Inbrija
- Ingrezza
- Isturisa
- Jynarque
- Keveyis
- Korlym
- Koselugo

Specialty Pharmacy Medications

- Livmarli
- Lupkynis
- Nityr
- Orfadin
- Orgovyx
- Pemazyre
- Qinlock
- Rezurock
- Ruzurgi
- Sucraid
- Tavalisse
- Tepmetko
- Thiola
- Tiglutik
- Truseltiq
- Tukysa
- Turalio
- Ukoniq
- Venclexta
- Vigadrone
- Vistogard
- Welireg
- Xermelo
- Xospata
- Xpovio
- Xuriden
- Xywav
- Yonsa
- Zejula
- Zokinvy
- Zydelig

Topical Medications Required to Be Filled at an In-Network Specialty Pharmacy

- Mugard
- Oxervate
- Panretin
- Valchlor

Topical Medications That Can Be Filled at Other In-Network Pharmacies

- Cystadrops
- Cystaran
- Qutenza
- Synarel

Fertility Medications Required to be Filled at an In-Network Specialty Fertility Pharmacy

- Bravelle
- Cetrotide
- Clomid
- Clomiphene
- Crinone
- Endometrin
- Follistim AQ
- Ganirelix
- Gonal-F/Gonal-F RFF
- Gonal-F RFF Redi-Ject
- Human Chorionic Gonadotropin (hCG)
- Hydroxyprogesterone
- Leuprolide
- Lupron Depot
- Lupron Depot-Ped
- Luveris
- Makena
- Menopur
- Novarel
- Ovidrel
- Pregnyl
- Serophene

Non-Covered Medications

Your pharmacy program provides coverage for more than 4,000 prescription medications. This section lists medications that aren't covered under your benefits. Most medications on our non-covered list have covered alternatives that have been proven to be equally safe and effective for treating the same medical conditions. If a non-covered medication is approved, it will be covered at the highest tier.

Check with your doctor about appropriate alternatives if you currently take any of these medications. Your doctor may request coverage for a non-covered medication if no covered alternative is appropriate for treating your condition.

Note: Some medications on this list may also be subject to Prior Authorization, Quality Care Dosing and/or Step Therapy requirements, or be considered a specialty medication. Please check the corresponding pages to determine coverage requirements.

This list of non-covered medications is up to date as of January 1, 2022, and may change from time to time.

For the most current list of non-covered medications, and to see covered alternatives, use our **Medication Lookup** tool at **bluecrossma.org/medication**.

Non-Covered Medications

Abilify
Abilify Discmelt
Abilify Mycite
Absorica
Absorica LD
Abstral
Acanya
Accolate
Accucaine
Accu-Chek Diabetic Testing Supplies
Accupril
Accuretic
Aciphex (excluded for 18 years and older)
Acticlate
Actigall
Actiq
Active Injection D
Activella
Active-Pac
ActoPlus Met
ActoPlus Met XR
Acular
Acular LS
Acuvail
Aczone
Adalat CC
Adazin
Adderall
Addyi
Adhansia XR
Adlyxin
Admelog
Advanced Allergy Collection Kit
Advocate Diabetic Testing Supplies
Adyphren
Adzenys XR
Aemcolo DR
Aerospan
Agoneaze
AirDuo DigiHaler
AirDuo RespiClick
Akynzeo
Albuterol HFA (Ventolin Authorized Product)
Alcortin-A
Alveicyn Antipruritic SG gel
Alevicyn Plus Kit
Alinia
Alkindi
Alodox
Alogliptin
Alogliptin/Metformin
Alogliptin/Pioglitazone
Aloquin
Alora
Alphagan P
Alrex
Alsuma
Altabax
Altace
Altoprev
Alvesco
Alzital
Ambien
Ambien CR
Amrix
Amzeeq
Anafranil
Ana-Lex
Angeliq
Anodyne LPT
Antara
Anusol HC suppository
Anzemet
Apadaz
Apidra
Aplenzin
Apriso
Aprizio Pak
Aprizio Pak II
Aptensio XR
Aqua Glycolic HC
Arakoda
Aranesp
Arava
Arazlo
Arcapta Neohaler
Arformoterol
Arimidex
Arixtra
ArmonAir DigiHaler
ArmonAir RespiClick
Aromasin
Arthrotec
Arymo ER
Arze-Ject-A Kit
Asacol HD
Ascensia Test Strips
Asmanex HFA
Asmanex Twisthaler
Aspirin/Omeprazole (excluded for 18 years and older)
Assure Diabetic Testing Supplies
Astepro
Atacand
Atacand HCT
Atelvia
Ativan
Atopaderm
Atopavo
Atopiclair
Atralin
Atrapo Dermal Spray
Atrapro CP
Atrapro Hydrogel
Atropen
Augmentin XR
Auryxia
Auvi-Q
Avalide
Avapro
Avelox
Avidoxy
Avidoxy DK
Avita
Axert
Azasite
Azeschew
Azesco
Azopt
Azor
Azstarys
Balcoltra
Basadrox
B-D Testing Strips
Belsomra
Benicar
Benicar HCT
Benzaclin
Benzaclin Kit
Benzhydrocodone/Acetaminophen
Benzonatate 150mg
Beser
Besivance
Betaloan Suik
Betimol
Betoptic S
Bevespi Aerosphere
Bg-Star Diabetic Testing Supplies
Bijuva
Binosto
Bionect
Boniva
Bravelle
Breo Ellipta
Brevicon
Brexafemme
Brilinta
Brisdelle
Bromsite
Brovana
BSP 0820
Brylhali
Budesonide/Formoterol (Symbicort Authorized Product)
Bunavail
Bystolic
Byvalson
Caduet
Calcipotriene Foam (Sorilux Authorized Product)
Calcitriol Topical
Cambia Powder
Caphosol
Caplyta

Non-Covered Medications

Capsfenac
Capxib
Carac
Cardene
Cardizem CD
Cardizem LA
Cardura XL
Careone Diabetic Testing Supplies
Caresens Diabetic Testing Supplies
Caretouch Diabetic Testing Supplies
Cataflam
Cedax
Celexa
Cem-Urea
Centany
Centany AT
Cequa
Ceracade Skin Barrier
Ceramax
Cesamet
Cetraxal
Chenodal
Chorionic Gonadotropin
Cialis
Cipro XR
Clenia Plus
Clenpiq
Cleocin T
Clever Choice Diabetic Testing Supplies
Clindcin ETZ Kit
Clindacin PAC
Clindagel
Clindavix
Clobetavix
Clobex
Clodan Kit
Colazal
Colchicine Capsules
Colcrys
Colyte
Combigan
Conjupri
Consensi
Contour Diabetic Testing Supplies
Conzip
Cool Diabetic Testing Supplies
Copaxone
Coreg
Coreg CR
Corlanor
Cosentyx
Cosopt PF
Contempla XR ODT
Cozaar
Crestor
CVS Advanced Diabetic testing supplies
Cyclobenzaprine 7.5mg
Cyclopak Kit
Cymbalta
Daklinza
Daliresp
Dapsone 7.5%
Daxbia
Daypro
Daytrana
D-Care 100X
DDAVP
Deluo
Delzicol
Delzicol XR
Depakote
Depakote ER
Depakote Sprinkle
Depo-Sub Q Provera 104
Derma-Smoothe/FS Body Oil
Derma-Smoothe/FS Scalp Oil
Dermacin Silazone Pharmapak
Dermacin Cinolone-1 CPI
DermacinRx Clorhexacin
DermacinRx Empricaine
DermacinRx PHN
DermacinRx Prenatrix
DermacinRx Prenatryl
DermacinRx Pretrate
DermacinRx Prizopak
DermacinRx Silapk
DermacinRx Surgical Pharmpak
DermacinRx Therazole Pak
DermacinRx ZRM
Dermalid
Dermasorb-AF
Dermasorb-HC
Dermasorb-TA
Dermasorb-XM
Dermawerx SDS
Dermawerx Surgical Plus Pack
Dermazone
Dermazyl
Dermotic
Desowen Kit
Desvenlafaxine ER
Detrol
Detrol LA
Dexedrine
Dexilant (Kapidex) (excluded for 18 years and older)
Diclo Gel
Diclofenac Epolamine
Diclofenac Potassium 25mg
Diclofenac Submicronized
Diclofono
Dicloheal-60
Diclopak
Diclopr Combo Pack
Diclotral
Diclotrex
Diclovix
Diclovix M
Diclo-Xrylix Sheet Kit
Diclozor
Differin
Dificid
Dilaudid
Dimentho
Diovan
Diovan HCT
Dipentum
Dithol Combo Pack
Ditropan XL
Divigel
DM2 kit
DMT Suik
Dolotranz
Doryx DR 80mg
Doubledex
Doxycycline DR 80mg
Doxycycline DR 200mg
Doxycycline Hyclate 50mg tablets
Drizalma Sprinkle
Duac
Duac CS
Duaklir Pressair
Duavee
Duexis
Duobrii
Duragesic
Durezol
Durlaza
Durolane
Duzallo
Dyloject
Easy Step Diabetic Testing Supplies
Easy Talk Diabetic Testing Supplies
Easy Touch Diabetic Testing Supplies
Easy Trak Diabetic Testing Supplies
Easymax Diabetic Testing Supplies
EC-Naprosyn
Econasil
Edarbi
Edarbyclor
Edluar
Effexor
Effexor XR
Elepsia XR
Elestrin
Eletone
Ellzia
Embeda

Non-Covered Medications

- Embrace Diabetic Testing Supplies
- Empraciane II
- Emsam
- Enablex
- Entresto
- Epaned
- Epiceram
- Epiduo
- Epiduo Forte
- Epinephrine Autoinject (Amneal Authorized Product For Adrenaclick)
- Epinephrine Snap-V
- Episil
- Episnap Convenience Kit
- Epogen
- EQ Diabetic Testing Supplies
- Equetro
- Ertaczo
- Esomeprazole Stronum (excluded for 18 years and older)
- Esomeprazole-EZS Kit (excluded for 18 years and older)
- Estrace
- Estrogel
- Eucrisa
- Euflexxa
- Evamist
- Evekeo
- Evencare Diabetic Tetsing Supplies
- Evoclin
- Exactech Diabetic Testing Supplies
- Exalgo
- Exforge
- Exforge HCT
- Exservan
- Extavia
- Extina
- EZ Use Joint Tunnel-Trigger
- Ezallor Sprinkle
- Fabior
- Factive
- Fanapt
- Fazaclo
- Femring
- Fenofibrate 50mg
- Fenofibrate 150mg
- Fenoglide
- Fentanyl Citrate
- Fentora
- Fetzima
- Fexmid
- Fiasp
- Fibricor
- Fifty50 Diabetic Testing Supplies
- Finacea Plus
- Fiorinal
- Fiorinal /Codeine #3
- Flagyl
- Flagyl ER
- Flagyl I.V.
- Flagyl I.V. RTU Vialflex
- Flarex
- Flector
- Flexipak
- Flolipid
- Fluopar
- Fluoroplex
- Fluovix
- Fluovix Plus
- Fluoxetine Tablets
- FML Forte
- FML Liquifilm
- FML S.O.P.
- Focalin
- Focalin XR
- Follistim
- Fora Diabetic Testing Supplies
- Forfivo XL
- Fortamet
- Fortesta
- Fortiscare Diabetic Testing Supplies
- Fosamax
- Fragmin
- Freestyle Diabetic Testing Supplies
- Frova
- Fusilev I.V.
- Gabacaine
- Gabapal
- Ganirelix
- GE 110 Diabetic Testing Supplies
- Gelclair
- Gelnique
- Gel-One
- Gelsyn-3
- Gelx
- Genotropin
- Genstrip Diabetic Testing Supplies
- Geodon
- Gialax
- Giazo
- Gimoti
- Gleevec
- Gloperba
- Glucocard Diabetic Testing Supplies
- Glucometer Diabetic Testing Supplies
- Glucophage
- Glucophage XR
- Glumetza
- Gmate Diabetic Testing Supplies
- Gnp Diabetic Testing Supplies
- Gocovri ER
- Golytely
- Halobetasol Foam
- Harmony Diabetic Testing Supplies
- Healthpro Diabetic Testing Supplies
- Helidac Therapy Pak
- Hemady
- Horizant
- HPR
- HPR Plus
- HPR Plus Hydrogel
- Humana True Metrix Diabetic Testing Supplies
- Hyalgan
- Hydrocodone ER (persion Pharmaceuticals)
- Hydrocortisone-Lidocaine
- Hylaguard
- Hylatopic
- Hylatopic Plus
- Hylatopic Plus-Aurstat
- Hymovis
- Hysingla ER
- Hyzaar
- Ibupak
- Ibuprofen/Famotidine
- Iglucose Diabetic Testing Supplies
- Ilevro
- Imitrex Kit Refill
- Imitrex Pen Injector
- Imitrex Vial
- Impeklo
- Imvexxy
- Inavix
- Inderal LA
- Inderal XL
- Indomethacin 20Mg (Branded Product)
- Inflamma-K
- Inflatherm
- Innopran XL
- Insulin Aspart
- Insulin Glargine
- Insulin Lispro
- Insulin Lispro Jr.
- Insulin Lispro Mix 75-25
- Intermezzo
- Intuniv
- Invega
- Inveltys
- Invokana
- Invokamet
- Invokamet XR
- Irenka DR
- Istalol
- Jentadueto
- Jentadueto XR
- Journay PM
- Jublia
- Kadian
- Kapvay

Non-Covered Medications

Kapzin DC
Kaspargo Sprinkle
Katerzia
Kazano
Keppra
Keppra XR
Keralyt Scalp 6% Kit
Kerydin
Ketoprofen 25mg
Ketorolac Nasal Spray (Branded Product)
Khedezla
Kitabis Pak
Klonopin
Krintafel
Kiristalose
KRO premium Diabetic supplies
Kuvan
Lamictal
Lamictal ODT
Lamictal XR
Lamisil
Lamisil Granules
Lancet Diabetic Testing Supplies
Latuda
Lazanda
Ledipasvir/Sofosbuvir
Lemtrada
Lescol
Lescol XL
Leva Set
Levalbuterol HFA
Levaquin
Levemir
Levicyn Antipruritic SG
Levitra
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Maxidex
Maxipime
Mb Hydrogel
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Medroloan Suik
Megace ES
Menostar
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- Oxytrol
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- Panixine
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- P-Care M
- P-Care MG
- P-Care X
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- PCE Dispertab
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- Penetrex
- Penlac
- Pennsaicin
- Pennsaid
- Pentican
- Pepcid
- Percocet
- Pergonal
- Perseris
- Pertzye
- Pexeva
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- Physicians USE EZ M-Pred Kit
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- Plaquenil
- Plixda
- PNV 20-1
- Pod-Care 100C
- Pod-Care 100CG
- Pod-Care 100K
- Pod-Care 100KG
- Pogo Diabetic Testing Supplies
- Pradaxa
- Pram-HCA
- Pramosone E
- Pravachol
- PR-Cream
- Precision Diabetic Testing Supplies
- Pred Mild
- Prefest
- Pregnyl
- Premium Diabetic Testing Supplies
- Prepopik
- Presera
- Prestalia
- Prestige Diabetic Testing Supplies
- Prevacid (excluded for 18 years and older)
- Prevpac
- Prikaan
- Prilo Patch Kit
- Prilo Patch II Kit
- Prilolid
- Prilosec (excluded for 18 years and older)
- Prilovix
- Prilovixil
- Prinivil
- Pristiq
- Prozopak II
- Prizotral
- Prizotral II
- ProAir DigiHaler
- ProAir HFA
- ProAir RespiClick
- Procentra
- Procort
- Procrit
- Prodigy Diabetic Testing Supplies
- Prolensa
- Promiseb
- Protonix (excluded for 18 years and older)
- Proventil HFA
- Proventil Inhaler
- Provigil
- Pro-Voice Diabetic Testing Supplies
- Prozac
- Prozac Weekly
- Pylera
- Qbrelis
- Qbrexza
- Qdolo
- Qmiiz ODT
- Qtern
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- Readysharp Bupivicaine
- Readysharp Dexamethasone
- Readysharp Ketorolac
- Readysharp Lidocaine
- Readysharp Methylprednisolone
- Readysharp Triamcinolone
- Realheal-1
- Recothrom
- Reditrex
- Regenecare
- Relador PAK
- Relador PAK Plus
- Relafen DS
- Relexxii ER
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- Remeron Soltab
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- Retin-A Cream
- Retin-A Micro

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Roszet
Roxybond
Rytary ER
Rythmol
Ryvent
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Salicylic Acid 6% Kit
Salicylic Acid/Ceramide Kit
Salkera
Salvax Duo
Salvax Duo Plus
SanadermRx Skin Repair
Sancuso
Saphris
Sarafem
Savaysa
Savella
Scalacort
Seasonique
Sebuderm
Secuado
Seebri Neohaler
Segluromet
Sernivo
Seroquel
Seroquel XR
Seysara
Sila III
Silalite Pak
Silazone-II
Silenor
Silvrstat
Simbrinza
Simvastatin Suspension (Flolipid Authorized Product)
Sinemet 25/100
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Sitavig
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SmartRx Gabakit
SmartRx Gaba-V
Sodium Hyaluronate
Sofosbuvir/Velpatasvir
Sof-Tact Diabetic Testing Supplies
Solaice
Solaravix
Solaraze
Soliqua
Solodyn
Solosec
Soltamox
Solupak
Solus Diabetic Testing Supplies
Soma
Sonata
Soolantra
Sovaldi
Spectracef
Sporanox
Spritam
Sprix
Stalevo
Staxyn
Steglatro
Steglujan
Stendra
Striant
Suboxone
Subsys
Suclear
Sular
Sumadan
Sumavel Dosepro
Sumaxin
Sumaxin CP
Sumaxin TS
Supartz
Suprep
Sure Result Tac Pak
Sustol
Suvicort
Sympazan
Symproic
Synalar Combo-Pack
Synalar TS
Synvexia TC
Synvisc
Synvisc-One
Talcia DR
Tanzeum
Targadox
Tarka
Tasoprol
Tavaborole
Taytulla
Tazorac
Tecfidera
Technivie
Teczem
Tekturna
Tekturna HCT
Tenormin
Tequin
Teriparatide
Tersi
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Testosterone (Vogelxo Authorized Product)
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Testosterone Gel (Fortesta Authorized Product)
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Tiazac
Timoptic
Timoptic Ocudose
Tindamax
Tirosint
Tivorbex
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Tolak
Tolsura
Topamax
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Toronova Suik
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Toviaz
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Trezix
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Triamcinolone 0.05%
Trianex
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Tricor
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Trileptal
Trilipix
Trilipx DR
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Triloan Suik
TriloCiclo Kit
Triluron
Trinaz
Tri-Norinyl
Trintellix (Formerly Brintellix)
Tritocin
Tri-Sila Topical
Trivisc
Trivix
Trixylitral
Trudhesa

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- Truetest Diabetic Testing Supplies
- Truetrack Diabetic Testing Supplies
- Trulance
- Twynsta
- Ultracet
- Ultram
- Ultram ER
- Ultrasal ER
- Ultravate PAC
- Ultravate X
- Unistrip Diabetic Testing Supplies
- Up & Up Diabetic Testing Supplies
- Uramaxin
- Urea Kit
- Utibron Neohaler
- Vacustim Silver Kit
- Valium
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- Vascepa
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- Vectical
- Velphoro
- Veltassa
- Veltin
- Venlafaxine ER Tablets
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- Ventolin HFA
- Verasens Diabetic Testing Supplies
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- Viberzi
- Victoza
- Viekira
- Viekira PAK
- Vigamox
- Viibryd
- Vimovo
- Virasal
- Visco-3
- Vivaguard Ino Diabetic Testing Supplies
- Vivlodex
- Vogelxo
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- Voltaren-XR
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- Welchol
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- Wellbutrin SR
- Wellbutrin XL
- Whytederm Surgipak
- Whytederm Trilasil Pak
- Winlevi
- Wound Debride 4% Lidocaine
- WPR Plus
- Wynzora
- Xadago
- Xalix
- Xanax
- Xanax XR
- Xartemis XR
- X-Clair
- Xelpros
- Xepi
- Xerese
- Xifaxan
- Xilapak
- Ximino ER
- Xolegel
- Xopenex HFA
- Xopenex Nebules
- Xryliderm
- Xrylix
- Xultophy
- Xyosted
- Xywav
- Yosprala DR
- Yupelri
- Zagam
- Zanaflex
- Zantac
- Zegerid (excluded for 18 years and older)
- Zelapar
- Zelnorm
- Zembrace Symtouch
- Zepatier
- Zestril
- Zetia
- Zeyocaine
- Ziana
- Zilacaine
- Zilxi
- Zinbryta
- Zioptan
- Zipsor
- Zithromax
- Zmax
- Zocor
- Zofran
- Zofran ODT
- Zohydro ER
- Zoloft
- Zolpak
- Zolpimist
- Zomacton
- Zomig
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- Zonegran
- Zontivity
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- Ztlido
- Zubsolv
- Zuplenz
- Zurampic
- Zyban
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- Zyflo
- Zyflo CR
- Zylet
- Zymaxid
- Zypitamag
- Zypram
- Zyprexa
- Zyprexa Intramuscular
- Zyprexa Relprevv
- Zyprexa Zydis

How to Request Coverage for Non-Covered Medications

To request coverage for non-covered medications, your doctor will need to contact our Pharmacy Operations department using one of the following methods, and provide the Massachusetts Standard Form for Medication for Prior Authorization Requests, along with any additional supporting documentation:

Phone
1-800-366-7778

Fax
1-800-583-6289

Phone and fax are recommended for faster service.

Mail
Blue Cross Blue Shield of Massachusetts
Pharmacy Operations Department
25 Technology Place
Hingham, MA 02043

Turnaround Time

Standard requests are reviewed within 48 hours of receipt. In certain life-threatening situations, your doctor may request an expedited review, which we'll respond to within 24 hours of receipt.

Criteria for Exception Requests

We may authorize coverage based on one of the following criteria:

- You have documented treatment failures with two covered medications.*
- You have documented adverse effects to two covered medications, which are significant enough to stop taking the medication.
- There is another specified clinical basis.

Note: If a non-covered medication is approved, it will be covered at the highest tier, and you'll pay the highest out-of-pocket costs for the medication.

*Or if there is only one covered alternative available for the requested medication, and the alternative medication fails.

Appealing a Coverage Decision

A coverage decision is a ruling we make about your health care and pharmacy coverage, or the amount of money we pay for health care services and medications. In some cases, we may decide that a service or medication isn't covered, or is no longer covered for you. If you're not satisfied with a coverage decision, you, your doctor, or an authorized representative can appeal the decision within 180 days of the date of the service, or when you receive a notice of the decision, by contacting the Member Appeal and Grievance Program by:

Phone
1-800-472-2689

Fax
1-617-246-3616

Email
grievances@bcbsma.com

Phone and fax are recommended for faster service.

Mail
Blue Cross Blue Shield of Massachusetts
Member Appeal and Grievance Program
One Enterprise Drive
Quincy, MA 02171-2126

What Happens When an Appeal Is Denied

If your appeal is denied in part or in full, we'll contact you to explain how we reached our decision. We'll also inform you if your appeal qualifies for an external review, and the steps you should take to file the request.

To read your full appeal and grievance rights, please refer to your Evidence of Coverage.

For more information:

1. Visit **bluecrossma.org**
2. Go to **Member Rights** at the bottom of the page
3. Click **Appeals & Grievances**

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This index is a list of the medications referenced in this guide.

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New Medication Approval Process

Our Pharmacy and Therapeutics Committee (the Committee), which is made up of pharmacists and doctors with various specialty backgrounds, reviews the effectiveness and overall value of new medications approved by the FDA on an ongoing basis. The Committee's expertise and advice help us give our members prescription drug options that meet their medical needs and achieve desired treatment goals. Approved medications are added to our list as they're approved by the Committee throughout the year.

While under review, new medications won't be covered by your plan. As with other medications that aren't covered, your doctor may request coverage when medically necessary. If a non-covered drug is approved, it will be covered at the highest tier.

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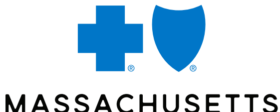

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24/7 NURSE LINE

VIDEO DOCTOR VISIT

DOCTOR'S OFFICE

LIMITED SERVICE CLINICS

URGENT CARE

Learn More

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24/7 NURSE LINE

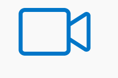
When you're uncertain if your symptoms are serious or if an injury needs immediate care, get a nurse's advice 24/7, even on holidays. And get answers at no additional cost to you. Speak to a registered nurse. Call 1-888-247-BLUE (2583).

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

Cost:

Time:

Severity:



VIDEO DOCTOR VISIT

See a licensed doctor online in real time, without leaving home. Doctors on call on your device visit wellconnection.com.

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

Cost:

Time:

Severity:

DOCTOR'S OFFICE

Go to your doctor's office for scheduled checkups and for urgent health concerns that occur during office hours. Use Find a Doctor & Estimate Costs at bluecrossma.org.

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

Cost:

Time:

Severity:

LIMITED SERVICE CLINICS

Go to a nearby clinic located within your local pharmacy for simple medical concerns.

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

Cost:

Time:

Severity:

URGENT CARE

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

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

Cost:

Time:

Severity:

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

The information in this document doesn't replace the advice of a health care provider. You should speak to your provider about any specific health concerns.

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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**).

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PHARMACY PROGRAM

SAVE TIME AND MONEY WITH $9 GENERIC MEDICATIONS

You can pay just $9 for certain generic medications when you order a 90-day supply through our mail order pharmacy.

Express Scripts®', an independent company that administers your pharmacy benefit on behalf of Blue Cross Blue Shield of Massachusetts, will deliver your prescriptions straight to your door at no additional cost. With fewer refills and no trips to the pharmacy, you'll be less likely to miss a dose, making it the most convenient and inexpensive way to get your medications.

Program Highlights

- Get a 90-day supply for $9
- Delivered to your door at no additional cost for standard shipping
- Fewer refills

See the Full List of $9 Generic Medications

1. Visit MyBlue at **bluecrossma.com/pharmacy**
2. Go to the **Mail Order Pharmacy** page
3. Click **View a list of $9 medications**

29% COST SAVINGS FOR EMPLOYEES, WHEN COMPARED TO RETAIL PHARMACIES[1]

TWO EASY WAYS TO GET HOME DELIVERY

Visit **express-scripts.com/starthd**

Call **1-800-892-5119**

1. Average percentage savings figure based on analysis of actual January–March 2012 claims for clients with a retail pharmacy and mail pharmacy benefit, excluding Medicare clients and clients participating in mandatory mail programs. Savings may vary based on your plan design.

Questions?

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

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DENTAL BLUE® QUICK-START GUIDE

Dental Blue 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, please refer to your subscriber certificate.

If you need help understanding your plan, or if you have any questions, call Member Service at the 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)..

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. Please 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.

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

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 in out-of-pocket costs.

Dental Blue PPO

You'll get better rates for services when you see one of our 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 our 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

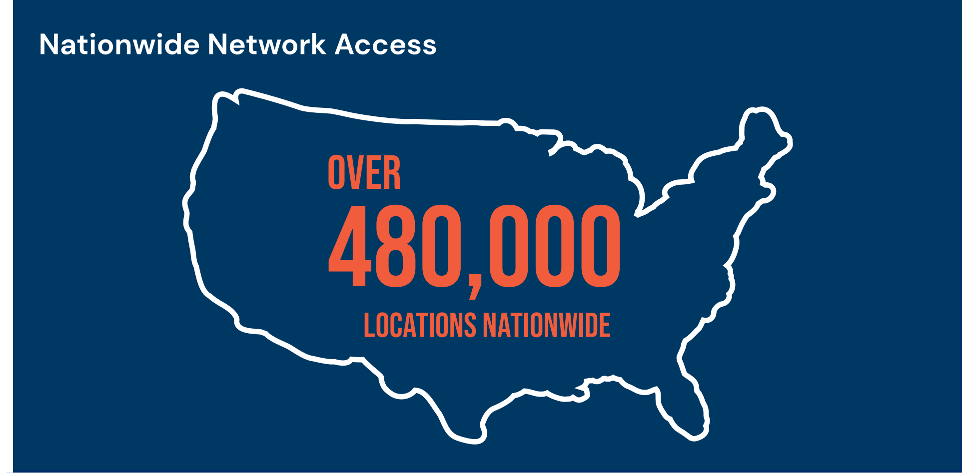
Dental Blue

Our traditional network offers access to more than 95 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.

Nationwide Network Access



Plan Name	Network Coverage			
	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	•	•	•	•

*Refer to your subscriber certificate to see if you have out-of-network options.

Your Claims

Participating Dentists

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

Non-Participating Dentists

If a dentist doesn't file the claim, download our dental claim form at **bluecrossma.org**.

Mail the completed form to:

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

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

- Call Member Service at the number on the front of your ID card
- Sign in to your MyBlue account at **bluecrossma.org**

Visit Dentists in Our Network

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

FOR MORE INFORMATION

Member Service

For general questions about your coverage, call Member Service at the number on the front of your ID card, Monday through Friday, 8:00 a.m. to 6:00 p.m. ET (TTY: **711**).

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

Visit **bluecrossma.com/findadoctor**, or call Member Service at the number on the front of your ID card. For questions about out-of-country provider access and services, call **1-800-810-BLUE (2583)**.

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, call Member Service at the number on the front of your ID card, or sign in to MyBlue at **bluecrossma.org**.

MyBlue

MyBlue is your key to more features and savings. Plus, up-to-date status for claims, your deductible, account balances, dentists, and other providers in your network. Learn more at **bluecrossma.org**. The MyBlue app is available on the Apple Store or Google Play.

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 online Find a Doctor & Estimate Costs tool at **bluecrossma.org** to search for dentists and other specialty providers that participate in your plan. Sign in for 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 more than 480,000 credentialed provider locations nationwide. To find a dentist, visit **bluecrossma.org**.

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**, reviewing your subscriber certificate, or by calling 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, you can sign in to MyBlue at **bluecrossma.org** for access to tools and resources that help you monitor your dental claims. You can also 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. An exception is when a member is also enrolled in our condition-specific Enhanced Dental Benefits program. Under this program, deductibles and co-insurance don't apply to condition-specific services provided in addition to dental benefits already covered by your plan. Condition-specific services are also excluded from the calendar-year maximum. Call Member Service at the number on the front of your ID card for more information.

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**).

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DENTAL BLUE® ACCUMULATED MAXIMUM ROLLOVER

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

HOW MAXIMUM ROLLOVER WORKS

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

There is no cost to you. You don't need to do anything. To figure out the amount of benefit dollars that are eligible to roll over, just use the chart below. Start by searching for your benefit period maximum in the first column. If Blue Cross doesn't pay out more claims dollars on your behalf than the amount in the second column, your benefit maximum for the next year will increase by the amount in the third column.

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

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

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

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

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

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DENTAL BLUE®
ENHANCED DENTAL BENEFITS

Additional Support for Members with Qualifying Conditions

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

Condition	One cleaning or periodontal maintenance, 4 per calendar year[1]	Periodontal scaling, once per quadrant every 24 months[1]	Oral cancer screening, twice per calendar year	Fluoride treatment, 4 per calendar year
DIABETES	✓	✓		
CORONARY ARTERY DISEASE	✓	✓		
STROKE	✓	✓		
PREGNANCY	✓	✓		
ORAL CANCER	✓		✓	✓
SJÖGREN'S SYNDROME	✓		✓	✓

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

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

NO ADDITIONAL COST TO RECEIVE THESE EXTRA SERVICES*

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

*Qualifying members only.

Questions?

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

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ENHANCED DENTAL BENEFITS ENROLLMENT FORM

Dear Physician:

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

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

Please check qualifying medical conditions:

❑ Diabetes ❑ Coronary Artery Disease ❑ Stroke ❑ Oral Cancer ❑ Sjögren's Syndrome
❑ Pregnancy (Expected date of birth ___/___/____)

Subscriber/Member Information

Subscriber Name		Member Name		Date of Birth ___/___/____
Member Address		City	State	ZIP Code
Member Telephone # (Home)		Member Telephone # (Other)		
Blue Cross Blue Shield of Massachusetts Dental ID #				

Physician Information

I hereby confirm that my patient has been diagnosed with the conditions listed above. Physician Signature		Date ___/___/____
Physician Name (please print, circle MD or DO) MD/DO	License #	State
Physician Address	Physician Telephone #	

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

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

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Blue MedicareRx℠ (PDP)

2022 SUMMARY OF BENEFITS

Blue MedicareRx (PDP)

EMPLOYER GROUP MEDICARE PRESCRIPTION DRUG PLAN
WITH SUPPLEMENTAL COVERAGE: $10 / $20 / $35

Option 26

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

SUMMARY OF BENEFITS

January 1, 2022 - December 31, 2022

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

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

For More Information

Hours of Operation

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

Blue MedicareRx Phone Numbers and Website

Please call Blue MedicareRx for more information about our plan.

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

Prospective Members, please contact your benefits administrator.

Visit us at **groups.rxmedicareplans.com**.

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

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

Who can join?

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

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

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

Which drugs are covered?

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our Document portal at: mydocumentsource.memberdoc.com. Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

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

Which pharmacies can I use?

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

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

SUMMARY OF BENEFITS

January 1, 2022 – December 31, 2022

Prescription Drug Benefits

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

Initial Coverage		You pay the following until your total yearly drug costs reach $4,430[1]:	
Standard Retail Cost Sharing		One-month supply	Three-month supply[2]
Tier 1	Generic	$10	$30
Tier 2	Preferred Brand	$20	$60
Tier 3	Non-Preferred Drug	$35	$105
		Specialty drugs are limited to a one-month supply per fill.	
Mail Order Cost Sharing		One-month supply	Three-month supply
Tier 1	Generic	$10	$20
Tier 2	Preferred Brand	$20	$40
Tier 3	Non-Preferred Drug	$35	$70
		Specialty drugs are limited to a one-month supply per fill.	

Coverage Gap	After your total yearly drug costs reach $4,430, your former employer provides supplemental coverage that will keep your copayments and/or coinsurance as outlined above. Your copayments and/or coinsurance will not change until you qualify for Catastrophic Coverage.

Catastrophic Coverage	After your yearly out-of-pocket drug costs reach $7,050, you pay:
Generic (including brand drugs treated as generic)	$3.95
All other Drugs	$9.85

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

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

GENERAL INFORMATION

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

Certain prescription drugs will have maximum quantity limits.

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

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

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

Medicare Coverage Gap Discount Program

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

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

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

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

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

Blue MedicareRx:

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

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

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

Blue MedicareRx (PDP)
Grievance Department Coordinator
P.O. Box 30016
Pittsburgh, PA 15222-0330
Phone: **1-866-884-9478**
Fax: **1-866-217-3353**

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

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **ocrportal.hhs.gov/ocr/portal/lobby.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, **800-537-7697** (TDD)

Complaint forms are available at **hhs.gov/ocr/office/file/index.html**.

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

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

Visit us at groups.rxmedicareplans.com.

Customer Care Hours:

24 hours a day, 7 days a week

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

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

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Blue MedicareRx℠ (PDP) 3 Tier Select 2022 Formulary (List of Covered Drugs)

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

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

Note to existing members: This formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take.

When this drug list (formulary) refers to "we," "us," or "our," it means Blue MedicareRx℠ (PDP). When it refers to "plan" or "our plan," it means Blue MedicareRx.

This document includes a list of the drugs (formulary) for our plan which is current as of January 1, 2022. For an updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2023, and from time to time during the year.

S2893_2111_GRP_C
09/13/2021

What is the Blue MedicareRx Formulary?

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

Can the Formulary (drug list) change?

Most changes in drug coverage happen on January 1, but Blue MedicareRx may add or remove drugs on the Drug List during the year, move them to different cost sharing tiers, or add new restrictions. We must follow the Medicare rules in making these changes.

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

New generic drugs. We may immediately remove a brand name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost sharing tier or add new restrictions. If you are currently taking that brand name drug, we may not tell you in advance before we make that change, but we will later provide you with information about the specific change(s) we have made.

- If we make such a change, you or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. The notice we provide you will also include information on how you may take to request an exception, and you can also find information in the section below titled "How do I request an exception to the Blue MedicareRx Formulary?"

Drugs removed from the market. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.

Other changes. We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to market to replace a brand name drug currently on the formulary; or add new restrictions to the brand name drug or move it to a different cost sharing tier, or both. Or we may make changes based on new clinical guidelines. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 30-day supply of the drug. The enclosed formulary is current as of January 1, 2022.

- If we make these other changes, you or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find the information in the section below entitled "How do I request an exception to the Blue MedicareRx Formulary?

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2022 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2022 coverage year except as described above. This means these drugs will remain available at the same cost sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs.

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

How do I use the Formulary?

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

Medical Condition

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

Alphabetical Listing

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

What are generic drugs?

Blue MedicareRx covers both brand name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand name drug. Generally, generic drugs cost less than brand name drugs.

Are there any restrictions on my coverage?

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

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

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

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

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

You can ask Blue MedicareRx to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, "How do I request an exception to the Blue MedicareRx formulary?" on page III for information about how to request an exception.

What if my drug is not on the Formulary?

If your drug is not included in this formulary (list of covered drugs), you should first contact Customer Care and ask if your drug is covered.

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

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

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

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

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

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

You can ask us to cover a drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost sharing level, and you would not be able to ask us to provide the drug at a lower cost sharing level.

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

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

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

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

You should contact us to ask us for an initial coverage decision for a formulary, tiering or utilization restriction exception. **When you request a formulary, tiering or utilization restriction exception you should submit a statement from your prescriber or physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get a supporting statement from your doctor or other prescriber.

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

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

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

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

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

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

For more information

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

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

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day/7 days a week. TTY/TDD users should call 1-877-486-2048. Or, visit www.medicare.gov.

Blue MedicareRx Formulary

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

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

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

- B/D stands for drugs covered under Medicare Part B or D.
- QL stands for Quantity Limits.
- PA stands for Prior Authorization.
- ST stands for Step Therapy.
- 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.
- 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.

Drug Name	Drug Tier	Requirements/ Limits
ANALGESICS		
GOUT		
allopurinol (generic of ZYLOPRIM) TABS 100mg, 300mg	Tier 1	
colchicine (generic of COLCRYS) TABS .6mg QL (120 tabs / 30 days)	Tier 3	QL
colchicine w/ probenecid tab 0.5-500 mg	Tier 2	
MITIGARE CAPS .6mg QL (60 caps / 30 days)	Tier 2	QL
probenecid TABS 500mg	Tier 2	
NSAIDS		
celecoxib (generic of CELEBREX) CAPS 50mg QL (240 caps / 30 days)	Tier 2	QL
celecoxib (generic of CELEBREX) CAPS 100mg QL (120 caps / 30 days)	Tier 2	QL
celecoxib (generic of CELEBREX) CAPS 200mg QL (60 caps / 30 days)	Tier 2	QL
celecoxib (generic of CELEBREX) CAPS 400mg QL (30 caps / 30 days)	Tier 2	QL
diclofenac potassium TABS 50mg QL (120 tabs / 30 days)	Tier 2	QL
diclofenac sodium TB24 100mg	Tier 2	
diclofenac sodium TBEC 25mg, 50mg, 75mg	Tier 1	
ec-naproxen (generic of EC-NAPROSYN) TBEC 375mg QL (120 tabs / 30 days)	Tier 1	QL
ec-naproxen (generic of EC-NAPROSYN) TBEC 500mg QL (90 tabs / 30 days)	Tier 3	QL
flurbiprofen TABS 100mg	Tier 2	
ibu TABS 600mg, 800mg	Tier 1	
ibuprofen SUSP 100mg/5ml	Tier 2	
ibuprofen TABS 400mg, 600mg, 800mg	Tier 1	
meloxicam (generic of MOBIC) TABS 7.5mg, 15mg	Tier 1	
nabumetone TABS 500mg, 750mg	Tier 1	
naproxen TABS 250mg, 375mg	Tier 1	
naproxen (generic of NAPROSYN) TABS 500mg	Tier 1	
naproxen (generic of EC-NAPROSYN) TBEC 375mg QL (120 tabs / 30 days)	Tier 1	QL
naproxen (generic of EC-NAPROSYN) TBEC 500mg QL (90 tabs / 30 days)	Tier 3	QL
sulindac TABS 150mg, 200mg	Tier 1	
OPIOID ANALGESICS, LONG-ACTING		
fentanyl PT72 12mcg/hr, 25mcg/hr, 50mcg/hr, 75mcg/hr, 100mcg/hr QL (10 patches / 30 days)	Tier 3	QL PA
hydrocodone bitartrate (generic of HYSINGLA ER) T24A 20mg, 30mg, 40mg, 60mg, 80mg, 100mg, 120mg QL (30 tabs / 30 days)	Tier 2	QL PA
HYSINGLA ER T24A 20mg, 30mg, 40mg, 60mg, 80mg, 100mg, 120mg QL (30 tabs / 30 days)	Tier 2	QL PA
methadone hcl SOLN 5mg/5ml, 10mg/5ml QL (450 mL / 30 days)	Tier 2	QL PA
methadone hcl TABS 5mg, 10mg QL (90 tabs / 30 days)	Tier 2	QL PA
methadone hydrochloride i (generic of METHADOSE) CONC 10mg/ml QL (90 mL / 30 days)	Tier 2	QL PA

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

Drug Name	Drug Tier	Requirements/ Limits
morphine sulfate TABS 15mg, 30mg QL (180 tabs / 30 days)	Tier 2	QL
nalbuphine hcl SOLN 10mg/ml, 20mg/ml	Tier 3	
oxycodone hcl SOLN 5mg/5ml QL (900 mL / 30 days)	Tier 3	QL
oxycodone hcl (generic of ROXICODONE) TABS 5mg, 15mg, 30mg QL (180 tabs / 30 days)	Tier 2	QL
oxycodone hcl TABS 10mg, 20mg QL (180 tabs / 30 days)	Tier 2	QL
oxycodone w/ acetaminophen tab 2.5-325 mg (generic of PERCOCET) QL (360 tabs / 30 days)	Tier 2	QL
oxycodone w/ acetaminophen tab 5-325 mg (generic of PERCOCET) QL (360 tabs / 30 days)	Tier 2	QL
oxycodone w/ acetaminophen tab 7.5-325 mg (generic of PERCOCET) QL (240 tabs / 30 days)	Tier 2	QL
oxycodone w/ acetaminophen tab 10-325 mg (generic of PERCOCET) QL (180 tabs / 30 days)	Tier 2	QL
tramadol hcl (generic of ULTRAM) TABS 50mg QL (240 tabs / 30 days)	Tier 1	QL
ANESTHETICS ***LOCAL ANESTHETICS***		
lidocaine hcl (local anesth.) (generic of XYLOCAINE-MPF) SOLN .5%, 1%, 1.5%	Tier 2	B/D
lidocaine hcl (local anesth.) (generic of XYLOCAINE) SOLN .5%, 1%, 2%	Tier 2	B/D
ANTI-INFECTIVES ***ANTI-INFECTIVES - MISCELLANEOUS***		
albendazole (generic of ALBENZA) TABS 200mg	Tier 1	
amikacin sulfate SOLN 1gm/4ml, 500mg/2ml	Tier 3	
atovaquone (generic of MEPRON) SUSP 750mg/5ml	Tier 3	
aztreonam (generic of AZACTAM) SOLR 1gm, 2gm	Tier 3	
CAYSTON SOLR 75mg	Tier 2	NM LA PA
clindamycin hcl (generic of CLEOCIN) CAPS 75mg, 150mg, 300mg	Tier 1	
clindamycin phosphate (generic of CLEOCIN PHOSPHATE) SOLN 300mg/2ml, 600mg/4ml, 900mg/6ml, 9000mg/60ml	Tier 2	
colistimethate sodium (generic of COLY-MYCIN M) SOLR 150mg	Tier 3	
dapsone TABS 25mg, 100mg	Tier 2	
DAPTOMYCIN SOLR 350mg	Tier 2	
daptomycin (generic of DAPTOMYCIN) SOLR 350mg	Tier 1	
daptomycin (generic of CUBICIN) SOLR 500mg	Tier 1	
EMVERM CHEW 100mg QL (12 tabs / year)	Tier 1	QL
ertapenem sodium (generic of INVANZ) SOLR 1gm	Tier 3	
gentamicin in saline inj 0.8 mg/ml	Tier 2	
gentamicin in saline inj 2 mg/ml	Tier 2	
gentamicin sulfate SOLN 10mg/ml, 40mg/ml	Tier 2	
imipenem-cilastatin intravenous for soln 250 mg	Tier 3	

Drug Name	Drug Tier	Requirements/ Limits
imipenem-cilastatin intravenous for soln 500 mg (generic of PRIMAXIN IV)	Tier 3	
ivermectin (generic of STROMECTOL) TABS 3mg	Tier 2	
linezolid (generic of ZYVOX) SOLN 600mg/300ml	Tier 3	
linezolid (generic of ZYVOX) SUSR 100mg/5ml QL (1800 mL / 30 days)	Tier 1	QL
linezolid (generic of ZYVOX) TABS 600mg QL (60 tabs / 30 days)	Tier 3	QL
linezolid in sodium chloride iv soln 600 mg/300ml-0.9%	Tier 3	
meropenem SOLR 1gm, 500mg	Tier 3	
methenamine hippurate (generic of HIPREX) TABS 1gm	Tier 3	
metronidazole TABS 250mg	Tier 1	
metronidazole (generic of FLAGYL) TABS 500mg	Tier 1	
metronidazole in nacl 0.79% iv soln 500 mg/100ml	Tier 2	
neomycin sulfate TABS 500mg	Tier 1	
nitazoxanide (generic of ALINIA) TABS 500mg QL (6 tabs / 30 days)	Tier 1	QL
nitrofurantoin macrocrystal (generic of MACRODANTIN) CAPS 50mg, 100mg	Tier 2	
nitrofurantoin monohyd macro (generic of MACROBID) CAPS 100mg	Tier 2	
paromomycin sulfate (generic of HUMATIN) CAPS 250mg	Tier 3	
pentamidine isethionate inh (generic of NEBUPENT) SOLR 300mg	Tier 3	B/D
pentamidine isethionate inj (generic of PENTAM 300) SOLR 300mg	Tier 3	

Drug Name	Drug Tier	Requirements/ Limits
praziquantel (generic of BILTRICIDE) TABS 600mg	Tier 3	
streptomycin sulfate SOLR 1gm	Tier 3	
SULFADIAZINE TABS 500mg	Tier 3	
sulfamethoxazole-trimethoprim iv soln 400-80 mg/5ml	Tier 3	
sulfamethoxazole-trimethoprim susp 200-40 mg/5ml	Tier 2	
sulfamethoxazole-trimethoprim tab 400-80 mg (generic of BACTRIM)	Tier 1	
sulfamethoxazole-trimethoprim tab 800-160 mg (generic of BACTRIM DS)	Tier 1	
SYNERCID INJ 500MG	Tier 2	
tobramycin (generic of KITABIS PAK) NEBU 300mg/5ml	Tier 1	NM PA
tobramycin sulfate SOLN 1.2gm/30ml, 10mg/ml, 40mg/ml, 80mg/2ml	Tier 2	
trimethoprim TABS 100mg	Tier 1	
vancomycin hcl (generic of VANCOCIN HCL) CAPS 125mg QL (80 caps / 180 days)	Tier 3	QL
vancomycin hcl (generic of VANCOCIN) CAPS 250mg QL (160 caps / 180 days)	Tier 3	QL
vancomycin hcl SOLR 1gm, 5gm, 10gm, 500mg, 750mg	Tier 3	
VANCOMYCIN INJ 1 GM	Tier 3	
VANCOMYCIN INJ 500MG	Tier 3	
VANCOMYCIN INJ 750MG	Tier 3	
ANTIFUNGALS		
ABELCET SUSP 5mg/ml	Tier 3	B/D
AMBISOME SUSR 50mg	Tier 2	B/D
amphotericin b SOLR 50mg	Tier 3	B/D
caspofungin acetate (generic of CANCIDAS) SOLR 50mg, 70mg	Tier 3	

Drug Name	Drug Tier	Requirements/ Limits
fluconazole (generic of DIFLUCAN) SUSR 10mg/ml, 40mg/ml; TABS 50mg, 100mg, 200mg	Tier 2	
fluconazole (generic of DIFLUCAN) TABS 150mg	Tier 1	
fluconazole in nacl 0.9% inj 200 mg/100ml	Tier 2	
fluconazole in nacl 0.9% inj 400 mg/200ml	Tier 2	
flucytosine (generic of ANCOBON) CAPS 250mg, 500mg	Tier 1	PA
griseofulvin microsize SUSP 125mg/5ml; TABS 500mg	Tier 3	
griseofulvin ultramicrosize TABS 125mg, 250mg	Tier 3	
itraconazole (generic of SPORANOX) CAPS 100mg	Tier 3	PA
ketoconazole TABS 200mg	Tier 2	PA
micafungin sodium (generic of MYCAMINE) SOLR 50mg, 100mg	Tier 1	
NOXAFIL SUSP 40mg/ml QL (630 mL / 30 days)	Tier 2	QL PA
nystatin TABS 500000unit	Tier 2	
posaconazole (generic of NOXAFIL) TBEC 100mg QL (93 tabs / 30 days)	Tier 1	QL PA
terbinafine hcl (generic of LAMISIL) TABS 250mg QL (90 tabs / year)	Tier 1	QL
voriconazole (generic of VFEND IV) SOLR 200mg	Tier 1	PA
voriconazole (generic of VFEND) SUSR 40mg/ml	Tier 1	PA
voriconazole (generic of VFEND) TABS 50mg QL (480 tabs / 30 days)	Tier 3	QL PA
voriconazole (generic of VFEND) TABS 200mg QL (120 tabs / 30 days)	Tier 3	QL PA
ANTIMALARIALS		
atovaquone-proguanil hcl tab 62.5-25 mg (generic of MALARONE)	Tier 3	
atovaquone-proguanil hcl tab 250-100 mg (generic of MALARONE)	Tier 3	
chloroquine phosphate TABS 250mg, 500mg	Tier 3	
COARTEM TAB 20-120MG	Tier 3	
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 3	PA
ANTIRETROVIRAL AGENTS		
abacavir sulfate (generic of ZIAGEN) SOLN 20mg/ml	Tier 3	NM
abacavir sulfate (generic of ZIAGEN) TABS 300mg	Tier 2	NM
APTIVUS CAPS 250mg	Tier 2	NM
atazanavir sulfate (generic of REYATAZ) CAPS 150mg, 200mg, 300mg	Tier 3	NM
EDURANT TABS 25mg	Tier 2	NM
efavirenz (generic of SUSTIVA) CAPS 50mg, 200mg; TABS 600mg	Tier 3	NM
emtricitabine (generic of EMTRIVA) CAPS 200mg	Tier 2	NM
EMTRIVA SOLN 10mg/ml	Tier 3	NM
etravirine (generic of INTELENCE) TABS 100mg, 200mg	Tier 1	NM
fosamprenavir calcium (generic of LEXIVA) TABS 700mg	Tier 1	NM
FUZEON SOLR 90mg	Tier 2	NM
INTELENCE TABS 25mg	Tier 3	NM
INTELENCE TABS 100mg, 200mg	Tier 2	NM

Drug Name	Drug Tier	Requirements/ Limits
INVIRASE TABS 500mg	Tier 2	NM
ISENTRESS CHEW 25mg; PACK 100mg	Tier 2	NM
ISENTRESS CHEW 100mg; TABS 400mg	Tier 2	NM
ISENTRESS HD TABS 600mg	Tier 2	NM
lamivudine (generic of EPIVIR) SOLN 10mg/ml; TABS 150mg, 300mg	Tier 2	NM
LEXIVA SUSP 50mg/ml	Tier 3	NM
nevirapine (generic of VIRAMUNE) SUSP 50mg/5ml	Tier 3	NM
nevirapine TABS 200mg	Tier 1	NM
nevirapine TB24 100mg	Tier 3	NM
nevirapine (generic of VIRAMUNE XR) TB24 400mg	Tier 3	NM
NORVIR PACK 100mg; SOLN 80mg/ml	Tier 3	NM
PIFELTRO TABS 100mg	Tier 2	NM
PREZISTA SUSP 100mg/ml QL (400 mL / 30 days)	Tier 2	QL NM
PREZISTA TABS 75mg QL (480 tabs / 30 days)	Tier 3	QL NM
PREZISTA TABS 150mg QL (240 tabs / 30 days)	Tier 2	QL NM
PREZISTA TABS 600mg QL (60 tabs / 30 days)	Tier 2	QL NM
PREZISTA TABS 800mg QL (30 tabs / 30 days)	Tier 2	QL NM
REYATAZ PACK 50mg	Tier 2	NM
ritonavir (generic of NORVIR) TABS 100mg	Tier 2	NM
RUKOBIA TB12 600mg	Tier 2	NM
SELZENTRY SOLN 20mg/ml; TABS 75mg, 150mg, 300mg	Tier 2	NM
SELZENTRY TABS 25mg	Tier 2	NM
tenofovir disoproxil fumarate (generic of VIREAD) TABS 300mg	Tier 2	NM
TIVICAY TABS 10mg	Tier 2	NM
TIVICAY TABS 25mg, 50mg	Tier 2	NM
TIVICAY PD TBSO 5mg	Tier 2	NM
TYBOST TABS 150mg	Tier 2	NM
VIRACEPT TABS 250mg, 625mg	Tier 2	NM
VIREAD POWD 40mg/gm; TABS 150mg, 200mg, 250mg	Tier 2	NM
zidovudine (generic of RETROVIR) CAPS 100mg; SYRP 50mg/5ml	Tier 3	NM
zidovudine TABS 300mg	Tier 2	NM
ANTIRETROVIRAL COMBINATION AGENTS		
abacavir sulfate-lamivudine tab 600-300 mg (generic of EPZICOM)	Tier 2	NM
abacavir sulfate-lamivudine-zidovudine tab 300-150-300 mg (generic of TRIZIVIR)	Tier 1	NM
BIKTARVY TAB	Tier 2	NM
CIMDUO TAB 300-300	Tier 2	NM
COMPLERA TAB	Tier 2	NM
DELSTRIGO TAB	Tier 2	NM
DESCOVY TAB 200/25MG	Tier 2	NM
DOVATO TAB 50-300MG	Tier 2	NM
efavirenz-emtricitabine-tenofovir df tab 600-200-300 mg (generic of ATRIPLA)	Tier 1	NM
efavirenz-lamivudine-tenofovir df tab 400-300-300 mg (generic of SYMFI LO)	Tier 1	NM
efavirenz-lamivudine-tenofovir df tab 600-300-300 mg (generic of SYMFI)	Tier 1	NM
emtricitabine-tenofovir disoproxil fumarate tab 100-150 mg (generic of TRUVADA) QL (30 tabs / 30 days)	Tier 1	QL NM
emtricitabine-tenofovir disoproxil fumarate tab 133-200 mg (generic of TRUVADA) QL (30 tabs / 30 days)	Tier 1	QL NM

Drug Name	Drug Tier	Requirements/ Limits
emtricitabine-tenofovir disoproxil fumarate tab 167-250 mg (generic of TRUVADA) QL (30 tabs / 30 days)	Tier 1	QL NM
emtricitabine-tenofovir disoproxil fumarate tab 200-300 mg (generic of TRUVADA) QL (30 tabs / 30 days)	Tier 1	QL NM
EVOTAZ TAB 300-150	Tier 2	NM
GENVOYA TAB	Tier 2	NM
JULUCA TAB 50-25MG	Tier 2	NM
KALETRA TAB 100-25MG	Tier 3	NM
KALETRA TAB 200-50MG	Tier 3	NM
lamivudine-zidovudine tab 150-300 mg (generic of COMBIVIR)	Tier 3	NM
lopinavir-ritonavir soln 400-100 mg/5ml (80-20 mg/ml) (generic of KALETRA)	Tier 3	NM
lopinavir-ritonavir tab 100-25 mg (generic of KALETRA)	Tier 3	NM
lopinavir-ritonavir tab 200-50 mg (generic of KALETRA)	Tier 3	NM
ODEFSEY TAB	Tier 2	NM
PREZCOBIX TAB 800-150	Tier 2	NM
STRIBILD TAB	Tier 2	NM
SYMTUZA TAB	Tier 2	NM
TEMIXYS TAB 300-300	Tier 2	NM
TRIUMEQ TAB	Tier 2	NM
ANTITUBERCULAR AGENTS		
cycloserine CAPS 250mg	Tier 1	
ethambutol hcl TABS 100mg	Tier 2	
ethambutol hcl (generic of MYAMBUTOL) TABS 400mg	Tier 2	
isoniazid TABS 100mg, 300mg	Tier 1	
PASER PACK 4gm	Tier 3	
PRIFTIN TABS 150mg	Tier 3	
pyrazinamide TABS 500mg	Tier 3	
rifabutin (generic of MYCOBUTIN) CAPS 150mg	Tier 3	
rifampin CAPS 150mg, 300mg	Tier 2	
rifampin (generic of RIFADIN) SOLR 600mg	Tier 3	
SIRTURO TABS 20mg, 100mg	Tier 2	LA PA
TRECATOR TABS 250mg	Tier 3	
ANTIVIRALS		
acyclovir CAPS 200mg; TABS 400mg, 800mg	Tier 1	
acyclovir sodium SOLN 50mg/ml	Tier 3	B/D
adefovir dipivoxil (generic of HEPSERA) TABS 10mg	Tier 3	NM
BARACLUDE SOLN .05mg/ml	Tier 2	NM
entecavir (generic of BARACLUDE) TABS .5mg, 1mg	Tier 3	NM
EPCLUSA TAB 200-50MG	Tier 2	NM PA
EPCLUSA TAB 400-100	Tier 2	NM PA
EPIVIR HBV SOLN 5mg/ml	Tier 3	NM
famciclovir TABS 125mg, 250mg, 500mg	Tier 2	
ganciclovir sodium SOLR 500mg	Tier 3	B/D
HARVONI PAK 33.75-150MG	Tier 2	NM PA
HARVONI PAK 45-200MG	Tier 2	NM PA
HARVONI TAB 45-200MG	Tier 2	NM PA
HARVONI TAB 90-400MG	Tier 2	NM PA
lamivudine (hbv) (generic of EPIVIR HBV) TABS 100mg	Tier 3	NM
MAVYRET TAB 100-40MG	Tier 2	NM PA
oseltamivir phosphate (generic of TAMIFLU) CAPS 30mg QL (168 caps / year)	Tier 2	QL
oseltamivir phosphate (generic of TAMIFLU) CAPS 45mg, 75mg QL (84 caps / year)	Tier 2	QL
oseltamivir phosphate (generic of TAMIFLU) SUSR 6mg/ml QL (1080 mL / year)	Tier 2	QL
PEGASYS SOLN 180mcg/0.5ml, 180mcg/ml	Tier 2	NM PA

Drug Name	Drug Tier	Requirements/ Limits
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	Tier 2	NM
ribavirin (hepatitis c) TABS 200mg	Tier 3	NM
rimantadine hydrochloride TABS 100mg	Tier 3	
valacyclovir hcl (generic of VALTREX) TABS 1gm, 500mg	Tier 2	
valganciclovir hcl (generic of VALCYTE) SOLR 50mg/ml	Tier 1	
valganciclovir hcl (generic of VALCYTE) TABS 450mg	Tier 2	
VOSEVI TAB	Tier 2	NM PA
CEPHALOSPORINS		
cefaclor CAPS 250mg, 500mg	Tier 2	
cefadroxil CAPS 500mg	Tier 1	
cefadroxil SUSR 250mg/5ml, 500mg/5ml	Tier 2	
CEFAZOLIN INJ 1GM/50ML	Tier 3	
cefazolin sodium SOLR 1gm, 10gm, 500mg	Tier 2	
CEFAZOLIN SOLN 2GM/100ML-4%	Tier 3	
cefdinir CAPS 300mg	Tier 1	
cefdinir SUSR 125mg/5ml, 250mg/5ml	Tier 2	
cefepime hcl SOLR 1gm, 2gm	Tier 3	
cefoxitin sodium SOLR 1gm, 2gm, 10gm	Tier 3	
cefpodoxime proxetil TABS 100mg, 200mg	Tier 2	
cefprozil TABS 250mg, 500mg	Tier 2	
ceftazidime (generic of FORTAZ) SOLR 1gm	Tier 3	
ceftazidime SOLR 2gm, 6gm	Tier 3	
ceftriaxone sodium SOLR 1gm, 2gm, 10gm, 250mg, 500mg	Tier 3	
cefuroxime axetil TABS 250mg, 500mg	Tier 2	
cefuroxime sodium SOLR 1.5gm, 7.5gm, 750mg	Tier 2	
cephalexin CAPS 250mg, 500mg	Tier 1	
cephalexin SUSR 125mg/5ml, 250mg/5ml	Tier 2	
tazicef (generic of FORTAZ) SOLR 1gm	Tier 3	
tazicef SOLR 1gm, 2gm, 6gm	Tier 3	
TEFLARO SOLR 400mg, 600mg	Tier 2	
ERYTHROMYCINS/MACROLIDES		
azithromycin PACK 1gm	Tier 2	
azithromycin (generic of ZITHROMAX) SOLR 500mg; SUSR 100mg/5ml, 200mg/5ml	Tier 2	
azithromycin (generic of ZITHROMAX) TABS 250mg, 500mg	Tier 1	
azithromycin TABS 600mg	Tier 1	
clarithromycin SUSR 125mg/5ml, 250mg/5ml	Tier 3	
clarithromycin TABS 250mg, 500mg	Tier 2	
ery-tab TBEC 250mg, 333mg, 500mg	Tier 3	
ERYTHROCIN LACTOBIONATE SOLR 500mg	Tier 2	
erythromycin base CPEP 250mg; TABS 250mg, 500mg; TBEC 250mg, 333mg, 500mg	Tier 3	
FLUOROQUINOLONES		
ciprofloxacin 200 mg/100ml in d5w	Tier 2	
ciprofloxacin 400 mg/200ml in d5w	Tier 2	
ciprofloxacin hcl TABS 100mg	Tier 3	

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

Drug Name	Drug Tier	Requirements/ Limits
piperacillin sod-tazobactam sod for inj 4.5 gm (4-0.5 gm)	Tier 3	
piperacillin sod-tazobactam sod for inj 13.5 gm (12-1.5 gm)	Tier 3	
piperacillin sod-tazobactam sod for inj 40.5 gm (36-4.5 gm)	Tier 3	
TETRACYCLINES		
doxy 100 SOLR 100mg	Tier 3	
doxycycline (monohydrate) CAPS 50mg, 100mg	Tier 1	
doxycycline (monohydrate) TABS 50mg, 75mg, 100mg	Tier 2	
doxycycline hyclate CAPS 50mg; TABS 20mg, 100mg	Tier 2	
doxycycline hyclate (generic of VIBRAMYCIN) CAPS 100mg	Tier 2	
doxycycline hyclate SOLR 100mg	Tier 3	
minocycline hcl CAPS 50mg, 75mg	Tier 2	
minocycline hcl (generic of MINOCIN) CAPS 100mg	Tier 2	
mondoxyne nl CAPS 100mg	Tier 1	
tetracycline hcl CAPS 250mg, 500mg	Tier 3	PA
TIGECYCLINE SOLR 50mg	Tier 2	
tigecycline (generic of TYGACIL) SOLR 50mg	Tier 3	
ANTINEOPLASTIC AGENTS		
ALKYLATING AGENTS		
cyclophosphamide CAPS 25mg, 50mg	Tier 2	B/D
CYCLOPHOSPHAMIDE TABS 25mg, 50mg	Tier 3	B/D
LEUKERAN TABS 2mg	Tier 3	
ANTIMETABOLITES		
INQOVI TAB 35-100MG	Tier 2	NM LA PA
LONSURF TAB 15-6.14	Tier 2	NM PA
LONSURF TAB 20-8.19	Tier 2	NM PA
mercaptopurine TABS 50mg	Tier 2	
methotrexate sodium SOLN 1gm/40ml, 50mg/2ml, 250mg/10ml; SOLR 1gm	Tier 2	B/D
ONUREG TABS 200mg, 300mg	Tier 2	NM LA PA
PURIXAN SUSP 2000mg/100ml	Tier 2	NM
TABLOID TABS 40mg	Tier 3	
HORMONAL ANTINEOPLASTIC AGENTS		
abiraterone acetate (generic of ZYTIGA) TABS 250mg, 500mg	Tier 1	NM PA
anastrozole (generic of ARIMIDEX) TABS 1mg	Tier 1	
bicalutamide (generic of CASODEX) TABS 50mg	Tier 1	
EMCYT CAPS 140mg	Tier 2	
ERLEADA TABS 60mg	Tier 2	NM LA PA
exemestane (generic of AROMASIN) TABS 25mg	Tier 3	
flutamide CAPS 125mg	Tier 2	
letrozole (generic of FEMARA) TABS 2.5mg	Tier 1	
leuprolide acetate KIT 1mg/0.2ml	Tier 3	NM PA
LUPRON DEPOT (1-MONTH) KIT 3.75mg	Tier 2	NM PA
LUPRON DEPOT (3-MONTH) KIT 11.25mg	Tier 2	NM PA
LYSODREN TABS 500mg	Tier 2	
megestrol acetate TABS 20mg, 40mg	Tier 2	
nilutamide (generic of NILANDRON) TABS 150mg	Tier 1	
NUBEQA TABS 300mg	Tier 2	NM LA PA
ORGOVYX TABS 120mg	Tier 2	NM LA PA
SOLTAMOX SOLN 10mg/5ml	Tier 2	
tamoxifen citrate TABS 10mg, 20mg	Tier 1	
toremifene citrate (generic of FARESTON) TABS 60mg	Tier 1	
TRELSTAR MIXJECT SUSR 3.75mg, 11.25mg	Tier 2	NM PA
XTANDI CAPS 40mg; TABS 40mg, 80mg	Tier 2	NM LA PA

Drug Name	Drug Tier	Requirements/ Limits
IMMUNOMODULATORS		
POMALYST CAPS 1mg, 2mg QL (21 caps / 21 days)	Tier 2	QL NM LA PA
POMALYST CAPS 3mg, 4mg QL (21 caps / 28 days)	Tier 2	QL NM LA PA
REVLIMID CAPS 2.5mg, 5mg, 10mg, 15mg QL (28 caps / 28 days)	Tier 2	QL NM LA PA
REVLIMID CAPS 20mg, 25mg QL (21 caps / 28 days)	Tier 2	QL NM LA PA
THALOMID CAPS 50mg, 100mg QL (28 caps / 28 days)	Tier 2	QL NM PA
THALOMID CAPS 150mg, 200mg QL (56 caps / 28 days)	Tier 2	QL NM PA
MISCELLANEOUS		
bexarotene (generic of TARGRETIN) CAPS 75mg	Tier 1	NM PA
hydroxyurea (generic of HYDREA) CAPS 500mg	Tier 1	
KISQALI 200 PAK FEMARA QL (49 tabs / 28 days)	Tier 2	QL NM PA
KISQALI 400 PAK FEMARA QL (70 tabs / 28 days)	Tier 2	QL NM PA
KISQALI 600 PAK FEMARA QL (91 tabs / 28 days)	Tier 2	QL NM PA
MATULANE CAPS 50mg	Tier 2	NM LA
SYNRIBO SOLR 3.5mg	Tier 2	NM PA
tretinoin (chemotherapy) CAPS 10mg	Tier 1	
MOLECULAR TARGET AGENTS		
AFINITOR TABS 10mg QL (30 tabs / 30 days)	Tier 2	QL NM PA
AFINITOR DISPERZ TBSO 2mg QL (150 tabs / 30 days)	Tier 2	QL NM PA
AFINITOR DISPERZ TBSO 3mg QL (90 tabs / 30 days)	Tier 2	QL NM PA
AFINITOR DISPERZ TBSO 5mg QL (60 tabs / 30 days)	Tier 2	QL NM PA
ALECENSA CAPS 150mg	Tier 2	NM LA PA
ALUNBRIG TABS 30mg, 90mg, 180mg	Tier 2	NM LA PA
ALUNBRIG PAK	Tier 2	NM LA PA
AYVAKIT TABS 25mg, 50mg, 100mg, 200mg, 300mg QL (30 tabs / 30 days)	Tier 2	QL NM LA PA
BALVERSA TABS 3mg, 4mg, 5mg	Tier 2	NM LA PA
BOSULIF TABS 100mg, 400mg, 500mg	Tier 2	NM PA
BRAFTOVI CAPS 75mg	Tier 2	NM LA PA
BRUKINSA CAPS 80mg	Tier 2	NM LA PA
CABOMETYX TABS 20mg, 40mg, 60mg QL (30 tabs / 30 days)	Tier 2	QL NM LA PA
CALQUENCE CAPS 100mg QL (60 caps / 30 days)	Tier 2	QL NM LA PA
CAPRELSA TABS 100mg, 300mg	Tier 2	NM LA PA
COMETRIQ (60MG DOSE) KIT 20mg	Tier 2	NM LA PA
COMETRIQ KIT 100MG	Tier 2	NM LA PA
COMETRIQ KIT 140MG	Tier 2	NM LA PA
COPIKTRA CAPS 15mg, 25mg	Tier 2	NM LA PA
COTELLIC TABS 20mg	Tier 2	NM LA PA
DAURISMO TABS 25mg, 100mg	Tier 2	NM LA PA
ERIVEDGE CAPS 150mg	Tier 2	NM LA PA
erlotinib hcl (generic of TARCEVA) TABS 25mg QL (90 tabs / 30 days)	Tier 1	QL NM PA
erlotinib hcl (generic of TARCEVA) TABS 100mg, 150mg QL (30 tabs / 30 days)	Tier 1	QL NM PA
everolimus (generic of AFINITOR) TABS 2.5mg, 5mg, 7.5mg QL (30 tabs / 30 days)	Tier 1	QL NM PA
FARYDAK CAPS 10mg, 15mg, 20mg	Tier 2	NM LA PA
FOTIVDA CAPS .89mg, 1.34mg QL (21 caps / 28 days)	Tier 2	QL NM LA PA
GAVRETO CAPS 100mg	Tier 2	NM LA PA

Drug Name	Drug Tier	Requirements/ Limits
GILOTRIF TABS 20mg, 30mg, 40mg	Tier 2	NM LA PA
IBRANCE CAPS 75mg, 100mg, 125mg QL (21 caps / 28 days)	Tier 2	QL NM LA PA
IBRANCE TABS 75mg, 100mg, 125mg QL (21 tabs / 28 days)	Tier 2	QL NM LA PA
ICLUSIG TABS 10mg QL (60 tabs / 30 days)	Tier 2	QL NM LA PA
ICLUSIG TABS 15mg, 30mg, 45mg QL (30 tabs / 30 days)	Tier 2	QL NM LA PA
IDHIFA TABS 50mg, 100mg QL (30 tabs / 30 days)	Tier 2	QL NM LA PA
imatinib mesylate (generic of GLEEVEC) TABS 100mg QL (90 tabs / 30 days)	Tier 1	QL NM PA
imatinib mesylate (generic of GLEEVEC) TABS 400mg QL (60 tabs / 30 days)	Tier 1	QL NM PA
IMBRUVICA CAPS 70mg QL (30 caps / 30 days)	Tier 2	QL NM LA PA
IMBRUVICA CAPS 140mg QL (120 caps / 30 days)	Tier 2	QL NM LA PA
IMBRUVICA TABS 140mg, 280mg, 420mg, 560mg QL (30 tabs / 30 days)	Tier 2	QL NM LA PA
INLYTA TABS 1mg QL (180 tabs / 30 days)	Tier 2	QL NM LA PA
INLYTA TABS 5mg QL (120 tabs / 30 days)	Tier 2	QL NM LA PA
INREBIC CAPS 100mg	Tier 2	NM LA PA
IRESSA TABS 250mg	Tier 2	NM LA PA
JAKAFI TABS 5mg, 10mg, 15mg, 20mg, 25mg QL (60 tabs / 30 days)	Tier 2	QL NM LA PA
KISQALI 200 DOSE TBPK 200mg QL (21 tabs / 28 days)	Tier 2	QL NM PA
KISQALI 400 DOSE TBPK 200mg QL (42 tabs / 28 days)	Tier 2	QL NM PA
KISQALI 600 DOSE TBPK 200mg QL (63 tabs / 28 days)	Tier 2	QL NM PA
lapatinib ditosylate (generic of TYKERB) TABS 250mg	Tier 1	NM PA
LENVIMA 4 MG DAILY DOSE CPPK 4mg QL (30 caps / 30 days)	Tier 2	QL NM LA PA
LENVIMA 8 MG DAILY DOSE CPPK 4mg QL (60 caps / 30 days)	Tier 2	QL NM LA PA
LENVIMA 10 MG DAILY DOSE CPPK 10mg QL (30 caps / 30 days)	Tier 2	QL NM LA PA
LENVIMA 12MG DAILY DOSE CPPK 4mg QL (90 caps / 30 days)	Tier 2	QL NM LA PA
LENVIMA 20 MG DAILY DOSE CPPK 10mg QL (60 caps / 30 days)	Tier 2	QL NM LA PA
LENVIMA CAP 14 MG QL (60 caps / 30 days)	Tier 2	QL NM LA PA
LENVIMA CAP 18 MG QL (90 caps / 30 days)	Tier 2	QL NM LA PA
LENVIMA CAP 24 MG QL (90 caps / 30 days)	Tier 2	QL NM LA PA
LORBRENA TABS 25mg, 100mg	Tier 2	NM LA PA
LUMAKRAS TABS 120mg	Tier 2	NM LA PA
LYNPARZA TABS 100mg, 150mg QL (120 tabs / 30 days)	Tier 2	QL NM LA PA
MEKINIST TABS .5mg, 2mg	Tier 2	NM LA PA
MEKTOVI TABS 15mg	Tier 2	NM LA PA
NERLYNX TABS 40mg	Tier 2	NM LA PA
NEXAVAR TABS 200mg QL (120 tabs / 30 days)	Tier 2	QL NM LA PA
NINLARO CAPS 2.3mg, 3mg, 4mg QL (3 caps / 28 days)	Tier 2	QL NM PA
ODOMZO CAPS 200mg	Tier 2	NM LA PA
PEMAZYRE TABS 4.5mg, 9mg, 13.5mg	Tier 2	NM LA PA
PIQRAY 200MG DAILY DOSE TBPK 200mg	Tier 2	NM PA

Drug Name	Drug Tier	Requirements/ Limits
PIQRAY 250MG TAB DOSE	Tier 2	NM PA
PIQRAY 300MG DAILY DOSE TBPK 150mg	Tier 2	NM PA
QINLOCK TABS 50mg	Tier 2	NM LA PA
RETEVMO CAPS 40mg, 80mg	Tier 2	NM LA PA
ROZLYTREK CAPS 100mg, 200mg	Tier 2	NM LA PA
RUBRACA TABS 200mg, 250mg, 300mg QL (120 tabs / 30 days)	Tier 2	QL NM LA PA
RYDAPT CAPS 25mg	Tier 2	NM PA
SPRYCEL TABS 20mg, 50mg, 70mg, 80mg, 100mg, 140mg	Tier 2	NM PA
STIVARGA TABS 40mg	Tier 2	NM LA PA
SUTENT CAPS 12.5mg, 25mg, 37.5mg, 50mg QL (30 caps / 30 days)	Tier 2	QL NM PA
TABRECTA TABS 150mg, 200mg	Tier 2	NM PA
TAFINLAR CAPS 50mg, 75mg	Tier 2	NM LA PA
TAGRISSO TABS 40mg, 80mg QL (30 tabs / 30 days)	Tier 2	QL NM LA PA
TALZENNA CAPS 1mg QL (30 caps / 30 days)	Tier 2	QL NM LA PA
TALZENNA CAPS .25mg QL (90 caps / 30 days)	Tier 2	QL NM LA PA
TASIGNA CAPS 50mg, 150mg, 200mg	Tier 2	NM PA
TAZVERIK TABS 200mg	Tier 2	NM LA PA
TEPMETKO TABS 225mg	Tier 2	NM LA PA
TIBSOVO TABS 250mg	Tier 2	NM LA PA
TRUSELTIQ 50 MG DAILY DOSE CPPK 25mg	Tier 2	NM LA PA
TRUSELTIQ 75 MG DAILY DOSE CPPK 25mg	Tier 2	NM LA PA
TRUSELTIQ 100 MG DAILY DOSE CPPK 100mg	Tier 2	NM LA PA
TRUSELTIQ 125 MG DAILY DOSE	Tier 2	NM LA PA
TUKYSA TABS 50mg, 150mg	Tier 2	NM LA PA
TURALIO CAPS 200mg	Tier 2	NM LA PA
UKONIQ TABS 200mg	Tier 2	NM LA PA
VENCLEXTA TABS 10mg QL (112 tabs / 28 days)	Tier 3	QL NM LA PA
VENCLEXTA TABS 50mg QL (112 tabs / 28 days)	Tier 2	QL NM LA PA
VENCLEXTA TABS 100mg QL (180 tabs / 30 days)	Tier 2	QL NM LA PA
VENCLEXTA TAB START PK QL (42 tabs / 28 days)	Tier 2	QL NM LA PA
VERZENIO TABS 50mg, 100mg, 150mg, 200mg QL (56 tabs / 28 days)	Tier 2	QL NM LA PA
VITRAKVI CAPS 25mg, 100mg; SOLN 20mg/ml	Tier 2	NM LA PA
VIZIMPRO TABS 15mg, 30mg, 45mg	Tier 2	NM LA PA
VOTRIENT TABS 200mg	Tier 2	NM LA PA
XALKORI CAPS 200mg, 250mg	Tier 2	NM LA PA
XOSPATA TABS 40mg	Tier 2	NM LA PA
XPOVIO 40 MG ONCE WEEKLY TBPK 20mg, 40mg	Tier 2	NM LA PA
XPOVIO 40 MG TWICE WEEKLY TBPK 20mg, 40mg	Tier 2	NM LA PA
XPOVIO 60 MG ONCE WEEKLY TBPK 20mg, 60mg	Tier 2	NM LA PA
XPOVIO 60 MG TWICE WEEKLY TBPK 20mg	Tier 2	NM LA PA
XPOVIO 80 MG ONCE WEEKLY TBPK 20mg, 40mg	Tier 2	NM LA PA
XPOVIO 80 MG TWICE WEEKLY TBPK 20mg	Tier 2	NM LA PA
XPOVIO 100 MG ONCE WEEKLY TBPK 20mg, 50mg	Tier 2	NM LA PA
ZEJULA CAPS 100mg QL (90 caps / 30 days)	Tier 2	QL NM LA PA
ZELBORAF TABS 240mg	Tier 2	NM LA PA
ZOLINZA CAPS 100mg	Tier 2	NM PA
ZYDELIG TABS 100mg, 150mg	Tier 2	NM LA PA

Drug Name	Drug Tier	Requirements/ Limits
ZYKADIA TABS 150mg	Tier 2	NM LA PA
PROTECTIVE AGENTS		
leucovorin calcium TABS 5mg, 10mg	Tier 2	
leucovorin calcium TABS 15mg, 25mg	Tier 3	
MESNEX TABS 400mg	Tier 2	
CARDIOVASCULAR ***ACE INHIBITOR COMBINATIONS***		
amlodipine besylate-benazepril hcl cap 2.5-10 mg QL (30 caps / 30 days)	Tier 1	QL
amlodipine besylate-benazepril hcl cap 5-10 mg (generic of LOTREL) QL (30 caps / 30 days)	Tier 1	QL
amlodipine besylate-benazepril hcl cap 5-20 mg (generic of LOTREL) QL (30 caps / 30 days)	Tier 1	QL
amlodipine besylate-benazepril hcl cap 5-40 mg QL (30 caps / 30 days)	Tier 1	QL
amlodipine besylate-benazepril hcl cap 10-20 mg (generic of LOTREL) QL (30 caps / 30 days)	Tier 1	QL
amlodipine besylate-benazepril hcl cap 10-40 mg (generic of LOTREL) QL (30 caps / 30 days)	Tier 1	QL
benazepril & hydrochlorothiazide tab 5-6.25 mg	Tier 2	
benazepril & hydrochlorothiazide tab 10-12.5 mg (generic of LOTENSIN HCT)	Tier 2	
benazepril & hydrochlorothiazide tab 20-12.5 mg (generic of LOTENSIN HCT)	Tier 2	
benazepril & hydrochlorothiazide tab 20-25 mg (generic of LOTENSIN HCT)	Tier 2	
enalapril maleate & hydrochlorothiazide tab 5-12.5 mg	Tier 1	
enalapril maleate & hydrochlorothiazide tab 10-25 mg (generic of VASERETIC)	Tier 1	
fosinopril sodium & hydrochlorothiazide tab 10-12.5 mg	Tier 2	
fosinopril sodium & hydrochlorothiazide tab 20-12.5 mg	Tier 2	
lisinopril & hydrochlorothiazide tab 10-12.5 mg (generic of ZESTORETIC)	Tier 1	
lisinopril & hydrochlorothiazide tab 20-12.5 mg (generic of ZESTORETIC)	Tier 1	
lisinopril & hydrochlorothiazide tab 20-25 mg (generic of ZESTORETIC)	Tier 1	
quinapril-hydrochlorothiazide tab 10-12.5 mg (generic of ACCURETIC)	Tier 1	
quinapril-hydrochlorothiazide tab 20-12.5 mg (generic of ACCURETIC)	Tier 1	
quinapril-hydrochlorothiazide tab 20-25 mg (generic of ACCURETIC)	Tier 1	
ACE INHIBITORS		
benazepril hcl TABS 5mg	Tier 1	
benazepril hcl (generic of LOTENSIN) TABS 10mg, 20mg, 40mg	Tier 1	
enalapril maleate (generic of VASOTEC) TABS 2.5mg, 5mg, 10mg, 20mg	Tier 1	
fosinopril sodium TABS 10mg, 20mg, 40mg	Tier 1	

Drug Name	Drug Tier	Requirements/ Limits
lisinopril (generic of ZESTRIL) TABS 2.5mg, 5mg, 10mg, 30mg, 40mg	Tier 1	
lisinopril (generic of PRINIVIL) TABS 20mg	Tier 1	
moexipril hcl TABS 7.5mg, 15mg	Tier 2	
perindopril erbumine TABS 2mg, 4mg, 8mg	Tier 2	
quinapril hcl (generic of ACCUPRIL) TABS 5mg, 10mg, 20mg, 40mg	Tier 1	
ramipril (generic of ALTACE) CAPS 1.25mg, 2.5mg, 5mg, 10mg	Tier 1	
trandolapril TABS 1mg, 2mg	Tier 1	
trandolapril (generic of MAVIK) TABS 4mg	Tier 1	
ALDOSTERONE RECEPTOR ANTAGONISTS		
eplerenone (generic of INSPRA) TABS 25mg, 50mg	Tier 2	
spironolactone (generic of ALDACTONE) TABS 25mg	Tier 1	
spironolactone (generic of ALDACTONE) TABS 50mg, 100mg	Tier 1	
ALPHA BLOCKERS		
doxazosin mesylate (generic of CARDURA) TABS 1mg, 2mg, 4mg, 8mg	Tier 1	
prazosin hcl (generic of MINIPRESS) CAPS 1mg, 2mg, 5mg	Tier 2	
terazosin hcl CAPS 1mg, 2mg, 5mg, 10mg	Tier 1	
ANGIOTENSIN II RECEPTOR ANTAGONIST COMBINATIONS		
amlodipine besylate-valsartan tab 5-160 mg (generic of EXFORGE) QL (30 tabs / 30 days)	Tier 2	QL
amlodipine besylate-valsartan tab 5-320 mg (generic of EXFORGE) QL (30 tabs / 30 days)	Tier 2	QL
amlodipine besylate-valsartan tab 10-160 mg (generic of EXFORGE) QL (30 tabs / 30 days)	Tier 2	QL
amlodipine besylate-valsartan tab 10-320 mg (generic of EXFORGE) QL (30 tabs / 30 days)	Tier 2	QL
ENTRESTO TAB 24-26MG	Tier 2	
ENTRESTO TAB 49-51MG	Tier 2	
ENTRESTO TAB 97-103MG	Tier 2	
irbesartan-hydrochlorothiazide tab 150-12.5 mg (generic of AVALIDE) QL (30 tabs / 30 days)	Tier 1	QL
irbesartan-hydrochlorothiazide tab 300-12.5 mg (generic of AVALIDE) QL (30 tabs / 30 days)	Tier 1	QL
losartan potassium & hydrochlorothiazide tab 50-12.5 mg (generic of HYZAAR)	Tier 2	
losartan potassium & hydrochlorothiazide tab 100-12.5 mg (generic of HYZAAR)	Tier 2	
losartan potassium & hydrochlorothiazide tab 100-25 mg (generic of HYZAAR)	Tier 2	
olmesartan medoxomil-hydrochlorothiazide tab 20-12.5 mg (generic of BENICAR HCT) QL (30 tabs / 30 days)	Tier 2	QL
olmesartan medoxomil-hydrochlorothiazide tab 40-12.5 mg (generic of BENICAR HCT) QL (30 tabs / 30 days)	Tier 2	QL
olmesartan medoxomil-hydrochlorothiazide tab 40-25 mg (generic of BENICAR HCT) QL (30 tabs / 30 days)	Tier 2	QL

Drug Name	Drug Tier	Requirements/ Limits
valsartan-hydrochlorothiazide tab 80-12.5 mg (generic of DIOVAN HCT) QL (30 tabs / 30 days)	Tier 2	QL
valsartan-hydrochlorothiazide tab 160-12.5 mg (generic of DIOVAN HCT) QL (30 tabs / 30 days)	Tier 2	QL
valsartan-hydrochlorothiazide tab 160-25 mg (generic of DIOVAN HCT) QL (30 tabs / 30 days)	Tier 2	QL
valsartan-hydrochlorothiazide tab 320-12.5 mg (generic of DIOVAN HCT) QL (30 tabs / 30 days)	Tier 2	QL
valsartan-hydrochlorothiazide tab 320-25 mg (generic of DIOVAN HCT) QL (30 tabs / 30 days)	Tier 2	QL
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
irbesartan (generic of AVAPRO) TABS 75mg, 150mg, 300mg QL (30 tabs / 30 days)	Tier 2	QL
losartan potassium (generic of COZAAR) TABS 25mg, 50mg, 100mg	Tier 1	
olmesartan medoxomil (generic of BENICAR) TABS 5mg QL (60 tabs / 30 days)	Tier 1	QL
olmesartan medoxomil (generic of BENICAR) TABS 20mg, 40mg QL (30 tabs / 30 days)	Tier 1	QL
telmisartan (generic of MICARDIS) TABS 20mg, 40mg, 80mg QL (30 tabs / 30 days)	Tier 2	QL
valsartan (generic of DIOVAN) TABS 40mg, 80mg, 160mg QL (60 tabs / 30 days)	Tier 2	QL
valsartan (generic of DIOVAN) TABS 320mg QL (30 tabs / 30 days)	Tier 2	QL
ANTIARRHYTHMICS		
amiodarone hcl SOLN 50mg/ml, 900mg/18ml; TABS 100mg, 400mg	Tier 3	
amiodarone hcl TABS 200mg	Tier 1	
disopyramide phosphate (generic of NORPACE) CAPS 100mg, 150mg	Tier 3	
dofetilide (generic of TIKOSYN) CAPS 125mcg, 250mcg, 500mcg	Tier 3	NM
flecainide acetate TABS 50mg, 100mg, 150mg	Tier 2	
MULTAQ TABS 400mg	Tier 3	
pacerone TABS 100mg, 400mg	Tier 3	
pacerone TABS 200mg	Tier 1	
propafenone hcl (generic of RYTHMOL SR) CP12 225mg, 325mg, 425mg	Tier 3	
propafenone hcl TABS 150mg, 225mg, 300mg	Tier 2	
quinidine sulfate TABS 200mg, 300mg	Tier 1	
sorine (generic of BETAPACE) TABS 80mg, 120mg, 160mg	Tier 1	
sorine TABS 240mg	Tier 1	
sotalol hcl (generic of BETAPACE) TABS 80mg, 120mg, 160mg	Tier 1	
sotalol hcl TABS 240mg	Tier 1	
sotalol hcl (afib/afl) (generic of BETAPACE AF) TABS 80mg, 120mg, 160mg	Tier 2	
ANTILIPEMICS, FIBRATES		
fenofibrate (generic of TRICOR) TABS 48mg, 145mg	Tier 2	

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

Drug Name	Drug Tier	Requirements/ Limits
BETA-BLOCKERS		
acebutolol hcl CAPS 200mg, 400mg	Tier 2	
atenolol (generic of TENORMIN) TABS 25mg, 50mg, 100mg	Tier 1	
bisoprolol fumarate TABS 5mg, 10mg	Tier 1	
BYSTOLIC TABS 2.5mg, 5mg, 10mg QL (30 tabs / 30 days)	Tier 3	QL
BYSTOLIC TABS 20mg QL (60 tabs / 30 days)	Tier 3	QL
carvedilol (generic of COREG) TABS 3.125mg, 6.25mg, 12.5mg, 25mg	Tier 1	
labetalol hcl TABS 100mg, 200mg, 300mg	Tier 2	
metoprolol succinate (generic of TOPROL XL) TB24 25mg, 50mg, 100mg, 200mg	Tier 1	
metoprolol tartrate SOLN 5mg/5ml	Tier 3	
metoprolol tartrate TABS 25mg	Tier 1	
metoprolol tartrate (generic of LOPRESSOR) TABS 50mg, 100mg	Tier 1	
pindolol TABS 5mg, 10mg	Tier 2	
propranolol hcl (generic of INDERAL LA) CP24 60mg, 80mg, 120mg, 160mg	Tier 2	
propranolol hcl SOLN 20mg/5ml, 40mg/5ml	Tier 2	
propranolol hcl TABS 10mg, 20mg, 40mg, 60mg, 80mg	Tier 1	
timolol maleate TABS 5mg, 10mg, 20mg	Tier 3	
CALCIUM CHANNEL BLOCKERS		
amlodipine besylate (generic of NORVASC) TABS 2.5mg, 5mg, 10mg	Tier 1	
cartia xt (generic of CARDIZEM CD) CP24 120mg, 180mg, 240mg, 300mg	Tier 1	
dilt-xr CP24 120mg, 180mg, 240mg	Tier 2	
diltiazem hcl CP12 60mg, 90mg, 120mg	Tier 3	
diltiazem hcl SOLN 25mg/5ml, 50mg/10ml, 125mg/25ml	Tier 2	
diltiazem hcl (generic of CARDIZEM) TABS 30mg, 60mg, 120mg	Tier 1	
diltiazem hcl TABS 90mg	Tier 1	
diltiazem hcl coated beads (generic of CARDIZEM CD) CP24 120mg, 180mg, 240mg, 300mg	Tier 1	
diltiazem hcl coated beads (generic of CARDIZEM CD) CP24 360mg	Tier 3	
diltiazem hcl extended release beads (generic of TIAZAC) CP24 120mg, 180mg, 240mg, 300mg, 360mg, 420mg	Tier 1	
felodipine TB24 2.5mg, 5mg, 10mg	Tier 1	
nifedipine TB24 30mg, 60mg, 90mg	Tier 2	
nifedipine (generic of PROCARDIA XL) TB24 30mg, 60mg, 90mg	Tier 2	
nimodipine CAPS 30mg	Tier 3	
NYMALIZE SOLN 6mg/ml	Tier 2	
taztia xt (generic of TIAZAC) CP24 120mg, 180mg, 240mg, 300mg, 360mg	Tier 1	
tiadylt er (generic of TIAZAC) CP24 120mg, 180mg, 240mg, 300mg, 360mg, 420mg	Tier 1	
verapamil hcl (generic of VERELAN PM) CP24 100mg, 200mg	Tier 3	
verapamil hcl (generic of VERELAN) CP24 120mg, 180mg, 240mg	Tier 2	
verapamil hcl CP24 300mg, 360mg; SOLN 2.5mg/ml	Tier 3	

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

Drug Name	Drug Tier	Requirements/ Limits
guanfacine hcl TABS 1mg, 2mg PA if 70 years and older	Tier 2	PA
hydralazine hcl SOLN 20mg/ml	Tier 3	
hydralazine hcl TABS 10mg, 25mg, 50mg, 100mg	Tier 1	
methyldopa TABS 250mg, 500mg PA if 70 years and older	Tier 1	PA
metyrosine (generic of DEMSER) CAPS 250mg	Tier 1	PA
midodrine hcl TABS 2.5mg, 5mg	Tier 2	
midodrine hcl TABS 10mg	Tier 3	
minoxidil TABS 2.5mg, 10mg	Tier 1	
ranolazine (generic of RANEXA) TB12 500mg, 1000mg	Tier 3	
NITRATES		
isosorbide dinitrate (generic of ISORDIL TITRADOSE) TABS 5mg	Tier 2	
isosorbide dinitrate TABS 10mg, 20mg, 30mg	Tier 2	
isosorbide mononitrate TABS 10mg, 20mg; TB24 30mg, 60mg, 120mg	Tier 1	
minitran (generic of NITRO-DUR) PT24 .1mg/hr, .2mg/hr, .4mg/hr, .6mg/hr	Tier 2	
NITRO-BID OINT 2%	Tier 2	
nitroglycerin PT24 .1mg/hr, .2mg/hr, .4mg/hr, .6mg/hr	Tier 2	
nitroglycerin (generic of NITROSTAT) SUBL .3mg, .4mg, .6mg	Tier 2	
PULMONARY ARTERIAL HYPERTENSION		
ADEMPAS TABS .5mg, 1mg, 1.5mg, 2mg, 2.5mg QL (90 tabs / 30 days)	Tier 2	QL NM LA PA
ambrisentan (generic of LETAIRIS) TABS 5mg, 10mg QL (30 tabs / 30 days)	Tier 1	QL NM LA PA
bosentan (generic of TRACLEER) TABS 62.5mg QL (120 tabs / 30 days)	Tier 1	QL NM LA PA
bosentan (generic of TRACLEER) TABS 125mg QL (60 tabs / 30 days)	Tier 1	QL NM LA PA
OPSUMIT TABS 10mg QL (30 tabs / 30 days)	Tier 2	QL NM LA PA
sildenafil citrate (pulmonary hypertension) (generic of REVATIO) TABS 20mg QL (90 tabs / 30 days)	Tier 2	QL NM PA
VENTAVIS SOLN 10mcg/ml, 20mcg/ml	Tier 2	NM PA
CENTRAL NERVOUS SYSTEM		
ANTIANXIETY		
alprazolam (generic of XANAX) TABS .25mg, .5mg, 1mg, 2mg QL (150 tabs / 30 days)	Tier 1	QL
buspirone hcl TABS 5mg, 10mg, 15mg	Tier 1	
buspirone hcl TABS 7.5mg, 30mg	Tier 2	
fluvoxamine maleate TABS 25mg, 50mg, 100mg	Tier 2	
lorazepam CONC 2mg/ml QL (150 mL / 30 days)	Tier 2	QL
lorazepam (generic of ATIVAN) SOLN 2mg/ml, 4mg/ml	Tier 1	
lorazepam (generic of ATIVAN) TABS .5mg, 1mg, 2mg QL (150 tabs / 30 days)	Tier 1	QL
lorazepam intensol CONC 2mg/ml QL (150 mL / 30 days)	Tier 2	QL
ANTICONVULSANTS		
APTIOM TABS 200mg, 400mg, 600mg, 800mg QL (60 tabs / 30 days)	Tier 3	QL
BRIVIACT SOLN 10mg/ml QL (600 mL / 30 days)	Tier 3	QL PA
BRIVIACT SOLN 50mg/5ml	Tier 3	PA

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

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

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

Drug Name	Drug Tier	Requirements/ Limits
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 (generic of PHENYTEK) 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 3	QL PA
primidone (generic of MYSOLINE) TABS 50mg, 250mg	Tier 1	
roweepra (generic of KEPPRA) TABS 500mg	Tier 2	
rufinamide (generic of BANZEL) SUSP 40mg/ml QL (2300 mL / 28 days)	Tier 3	QL PA
rufinamide (generic of BANZEL) TABS 200mg QL (480 tabs / 30 days)	Tier 3	QL PA
rufinamide (generic of BANZEL) TABS 400mg QL (240 tabs / 30 days)	Tier 3	QL PA
SPRITAM TB3D 250mg QL (360 tabs / 30 days)	Tier 3	QL
SPRITAM TB3D 500mg QL (180 tabs / 30 days)	Tier 3	QL
SPRITAM TB3D 750mg QL (120 tabs / 30 days)	Tier 3	QL
SPRITAM TB3D 1000mg QL (90 tabs / 30 days)	Tier 3	QL
subvenite (generic of LAMICTAL) TABS 25mg, 100mg, 150mg, 200mg	Tier 1	
SYMPAZAN FILM 5mg, 10mg, 20mg QL (60 films / 30 days)	Tier 3	QL PA
tiagabine hcl (generic of GABITRIL) TABS 2mg, 4mg, 12mg, 16mg	Tier 3	
topiramate (generic of TOPAMAX SPRINKLE) CPSP 15mg, 25mg	Tier 2	
topiramate (generic of TOPAMAX) TABS 25mg, 50mg, 100mg, 200mg	Tier 1	
valproate sodium SOLN 100mg/ml	Tier 3	
valproate sodium SOLN 250mg/5ml	Tier 2	
valproic acid CAPS 250mg	Tier 2	
VALTOCO LIQD 5mg/0.1ml, 10mg/0.1ml; LQPK 7.5mg/0.1ml, 10mg/0.1ml	Tier 3	
vigabatrin (generic of SABRIL) PACK 500mg QL (180 packets / 30 days)	Tier 1	QL NM LA PA
vigabatrin (generic of SABRIL) TABS 500mg QL (180 tabs / 30 days)	Tier 1	QL NM LA PA
vigadrone (generic of SABRIL) PACK 500mg QL (180 packets / 30 days)	Tier 1	QL NM LA PA

Drug Name	Drug Tier	Requirements/ Limits
VIMPAT SOLN 10mg/ml QL (1200 mL / 30 days)	Tier 3	QL
VIMPAT SOLN 200mg/20ml	Tier 3	
VIMPAT TABS 50mg QL (120 tabs / 30 days)	Tier 3	QL
VIMPAT TABS 100mg, 150mg, 200mg QL (60 tabs / 30 days)	Tier 3	QL
XCOPRI TABS 50mg QL (90 tabs / 30 days)	Tier 3	QL
XCOPRI TABS 100mg, 150mg, 200mg QL (60 tabs / 30 days)	Tier 3	QL
XCOPRI PAK 12.5-25 QL (28 tabs / 28 days)	Tier 3	QL
XCOPRI PAK 50-100MG QL (28 tabs / 28 days)	Tier 3	QL
XCOPRI PAK 50-200MG QL (56 tabs / 28 days)	Tier 3	QL
XCOPRI PAK 100-150 QL (56 tabs / 28 days)	Tier 3	QL
XCOPRI PAK 150-200MG (MAINTENANCE) QL (56 tabs / 28 days)	Tier 3	QL
XCOPRI PAK 150-200MG (TITRATION) QL (28 tabs / 28 days)	Tier 3	QL
zonisamide (generic of ZONEGRAN) CAPS 25mg, 100mg	Tier 1	
zonisamide CAPS 50mg	Tier 1	
ANTIDEMENTIA		
donepezil hydrochloride (generic of ARICEPT) TABS 5mg QL (30 tabs / 30 days)	Tier 1	QL
donepezil hydrochloride (generic of ARICEPT) TABS 10mg	Tier 1	
donepezil hydrochloride TBDP 5mg QL (30 tabs / 30 days)	Tier 1	QL
donepezil hydrochloride TBDP 10mg	Tier 1	
galantamine hydrobromide (generic of RAZADYNE ER) CP24 8mg, 16mg, 24mg QL (30 caps / 30 days)	Tier 2	QL
galantamine hydrobromide SOLN 4mg/ml	Tier 3	
galantamine hydrobromide TABS 4mg, 8mg, 12mg QL (60 tabs / 30 days)	Tier 2	QL
memantine hcl (generic of NAMENDA XR) CP24 7mg, 14mg, 21mg, 28mg PA if < 30 yrs	Tier 3	PA
memantine hcl SOLN 2mg/ml PA if < 30 yrs	Tier 3	PA
memantine hcl TABS 5mg, 10mg PA if < 30 yrs	Tier 2	PA
NAMZARIC CAP 7-10MG	Tier 3	
NAMZARIC CAP 14-10MG	Tier 3	
NAMZARIC CAP 21-10MG	Tier 3	
NAMZARIC CAP 28-10MG	Tier 3	
NAMZARIC CAP PACK	Tier 3	
rivastigmine (generic of EXELON) PT24 4.6mg/24hr, 9.5mg/24hr, 13.3mg/24hr QL (30 patches / 30 days)	Tier 3	QL
rivastigmine tartrate CAPS 1.5mg, 3mg QL (90 caps / 30 days)	Tier 2	QL
rivastigmine tartrate CAPS 4.5mg, 6mg QL (60 caps / 30 days)	Tier 2	QL
ANTIDEPRESSANTS		
amitriptyline hcl TABS 10mg, 25mg, 50mg, 75mg, 100mg, 150mg	Tier 2	
amoxapine TABS 25mg, 50mg, 100mg, 150mg	Tier 2	
bupropion hcl TABS 75mg, 100mg	Tier 2	
bupropion hcl (generic of WELLBUTRIN SR) TB12 100mg, 150mg, 200mg	Tier 2	

Drug Name	Drug Tier	Requirements/ Limits
bupropion hcl (generic of WELLBUTRIN XL) TB24 150mg, 300mg	Tier 2	
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 3	PA
desipramine hcl (generic of NORPRAMIN) TABS 10mg, 25mg	Tier 3	
desipramine hcl TABS 50mg, 75mg, 100mg, 150mg	Tier 3	
desvenlafaxine succinate (generic of PRISTIQ) TB24 25mg, 50mg, 100mg QL (30 tabs / 30 days)	Tier 3	QL PA
doxepin hcl CAPS 10mg, 25mg, 50mg, 75mg, 100mg; CONC 10mg/ml	Tier 2	
doxepin hcl CAPS 150mg	Tier 3	
DRIZALMA SPRINKLE CSDR 20mg, 30mg, 40mg, 60mg QL (60 caps / 30 days)	Tier 3	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 3	
escitalopram oxalate (generic of LEXAPRO) TABS 5mg, 10mg, 20mg	Tier 1	
FETZIMA CP24 20mg, 40mg QL (60 caps / 30 days)	Tier 3	QL PA
FETZIMA CP24 80mg, 120mg QL (30 caps / 30 days)	Tier 3	QL PA
FETZIMA CAP TITRATIO	Tier 3	PA
fluoxetine hcl (generic of PROZAC) CAPS 10mg, 20mg	Tier 1	
fluoxetine hcl (generic of PROZAC) CAPS 40mg	Tier 1	
fluoxetine hcl SOLN 20mg/5ml	Tier 2	
imipramine hcl TABS 10mg, 25mg, 50mg	Tier 1	
MARPLAN TABS 10mg QL (180 tabs / 30 days)	Tier 3	QL
mirtazapine TABS 7.5mg	Tier 2	
mirtazapine (generic of REMERON) TABS 15mg, 30mg	Tier 1	
mirtazapine TABS 45mg	Tier 1	
mirtazapine (generic of REMERON SOLTAB) TBDP 15mg, 30mg, 45mg	Tier 2	
nefazodone hcl TABS 50mg, 100mg, 150mg, 200mg, 250mg	Tier 3	
nortriptyline hcl (generic of PAMELOR) CAPS 10mg, 25mg, 50mg, 75mg	Tier 1	
nortriptyline hcl SOLN 10mg/5ml	Tier 3	
paroxetine hcl (generic of PAXIL) TABS 10mg, 20mg, 30mg, 40mg	Tier 1	
PAXIL SUSP 10mg/5ml QL (900 mL / 30 days)	Tier 3	QL PA
phenelzine sulfate (generic of NARDIL) TABS 15mg	Tier 2	
protriptyline hcl TABS 5mg, 10mg	Tier 3	
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 3	
trazodone hcl TABS 50mg, 100mg, 150mg	Tier 1	

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

Drug Name	Drug Tier	Requirements/ Limits
pramipexole dihydrochloride (generic of MIRAPEX) TABS .125mg, .5mg, .75mg, 1mg	Tier 1	
rasagiline mesylate (generic of AZILECT) TABS 1mg QL (30 tabs / 30 days)	Tier 3	QL
rasagiline mesylate (generic of AZILECT) TABS .5mg QL (60 tabs / 30 days)	Tier 3	QL
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; TABS 2mg, 5mg PA if 70 years and older	Tier 2	PA
ANTIPSYCHOTICS		
ABILIFY MAINTENA PRSY 300mg, 400mg QL (1 syringe / 28 days)	Tier 3	QL
ABILIFY MAINTENA SRER 300mg, 400mg QL (1 injection / 28 days)	Tier 3	QL
aripiprazole SOLN 1mg/ml QL (900 mL / 30 days)	Tier 3	QL
aripiprazole (generic of ABILIFY) TABS 2mg, 5mg, 10mg, 15mg, 20mg, 30mg QL (30 tabs / 30 days)	Tier 3	QL
aripiprazole TBDP 10mg, 15mg QL (60 tabs / 30 days)	Tier 3	QL
ARISTADA PRSY 441mg/1.6ml, 662mg/2.4ml, 882mg/3.2ml QL (1 syringe / 28 days)	Tier 3	QL
ARISTADA PRSY 1064mg/3.9ml QL (1 syringe / 56 days)	Tier 3	QL
ARISTADA INITIO PRSY 675mg/2.4ml	Tier 3	
asenapine maleate (generic of SAPHRIS) SUBL 2.5mg, 5mg, 10mg QL (60 tabs / 30 days)	Tier 3	QL
CAPLYTA CAPS 42mg QL (30 caps / 30 days)	Tier 3	QL PA
chlorpromazine hcl SOLN 25mg/ml, 50mg/2ml; TABS 10mg, 25mg, 50mg, 100mg, 200mg	Tier 3	
clozapine (generic of CLOZARIL) TABS 25mg, 50mg	Tier 2	
clozapine (generic of CLOZARIL) TABS 100mg QL (270 tabs / 30 days)	Tier 3	QL
clozapine (generic of CLOZARIL) TABS 200mg QL (135 tabs / 30 days)	Tier 3	QL
clozapine TBDP 12.5mg, 25mg	Tier 3	PA
clozapine TBDP 100mg QL (270 tabs / 30 days)	Tier 3	QL PA
clozapine TBDP 150mg QL (180 tabs / 30 days)	Tier 3	QL PA
clozapine TBDP 200mg QL (135 tabs / 30 days)	Tier 3	QL PA
FANAPT TABS 1mg, 2mg, 4mg, 6mg, 8mg, 10mg, 12mg QL (60 tabs / 30 days)	Tier 3	QL PA
FANAPT PAK	Tier 3	PA
fluphenazine decanoate SOLN 25mg/ml	Tier 3	
fluphenazine hcl CONC 5mg/ml; ELIX 2.5mg/5ml; SOLN 2.5mg/ml; TABS 1mg, 2.5mg, 5mg, 10mg	Tier 3	
haloperidol TABS .5mg, 1mg, 2mg, 5mg, 10mg, 20mg	Tier 2	

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

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

Drug Name	Drug Tier	Requirements/ Limits
ATTENTION DEFICIT HYPERACTIVITY DISORDER		
amphetamine-dextroamphetamine tab 5 mg (generic of ADDERALL) QL (60 tabs / 30 days)	Tier 2	QL PA
amphetamine-dextroamphetamine tab 7.5 mg (generic of ADDERALL) QL (60 tabs / 30 days)	Tier 2	QL PA
amphetamine-dextroamphetamine tab 10 mg (generic of ADDERALL) QL (60 tabs / 30 days)	Tier 2	QL PA
amphetamine-dextroamphetamine tab 12.5 mg (generic of ADDERALL) QL (60 tabs / 30 days)	Tier 2	QL PA
amphetamine-dextroamphetamine tab 15 mg (generic of ADDERALL) QL (60 tabs / 30 days)	Tier 2	QL PA
amphetamine-dextroamphetamine tab 20 mg (generic of ADDERALL) QL (90 tabs / 30 days)	Tier 2	QL PA
amphetamine-dextroamphetamine tab 30 mg (generic of ADDERALL) QL (60 tabs / 30 days)	Tier 2	QL PA
atomoxetine hcl (generic of STRATTERA) CAPS 10mg, 18mg, 25mg QL (120 caps / 30 days)	Tier 3	QL
atomoxetine hcl (generic of STRATTERA) CAPS 40mg QL (60 caps / 30 days)	Tier 3	QL
atomoxetine hcl (generic of STRATTERA) CAPS 60mg, 80mg, 100mg QL (30 caps / 30 days)	Tier 3	QL
dexmethylphenidate hcl (generic of FOCALIN) TABS 2.5mg, 5mg QL (120 tabs / 30 days)	Tier 2	QL PA

Drug Name	Drug Tier	Requirements/ Limits
dexmethylphenidate hcl (generic of FOCALIN) TABS 10mg QL (60 tabs / 30 days)	Tier 2	QL PA
guanfacine hcl (adhd) (generic of INTUNIV) TB24 1mg, 2mg, 3mg, 4mg QL (30 tabs / 30 days) PA if 70 years and older	Tier 2	QL PA
metadate er TBCR 20mg QL (90 tabs / 30 days)	Tier 3	QL PA
methylphenidate hcl (generic of METHYLIN) SOLN 5mg/5ml QL (1800 mL / 30 days)	Tier 3	QL PA
methylphenidate hcl (generic of METHYLIN) SOLN 10mg/5ml QL (900 mL / 30 days)	Tier 3	QL PA
methylphenidate hcl (generic of RITALIN) TABS 5mg, 10mg QL (180 tabs / 30 days)	Tier 2	QL PA
methylphenidate hcl (generic of RITALIN) TABS 20mg QL (90 tabs / 30 days)	Tier 2	QL PA
methylphenidate hcl TBCR 10mg, 20mg QL (90 tabs / 30 days)	Tier 3	QL PA
HYPNOTICS		
BELSOMRA TABS 5mg, 10mg, 15mg, 20mg QL (30 tabs / 30 days)	Tier 3	QL
doxepin hcl (sleep) (generic of SILENOR) TABS 3mg, 6mg QL (30 tabs / 30 days)	Tier 2	QL
HETLIOZ CAPS 20mg QL (30 caps / 30 days)	Tier 2	QL NM LA PA
temazepam (generic of RESTORIL) CAPS 7.5mg QL (30 caps / 30 days) PA applies if 65 years and older after a 90 day supply in a calendar year	Tier 3	QL PA
temazepam (generic of RESTORIL) CAPS 15mg QL (60 caps / 30 days) PA applies if 65 years and older after a 90 day supply in a calendar year	Tier 3	QL PA
temazepam (generic of RESTORIL) CAPS 30mg QL (30 caps / 30 days) PA if 65 years and older	Tier 3	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	Tier 1	QL PA
MIGRAINE		
AIMOVIG SOAJ 70mg/ml, 140mg/ml QL (1 pen / 30 days)	Tier 2	QL NM PA
dihydroergotamine mesylate (generic of D.H.E. 45) SOLN 1mg/ml	Tier 1	
dihydroergotamine mesylate (generic of MIGRANAL) SOLN 4mg/ml QL (8 mL / 30 days)	Tier 1	QL PA
ergotamine w/ caffeine tab 1-100 mg (generic of CAFERGOT) QL (40 tabs / 28 days)	Tier 2	QL PA
rizatriptan benzoate TABS 5mg; TBDP 5mg QL (18 tabs / 30 days)	Tier 2	QL
rizatriptan benzoate (generic of MAXALT) TABS 10mg QL (18 tabs / 30 days)	Tier 2	QL
rizatriptan benzoate (generic of MAXALT-MLT) TBDP 10mg QL (18 tabs / 30 days)	Tier 2	QL
sumatriptan (generic of IMITREX) SOLN 5mg/act QL (24 units / 30 days)	Tier 3	QL
sumatriptan (generic of IMITREX) SOLN 20mg/act QL (12 units / 30 days)	Tier 3	QL

Drug Name	Drug Tier	Requirements/ Limits
sumatriptan succinate (generic of IMITREX STATDOSE SYSTEM) SOAJ 4mg/0.5ml QL (18 injections / 30 days)	Tier 3	QL
sumatriptan succinate (generic of IMITREX STATDOSE SYSTEM) SOAJ 6mg/0.5ml QL (12 injections / 30 days)	Tier 3	QL
sumatriptan succinate (generic of IMITREX STATDOSE REFILL) SOCT 4mg/0.5ml QL (18 injections / 30 days)	Tier 3	QL
sumatriptan succinate (generic of IMITREX STATDOSE REFILL) SOCT 6mg/0.5ml QL (12 injections / 30 days)	Tier 3	QL
sumatriptan succinate (generic of IMITREX) SOLN 6mg/0.5ml QL (12 injections / 30 days)	Tier 3	QL
sumatriptan succinate (generic of IMITREX) TABS 25mg, 50mg, 100mg QL (12 tabs / 30 days)	Tier 1	QL
UBRELVY TABS 50mg, 100mg QL (16 tabs / 30 days)	Tier 3	QL PA
MISCELLANEOUS		
AUSTEDO TABS 6mg QL (60 tabs / 30 days)	Tier 2	QL NM PA
AUSTEDO TABS 9mg, 12mg QL (120 tabs / 30 days)	Tier 2	QL NM PA
INGREZZA CAPS 40mg, 60mg, 80mg QL (30 caps / 30 days)	Tier 2	QL NM LA PA
INGREZZA CAP 40-80MG QL (28 caps / 28 days)	Tier 2	QL NM LA PA
LITHIUM SOLN 8meq/5ml	Tier 3	
lithium carbonate CAPS 150mg, 300mg, 600mg; TABS 300mg; TBCR 450mg	Tier 1	
lithium carbonate (generic of LITHOBID) TBCR 300mg	Tier 1	
NUEDEXTA CAP 20-10MG QL (60 caps / 30 days)	Tier 3	QL PA
pregabalin (once-daily) (generic of LYRICA CR) TB24 82.5mg, 165mg, 330mg QL (60 tabs / 30 days)	Tier 3	QL PA
pyridostigmine bromide (generic of MESTINON) TABS 60mg	Tier 2	
riluzole (generic of RILUTEK) TABS 50mg	Tier 3	
tetrabenazine (generic of XENAZINE) TABS 12.5mg QL (90 tabs / 30 days)	Tier 1	QL NM PA
tetrabenazine (generic of XENAZINE) TABS 25mg QL (120 tabs / 30 days)	Tier 1	QL NM PA
MULTIPLE SCLEROSIS AGENTS		
BETASERON KIT .3mg QL (14 syringes / 28 days)	Tier 2	QL NM PA
dalfampridine (generic of AMPYRA) TB12 10mg	Tier 2	NM PA
GILENYA CAPS .5mg QL (28 caps / 28 days)	Tier 2	QL NM PA
glatiramer acetate (generic of COPAXONE) SOSY 20mg/ml QL (30 syringes / 30 days)	Tier 1	QL NM PA
glatiramer acetate (generic of COPAXONE) SOSY 40mg/ml QL (12 syringes / 28 days)	Tier 1	QL NM PA
glatopa (generic of COPAXONE) SOSY 20mg/ml QL (30 syringes / 30 days)	Tier 1	QL NM PA

Drug Name	Drug Tier	Requirements/ Limits
glatopa (generic of COPAXONE) SOSY 40mg/ml QL (12 syringes / 28 days)	Tier 1	QL NM PA
MUSCULOSKELETAL THERAPY AGENTS		
baclofen TABS 10mg, 20mg	Tier 2	
cyclobenzaprine hcl TABS 5mg, 10mg PA if 70 years and older	Tier 2	PA
dantrolene sodium (generic of DANTRIUM) CAPS 25mg, 50mg	Tier 3	
dantrolene sodium CAPS 100mg	Tier 3	
tizanidine hcl TABS 2mg	Tier 1	
tizanidine hcl (generic of ZANAFLEX) TABS 4mg	Tier 1	
NARCOLEPSY/CATAPLEXY		
armodafinil (generic of NUVIGIL) TABS 50mg QL (90 tabs / 30 days)	Tier 2	QL PA
armodafinil (generic of NUVIGIL) TABS 150mg, 200mg, 250mg QL (30 tabs / 30 days)	Tier 2	QL PA
XYREM SOLN 500mg/ml QL (540 mL / 30 days)	Tier 2	QL NM LA PA
PSYCHOTHERAPEUTIC-MISC		
acamprosate calcium TBEC 333mg	Tier 3	
buprenorphine hcl SUBL 2mg, 8mg QL (90 tabs / 30 days)	Tier 2	QL PA
buprenorphine hcl-naloxone hcl sl film 2-0.5 mg (base equiv) (generic of SUBOXONE) QL (90 films / 30 days)	Tier 3	QL
buprenorphine hcl-naloxone hcl sl film 4-1 mg (base equiv) (generic of SUBOXONE) QL (90 films / 30 days)	Tier 3	QL
buprenorphine hcl-naloxone hcl sl film 8-2 mg (base equiv) (generic of SUBOXONE) QL (90 films / 30 days)	Tier 3	QL
buprenorphine hcl-naloxone hcl sl film 12-3 mg (base equiv) (generic of SUBOXONE) QL (60 films / 30 days)	Tier 3	QL
buprenorphine hcl-naloxone hcl sl tab 2-0.5 mg (base equiv) QL (90 tabs / 30 days)	Tier 1	QL
buprenorphine hcl-naloxone hcl sl tab 8-2 mg (base equiv) QL (90 tabs / 30 days)	Tier 1	QL
bupropion hcl (smoking deterrent) TB12 150mg	Tier 2	
CHANTIX TABS .5mg, 1mg QL (56 tabs / 28 days)	Tier 3	QL PA
CHANTIX CONTINUING MONTH TABS 1mg QL (56 tabs / 28 days)	Tier 3	QL PA
CHANTIX PAK 0.5& 1MG QL (106 tabs / year)	Tier 3	QL PA
disulfiram TABS 250mg, 500mg	Tier 2	
naloxone hcl SOCT .4mg/ml; SOLN .4mg/ml, 4mg/10ml; SOSY 2mg/2ml	Tier 1	
naltrexone hcl TABS 50mg	Tier 2	
NARCAN LIQD 4mg/0.1ml	Tier 2	
NICOTROL INHALER INHA 10mg	Tier 3	
NICOTROL NS SOLN 10mg/ml	Tier 3	
VIVITROL SUSR 380mg	Tier 2	NM
ENDOCRINE AND METABOLIC		
ANDROGENS		
ANDRODERM PT24 2mg/24hr, 4mg/24hr QL (30 patches / 30 days)	Tier 3	QL PA
oxandrolone TABS 2.5mg QL (120 tabs / 30 days)	Tier 2	QL PA

Drug Name	Drug Tier	Requirements/ Limits
oxandrolone TABS 10mg QL (60 tabs / 30 days)	Tier 3	QL PA
testosterone GEL 1% QL (300 gm / 30 days)	Tier 3	QL PA
testosterone (generic of ANDROGEL) GEL 25mg/2.5gm, 50mg/5gm QL (300 gm / 30 days)	Tier 3	QL PA
testosterone cypionate (generic of DEPO-TESTOSTERONE) SOLN 100mg/ml, 200mg/ml	Tier 2	PA
testosterone enanthate SOLN 200mg/ml	Tier 2	PA
ANTIDIABETICS		
acarbose (generic of PRECOSE) TABS 25mg, 50mg, 100mg	Tier 2	
BYDUREON BCISE AUIJ 2mg/0.85ml QL (4 pens / 28 days)	Tier 2	QL
BYETTA SOPN 5mcg/0.02ml, 10mcg/0.04ml QL (1 pen / 30 days)	Tier 3	QL
FARXIGA TABS 5mg, 10mg QL (30 tabs / 30 days)	Tier 2	QL
glimepiride (generic of AMARYL) TABS 1mg, 2mg QL (90 tabs / 30 days)	Tier 1	QL
glimepiride (generic of AMARYL) TABS 4mg QL (60 tabs / 30 days)	Tier 1	QL
glipizide TABS 5mg QL (240 tabs / 30 days)	Tier 1	QL
glipizide TABS 10mg QL (120 tabs / 30 days)	Tier 1	QL
glipizide (generic of GLUCOTROL XL) TB24 2.5mg, 5mg QL (90 tabs / 30 days)	Tier 1	QL
glipizide (generic of GLUCOTROL XL) TB24 10mg QL (60 tabs / 30 days)	Tier 1	QL
glipizide xl (generic of GLUCOTROL XL) TB24 2.5mg, 5mg QL (90 tabs / 30 days)	Tier 1	QL
glipizide xl (generic of GLUCOTROL XL) TB24 10mg QL (60 tabs / 30 days)	Tier 1	QL
glipizide-metformin hcl tab 2.5-250 mg QL (240 tabs / 30 days)	Tier 2	QL
glipizide-metformin hcl tab 2.5-500 mg QL (120 tabs / 30 days)	Tier 2	QL
glipizide-metformin hcl tab 5-500 mg QL (120 tabs / 30 days)	Tier 2	QL
GLYXAMBI TAB 10-5 MG QL (30 tabs / 30 days)	Tier 2	QL
GLYXAMBI TAB 25-5 MG QL (30 tabs / 30 days)	Tier 2	QL
JANUMET TAB 50-500MG QL (60 tabs / 30 days)	Tier 2	QL
JANUMET TAB 50-1000 QL (60 tabs / 30 days)	Tier 2	QL
JANUMET XR TAB 50-500MG QL (60 tabs / 30 days)	Tier 2	QL
JANUMET XR TAB 50-1000 QL (60 tabs / 30 days)	Tier 2	QL
JANUMET XR TAB 100-1000 QL (30 tabs / 30 days)	Tier 2	QL
JANUVIA TABS 25mg, 50mg, 100mg QL (30 tabs / 30 days)	Tier 2	QL
JARDIANCE TABS 10mg QL (60 tabs / 30 days)	Tier 2	QL
JARDIANCE TABS 25mg QL (30 tabs / 30 days)	Tier 2	QL
JENTADUETO TAB 2.5-500 QL (60 tabs / 30 days)	Tier 2	QL
JENTADUETO TAB 2.5-850 QL (60 tabs / 30 days)	Tier 2	QL

Drug Name	Drug Tier	Requirements/ Limits
JENTADUETO TAB 2.5-1000 QL (60 tabs / 30 days)	Tier 2	QL
JENTADUETO TAB XR 2.5-1000MG QL (60 tabs / 30 days)	Tier 2	QL
JENTADUETO TAB XR 5-1000MG QL (30 tabs / 30 days)	Tier 2	QL
metformin hcl TABS 500mg QL (150 tabs / 30 days)	Tier 1	QL
metformin hcl TABS 850mg QL (90 tabs / 30 days)	Tier 1	QL
metformin hcl TABS 1000mg QL (75 tabs / 30 days)	Tier 1	QL
metformin hcl TB24 500mg QL (120 tabs / 30 days) (generic of GLUCOPHAGE XR)	Tier 1	QL
metformin hcl TB24 750mg QL (60 tabs / 30 days) (generic of GLUCOPHAGE XR)	Tier 1	QL
nateglinide TABS 60mg, 120mg QL (90 tabs / 30 days)	Tier 2	QL
OZEMPIC (0.25 OR 0.5MG/DOSE) SOPN 2mg/1.5ml QL (1 pen / 28 days)	Tier 2	QL
OZEMPIC (1MG/DOSE) SOPN 2mg/1.5ml QL (2 pens / 28 days)	Tier 2	QL
OZEMPIC (1MG/DOSE) SOPN 4mg/3ml QL (1 pen / 28 days)	Tier 2	QL
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 2	QL
repaglinide TABS .5mg, 1mg QL (120 tabs / 30 days)	Tier 2	QL
RYBELSUS TABS 3mg, 7mg, 14mg QL (30 tabs / 30 days)	Tier 2	QL
SYNJARDY TAB 5-500MG QL (120 tabs / 30 days)	Tier 2	QL
SYNJARDY TAB 5-1000MG QL (60 tabs / 30 days)	Tier 2	QL
SYNJARDY TAB 12.5-500 QL (60 tabs / 30 days)	Tier 2	QL
SYNJARDY TAB 12.5-1000MG QL (60 tabs / 30 days)	Tier 2	QL
SYNJARDY XR TAB 5-1000MG QL (60 tabs / 30 days)	Tier 2	QL
SYNJARDY XR TAB 10-1000 QL (60 tabs / 30 days)	Tier 2	QL
SYNJARDY XR TAB 12.5-1000MG QL (60 tabs / 30 days)	Tier 2	QL
SYNJARDY XR TAB 25-1000 QL (30 tabs / 30 days)	Tier 2	QL
TRADJENTA TABS 5mg QL (30 tabs / 30 days)	Tier 2	QL
TRIJARDY XR TAB ER 24HR 5-2.5-1000MG QL (60 tabs / 30 days)	Tier 2	QL
TRIJARDY XR TAB ER 24HR 10-5-1000MG QL (30 tabs / 30 days)	Tier 2	QL
TRIJARDY XR TAB ER 24HR 12.5-2.5-1000MG QL (60 tabs / 30 days)	Tier 2	QL
TRIJARDY XR TAB ER 24HR 25-5-1000MG QL (30 tabs / 30 days)	Tier 2	QL
TRULICITY SOPN .75mg/0.5ml, 1.5mg/0.5ml, 3mg/0.5ml, 4.5mg/0.5ml QL (4 pens / 28 days)	Tier 2	QL

Drug Name	Drug Tier	Requirements/ Limits
VICTOZA SOPN 18mg/3ml QL (3 pens / 30 days)	Tier 2	QL
XIGDUO XR TAB 2.5-1000 QL (60 tabs / 30 days)	Tier 2	QL
XIGDUO XR TAB 5-500MG QL (60 tabs / 30 days)	Tier 2	QL
XIGDUO XR TAB 5-1000MG QL (60 tabs / 30 days)	Tier 2	QL
XIGDUO XR TAB 10-500MG QL (30 tabs / 30 days)	Tier 2	QL
XIGDUO XR TAB 10-1000 QL (30 tabs / 30 days)	Tier 2	QL
ANTIDIABETICS, INSULINS		
BASAGLAR KWIKPEN SOPN 100unit/ml	Tier 2	
BD ALCOHOL SWABS	Tier 2	
FIASP FLEX INJ TOUCH	Tier 2	
FIASP INJ 100/ML	Tier 2	
FIASP PENFIL INJ U-100	Tier 2	
GAUZE PADS 2" X 2"	Tier 2	
HUMULIN R U-500 (CONCENTR SOLN 500unit/ml	Tier 2	B/D
HUMULIN R U-500 KWIKPEN SOPN 500unit/ml	Tier 2	
INSULIN SAFETY NEEDLES	Tier 2	
INSULIN SYRINGES: BD/ULTIMED/ALLISON/TRIVIDIA/MHC	Tier 2	
LEVEMIR SOLN 100unit/ml	Tier 2	
LEVEMIR FLEXTOUCH SOPN 100unit/ml	Tier 2	
NOVOLIN INJ 70/30 (brand RELION not covered)	Tier 2	
NOVOLIN INJ 70/30 FP (brand RELION not covered)	Tier 2	
NOVOLIN N SUSP 100unit/ml (brand RELION not covered)	Tier 2	
NOVOLIN N FLEXPEN SUPN 100unit/ml (brand RELION not covered)	Tier 2	
NOVOLIN R SOLN 100unit/ml (brand RELION not covered)	Tier 2	
NOVOLIN R FLEXPEN SOPN 100unit/ml (brand RELION not covered)	Tier 2	
NOVOLOG SOLN 100unit/ml (brand RELION not covered)	Tier 2	
NOVOLOG FLEXPEN SOPN 100unit/ml (brand RELION not covered)	Tier 2	
NOVOLOG MIX INJ 70/30 (brand RELION not covered)	Tier 2	
NOVOLOG MIX INJ FLEXPEN (brand RELION not covered)	Tier 2	
NOVOLOG PENFILL SOCT 100unit/ml (brand RELION not covered)	Tier 2	
OMNIPOD KIT STARTER QL (1 kit / year)	Tier 3	QL PA
OMNIPOD MIS 5 PACK QL (10 pods / 30 days)	Tier 3	QL PA
PEN NEEDLES: NOVO/BD/ULTIMED/OWEN/TRIVIDIA	Tier 2	
SOLIQUA INJ 100/33 QL (10 pens / 30 days)	Tier 2	QL
TRESIBA SOLN 100unit/ml	Tier 2	
TRESIBA FLEXTOUCH SOPN 100unit/ml, 200unit/ml	Tier 2	
V-GO 20 KIT QL (1 kit / 30 days)	Tier 3	QL PA
V-GO 30 KIT QL (1 kit / 30 days)	Tier 3	QL PA

Drug Name	Drug Tier	Requirements/ Limits
V-GO 40 KIT QL (1 kit / 30 days)	Tier 3	QL PA
XULTOPHY INJ 100/3.6 QL (5 pens / 30 days)	Tier 2	QL
CALCIUM REGULATORS		
alendronate sodium TABS 10mg, 35mg	Tier 1	
alendronate sodium (generic of FOSAMAX) TABS 70mg	Tier 1	
calcitonin (salmon) spray (generic of MIACALCIN) SOLN 200unit/act	Tier 2	B/D
FORTEO SOPN 620mcg/2.48ml	Tier 2	NM PA
ibandronate sodium (generic of BONIVA) TABS 150mg	Tier 2	B/D
NATPARA CART 25mcg, 50mcg, 75mcg, 100mcg	Tier 2	NM PA
PAMIDRONATE DISODIUM SOLN 6mg/ml	Tier 2	B/D
pamidronate disodium SOLN 30mg/10ml, 90mg/10ml; SOLR 30mg, 90mg	Tier 2	B/D
PROLIA SOSY 60mg/ml QL (1 syringe / 180 days)	Tier 3	QL NM
XGEVA SOLN 120mg/1.7ml	Tier 2	NM PA
zoledronic acid CONC 4mg/5ml; SOLN 4mg/100ml	Tier 3	B/D NM
zoledronic acid (generic of RECLAST) SOLN 5mg/100ml	Tier 3	B/D NM
CHELATING AGENTS		
CHEMET CAPS 100mg	Tier 3	
deferasirox (generic of JADENU SPRINKLE) PACK 90mg, 180mg, 360mg	Tier 1	NM PA
deferasirox (generic of JADENU) TABS 90mg, 180mg, 360mg	Tier 1	NM PA
LOKELMA PACK 5gm, 10gm	Tier 2	
penicillamine (generic of DEPEN TITRATABS) TABS 250mg	Tier 1	NM
sodium polystyrene sulfonate powder	Tier 2	
sps SUSP 15gm/60ml	Tier 2	
trientine hcl (generic of SYPRINE) CAPS 250mg	Tier 1	NM PA
VELTASSA PACK 8.4gm, 16.8gm, 25.2gm	Tier 3	PA
CONTRACEPTIVES		
afirmelle	Tier 2	
altavera	Tier 2	
alyacen 1/35	Tier 2	
alyacen 7/7/7	Tier 2	
apri	Tier 2	
aranelle	Tier 2	
aubra eq	Tier 2	
aurovela 1/20	Tier 2	
aurovela fe 1.5/30	Tier 2	
aurovela fe 1/20	Tier 2	
aviane	Tier 2	
ayuna	Tier 2	
azurette (generic of MIRCETTE)	Tier 2	
balziva	Tier 2	
bekyree (generic of MIRCETTE)	Tier 2	
blisovi fe 1.5/30	Tier 2	
briellyn	Tier 2	
camila TABS .35mg	Tier 2	
caziant	Tier 2	
chateal	Tier 2	
cryselle-28	Tier 2	
cyclafem 1/35	Tier 2	
cyclafem 7/7/7	Tier 2	
cyred eq	Tier 2	
dasetta 1/35	Tier 2	
dasetta 7/7/7	Tier 2	
deblitane TABS .35mg	Tier 2	
desogest-eth estrad & eth estrad tab 0.15-0.02/0.01 mg(21/5) (generic of MIRCETTE)	Tier 2	
desogestrel & ethinyl estradiol tab 0.15 mg-30 mcg	Tier 2	

Drug Name	Drug Tier	Requirements/ Limits
drospirenone-ethinyl estradiol tab 3-0.02 mg (generic of YAZ)	Tier 2	
drospirenone-ethinyl estradiol tab 3-0.03 mg (generic of YASMIN 28)	Tier 2	
elinest	Tier 2	
ELLA TABS 30mg	Tier 2	
emoquette	Tier 2	
enpresse-28	Tier 2	
enskyce	Tier 2	
errin TABS .35mg	Tier 2	
estarylla	Tier 2	
ethynodiol diacetate & ethinyl estradiol tab 1 mg-35 mcg	Tier 2	
ethynodiol diacetate & ethinyl estradiol tab 1 mg-50 mcg	Tier 2	
falmina	Tier 2	
femynor	Tier 2	
hailey 1.5/30	Tier 2	
heather TABS .35mg	Tier 2	
iclevia	Tier 2	
incassia TABS .35mg	Tier 2	
introvale	Tier 2	
isibloom	Tier 2	
jasmiel (generic of YAZ)	Tier 2	
jolessa	Tier 2	
juleber	Tier 2	
junel 1.5/30	Tier 2	
junel 1/20	Tier 2	
junel fe 1.5/30	Tier 2	
junel fe 1/20	Tier 2	
kariva (generic of MIRCETTE)	Tier 2	
kelnor 1/35	Tier 2	
kelnor 1/50	Tier 2	
kurvelo	Tier 2	
larin 1.5/30	Tier 2	
larin 1/20	Tier 2	
larin fe 1.5/30	Tier 2	
larin fe 1/20	Tier 2	
larissia	Tier 2	
leena	Tier 2	
lessina	Tier 2	
levonest	Tier 2	
levonorgestrel & ethinyl estradiol (91-day) tab 0.15-0.03 mg	Tier 2	
levonorgestrel & ethinyl estradiol tab 0.1 mg-20 mcg	Tier 2	
levonorgestrel & ethinyl estradiol tab 0.15 mg-30 mcg	Tier 2	
levonorgestrel-eth estra tab 0.05-30/0.075-40/0.125-30mg-mcg	Tier 2	
levora 0.15/30-28	Tier 2	
lillow	Tier 2	
loestrin 1.5/30-21	Tier 2	
loestrin 1/20-21	Tier 2	
loestrin fe 1.5/30	Tier 2	
loestrin fe 1/20	Tier 2	
loryna (generic of YAZ)	Tier 2	
low-ogestrel	Tier 2	
lutera	Tier 2	
lyleq TABS .35mg	Tier 2	
lyza TABS .35mg	Tier 2	
marlissa	Tier 2	
medroxyprogesterone acetate (contraceptive) (generic of DEPO-PROVERA CONTRACEPTIV) SUSP 150mg/ml; SUSY 150mg/ml	Tier 2	
microgestin 1.5/30	Tier 2	
microgestin 1/20	Tier 2	
microgestin fe 1.5/30	Tier 2	
microgestin fe 1/20	Tier 2	
mili	Tier 2	
mono-linyah	Tier 2	
necon 0.5/35-28	Tier 2	
nikki (generic of YAZ)	Tier 2	
nora-be TABS .35mg	Tier 2	
norethindrone (contraceptive) TABS .35mg	Tier 2	
norethindrone ace & ethinyl estradiol tab 1 mg-20 mcg	Tier 2	

Drug Name	Drug Tier	Requirements/ Limits
norethindrone ace & ethinyl estradiol tab 1.5 mg-30 mcg	Tier 2	
norethindrone ace & ethinyl estradiol-fe tab 1 mg-20 mcg	Tier 2	
norgestimate & ethinyl estradiol tab 0.25 mg-35 mcg	Tier 2	
norgestimate-eth estrad tab 0.18-25/0.215-25/0.25-25 mg-mcg (generic of ORTHO TRI-CYCLEN LO)	Tier 2	
norgestimate-eth estrad tab 0.18-35/0.215-35/0.25-35 mg-mcg	Tier 2	
norlyroc TABS .35mg	Tier 2	
nortrel 0.5/35 (28)	Tier 2	
nortrel 1/35 (21)	Tier 2	
nortrel 1/35 (28)	Tier 2	
nortrel 7/7/7	Tier 2	
nylia 7/7/7	Tier 2	
nymyo	Tier 2	
ocella (generic of YASMIN 28)	Tier 2	
orsythia	Tier 2	
philith	Tier 2	
pimtrea (generic of MIRCETTE)	Tier 2	
pirmella 1/35	Tier 2	
portia-28	Tier 2	
previfem	Tier 2	
reclipsen	Tier 2	
setlakin	Tier 2	
sharobel TABS .35mg	Tier 2	
simliya (generic of MIRCETTE)	Tier 2	
sprintec 28	Tier 2	
sronyx	Tier 2	
syeda (generic of YASMIN 28)	Tier 2	
tarina fe 1/20 eq	Tier 2	
tilia fe (generic of ESTROSTEP FE)	Tier 3	
tri-estarylla	Tier 2	
tri-legest fe (generic of ESTROSTEP FE)	Tier 3	
tri-linyah	Tier 2	
tri-lo-estarylla (generic of ORTHO TRI-CYCLEN LO)	Tier 2	
tri-lo-marzia (generic of ORTHO TRI-CYCLEN LO)	Tier 2	
tri-lo-mili (generic of ORTHO TRI-CYCLEN LO)	Tier 2	
tri-lo-sprintec (generic of ORTHO TRI-CYCLEN LO)	Tier 2	
tri-mili	Tier 2	
tri-nymyo	Tier 2	
tri-previfem	Tier 2	
tri-sprintec	Tier 2	
tri-vylibra	Tier 2	
tri-vylibra lo (generic of ORTHO TRI-CYCLEN LO)	Tier 2	
trivora-28	Tier 2	
velivet	Tier 2	
vestura (generic of YAZ)	Tier 2	
vienva	Tier 2	
viorele (generic of MIRCETTE)	Tier 2	
vyfemla	Tier 2	
vylibra	Tier 2	
wera	Tier 2	
xulane	Tier 3	
zafemy	Tier 3	
zarah (generic of YASMIN 28)	Tier 2	
zovia 1/35	Tier 2	
zumandimine (generic of YASMIN 28)	Tier 2	
ENDOMETRIOSIS		
danazol CAPS 50mg, 100mg, 200mg	Tier 3	
SYNAREL SOLN 2mg/ml	Tier 2	
ESTROGENS		
amabelz	Tier 2	
amabelz (generic of ACTIVELLA)	Tier 2	
dotti (generic of VIVELLE-DOT) PTTW .025mg/24hr, .037mg/24hr, .05mg/24hr, .075mg/24hr, .1mg/24hr	Tier 2	

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

Drug Name	Drug Tier	Requirements/ Limits
GLUCOCORTICOIDS		
dexamethasone ELIX .5mg/5ml; SOLN .5mg/5ml; TABS .5mg, .75mg, 1mg, 1.5mg, 2mg, 4mg, 6mg	Tier 2	
dexamethasone sodium phosphate SOLN 4mg/ml, 10mg/ml, 20mg/5ml, 100mg/10ml, 120mg/30ml	Tier 2	
fludrocortisone acetate TABS .1mg	Tier 1	
hydrocortisone (generic of CORTEF) TABS 5mg, 10mg, 20mg	Tier 2	
methylprednisolone (generic of MEDROL) TABS 4mg, 8mg, 16mg, 32mg	Tier 2	B/D
methylprednisolone (generic of MEDROL DOSEPAK) TBPK 4mg	Tier 1	
methylprednisolone acetate (generic of DEPO-MEDROL) SUSP 40mg/ml, 80mg/ml	Tier 2	B/D
methylprednisolone sod succ (generic of SOLU-MEDROL) SOLR 40mg, 125mg, 1000mg	Tier 2	B/D
prednisolone SOLN 15mg/5ml	Tier 1	B/D
prednisolone sodium phosphate SOLN 15mg/5ml	Tier 1	B/D
prednisone SOLN 5mg/5ml	Tier 3	B/D
prednisone TABS 1mg, 2.5mg, 5mg, 10mg, 20mg, 50mg	Tier 1	B/D
prednisone TBPK 5mg, 10mg	Tier 2	
SOLU-CORTEF SOLR 100mg, 250mg, 500mg, 1000mg	Tier 3	
GLUCOSE ELEVATING AGENTS		
diazoxide (generic of PROGLYCEM) SUSP 50mg/ml	Tier 1	
GVOKE HYPOPEN 2-PACK SOAJ .5mg/0.1ml, 1mg/0.2ml	Tier 2	

Drug Name	Drug Tier	Requirements/ Limits
GVOKE PFS SOSY .5mg/0.1ml, 1mg/0.2ml	Tier 2	
MISCELLANEOUS		
cabergoline TABS .5mg	Tier 2	
CARBAGLU TABS 200mg	Tier 2	NM LA PA
CERDELGA CAPS 84mg	Tier 2	NM PA
cinacalcet hcl (generic of SENSIPAR) TABS 30mg QL (120 tabs / 30 days)	Tier 3	B/D QL NM
cinacalcet hcl (generic of SENSIPAR) TABS 60mg QL (60 tabs / 30 days)	Tier 1	B/D QL NM
cinacalcet hcl (generic of SENSIPAR) TABS 90mg QL (120 tabs / 30 days)	Tier 1	B/D QL NM
CYSTADANE POW	Tier 2	NM LA
CYSTAGON CAPS 50mg, 150mg	Tier 3	NM LA PA
desmopressin acetate (generic of DDAVP) SOLN 4mcg/ml	Tier 1	
desmopressin acetate (generic of DDAVP) TABS .1mg, .2mg	Tier 2	
desmopressin acetate spray SOLN .01%	Tier 3	
desmopressin acetate spray refrigerated SOLN .01%	Tier 3	
GENOTROPIN SOLR 5mg, 12mg	Tier 2	NM PA
GENOTROPIN MINIQUICK SOLR .2mg, .4mg, .6mg, .8mg, 1mg, 1.2mg, 1.4mg, 1.6mg, 1.8mg, 2mg	Tier 2	NM PA
INCRELEX SOLN 40mg/4ml	Tier 2	NM LA PA
KORLYM TABS 300mg	Tier 2	NM LA PA
levocarnitine (metabolic modifiers) (generic of CARNITOR) SOLN 1gm/10ml	Tier 3	B/D
levocarnitine (metabolic modifiers) (generic of CARNITOR) TABS 330mg	Tier 2	B/D
miglustat (generic of ZAVESCA) CAPS 100mg QL (90 caps / 30 days)	Tier 1	QL NM PA
nitisinone (generic of ORFADIN) CAPS 2mg, 5mg, 10mg	Tier 1	NM PA
octreotide acetate (generic of SANDOSTATIN) SOLN 50mcg/ml, 100mcg/ml	Tier 3	NM PA
octreotide acetate SOLN 200mcg/ml	Tier 3	NM PA
octreotide acetate (generic of SANDOSTATIN) SOLN 500mcg/ml	Tier 1	NM PA
octreotide acetate SOLN 1000mcg/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 LA 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 LA PA
PHOSPHATE BINDER AGENTS		
calcium acetate (phosphate binder) (generic of PHOSLO) CAPS 667mg QL (360 caps / 30 days)	Tier 2	QL
calcium acetate (phosphate binder) TABS 667mg QL (360 tabs / 30 days)	Tier 2	QL
sevelamer carbonate (generic of RENVELA) PACK 2.4gm QL (180 packets / 30 days)	Tier 3	QL

Drug Name	Drug Tier	Requirements/ Limits
sevelamer carbonate (generic of RENVELA) PACK .8gm QL (540 packets / 30 days)	Tier 1	QL
sevelamer carbonate (generic of RENVELA) TABS 800mg QL (540 tabs / 30 days)	Tier 3	QL
PROGESTINS		
medroxyprogesterone acetate (generic of PROVERA) TABS 2.5mg, 5mg, 10mg	Tier 1	
megestrol acetate SUSP 40mg/ml	Tier 2	
norethindrone acetate (generic of AYGESTIN) TABS 5mg	Tier 2	
THYROID AGENTS		
euthyrox (generic of SYNTHROID) TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg	Tier 1	
levo-t (generic of SYNTHROID) TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	Tier 1	
levothyroxine sodium (generic of SYNTHROID) TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	Tier 1	
levoxyl (generic of SYNTHROID) TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg	Tier 1	
liothyronine sodium (generic of CYTOMEL) TABS 5mcg, 25mcg, 50mcg	Tier 2	
methimazole (generic of TAPAZOLE) TABS 5mg, 10mg	Tier 1	
propylthiouracil TABS 50mg	Tier 2	
SYNTHROID TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	Tier 3	
unithroid (generic of SYNTHROID) TABS 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg	Tier 1	
VITAMIN D ANALOGS		
calcitriol (generic of ROCALTROL) CAPS .25mcg, .5mcg	Tier 1	B/D
calcitriol SOLN 1mcg/ml	Tier 3	B/D
calcitriol (generic of ROCALTROL) SOLN 1mcg/ml	Tier 3	B/D
paricalcitol (generic of ZEMPLAR) CAPS 1mcg, 2mcg	Tier 3	B/D
paricalcitol CAPS 4mcg	Tier 3	B/D
RAYALDEE CPCR 30mcg	Tier 2	
GASTROINTESTINAL ***ANTIEMETICS***		
aprepitant CAPS 40mg, 125mg	Tier 3	B/D
aprepitant (generic of EMEND) CAPS 80mg	Tier 3	B/D
aprepitant capsule therapy pack 80 & 125 mg	Tier 3	B/D
compro SUPP 25mg	Tier 3	
dronabinol (generic of MARINOL) CAPS 2.5mg, 5mg, 10mg QL (60 caps / 30 days)	Tier 3	B/D QL
meclizine hcl TABS 12.5mg, 25mg	Tier 1	
metoclopramide hcl SOLN 5mg/5ml, 5mg/ml	Tier 2	
metoclopramide hcl (generic of REGLAN) TABS 5mg, 10mg	Tier 1	

Drug Name	Drug Tier	Requirements/ Limits
ondansetron TBDP 4mg, 8mg	Tier 2	B/D
ondansetron hcl SOLN 4mg/2ml, 40mg/20ml	Tier 2	
ondansetron hcl (generic of ZOFRAN) TABS 4mg	Tier 2	B/D
ondansetron hcl TABS 8mg, 24mg	Tier 2	B/D
prochlorperazine SUPP 25mg	Tier 3	
prochlorperazine edisylate SOLN 10mg/2ml	Tier 3	
prochlorperazine maleate TABS 5mg, 10mg	Tier 1	
promethazine hcl (generic of PHENERGAN) SOLN 25mg/ml, 50mg/ml PA if 70 years and older	Tier 2	PA
promethazine hcl SYRP 6.25mg/5ml; TABS 12.5mg, 25mg, 50mg PA if 70 years and older	Tier 2	PA
scopolamine (generic of TRANSDERM SCOP) PT72 1mg/3days QL (10 patches / 30 days) PA if 70 years and older	Tier 3	QL PA
ANTISPASMODICS		
dicyclomine hcl CAPS 10mg; TABS 20mg	Tier 2	
dicyclomine hcl SOLN 10mg/5ml	Tier 3	
glycopyrrolate TABS 1mg, 2mg	Tier 2	
H2-RECEPTOR ANTAGONISTS		
famotidine SOLN 20mg/2ml, 40mg/4ml, 200mg/20ml	Tier 2	
famotidine (generic of PEPCID) TABS 20mg QL (120 tabs / 30 days)	Tier 1	QL
famotidine (generic of PEPCID) TABS 40mg QL (60 tabs / 30 days)	Tier 1	QL
famotidine in nacl 0.9% iv soln 20 mg/50ml	Tier 2	
nizatidine CAPS 150mg, 300mg	Tier 3	
INFLAMMATORY BOWEL DISEASE		
balsalazide disodium (generic of COLAZAL) CAPS 750mg	Tier 2	
budesonide (generic of ENTOCORT EC) CPEP 3mg	Tier 3	PA
budesonide (generic of UCERIS) TB24 9mg	Tier 1	PA
hydrocortisone (intrarectal) (generic of CORTENEMA) ENEM 100mg/60ml	Tier 3	
mesalamine (generic of APRISO) CP24 .375gm QL (120 caps / 30 days)	Tier 3	QL
mesalamine (generic of DELZICOL) CPDR 400mg QL (180 caps / 30 days)	Tier 3	QL
mesalamine ENEM 4gm	Tier 3	
mesalamine (generic of CANASA) SUPP 1000mg	Tier 3	
mesalamine (generic of LIALDA) TBEC 1.2gm QL (120 tabs / 30 days)	Tier 3	QL
mesalamine w/ cleanser (generic of ROWASA) KIT 4gm	Tier 3	
sulfasalazine (generic of AZULFIDINE) TABS 500mg	Tier 1	
sulfasalazine (generic of AZULFIDINE EN-TABS) TBEC 500mg	Tier 2	
LAXATIVES		
constulose SOLN 10gm/15ml	Tier 2	
enulose SOLN 10gm/15ml	Tier 2	
gavilyte-c	Tier 1	
gavilyte-g (generic of GOLYTELY)	Tier 1	
gavilyte-n/flavor pack (generic of NULYTELY)	Tier 1	
generlac SOLN 10gm/15ml	Tier 2	
GOLYTELY SOL	Tier 2	

Drug Name	Drug Tier	Requirements/ Limits
lactulose SOLN 10gm/15ml	Tier 2	
lactulose (encephalopathy) SOLN 10gm/15ml	Tier 2	
NULYTELY SOL LMN/LIME	Tier 2	
peg 3350-kcl-na bicarb-nacl-na sulfate for soln 236 gm (generic of GOLYTELY)	Tier 1	
peg 3350-kcl-sod bicarb-nacl for soln 420 gm (generic of NULYTELY)	Tier 1	
PLENVU SOL	Tier 3	
SUPREP BOWEL SOL PREP KIT	Tier 3	
trilyte (generic of NULYTELY)	Tier 1	
MISCELLANEOUS		
alosetron hcl (generic of LOTRONEX) TABS 1mg QL (60 tabs / 30 days)	Tier 1	QL PA
alosetron hcl (generic of LOTRONEX) TABS .5mg QL (60 tabs / 30 days)	Tier 3	QL PA
cromolyn sodium (mastocytosis) (generic of GASTROCROM) CONC 100mg/5ml	Tier 3	
diphenoxylate w/ atropine tab 2.5-0.025 mg (generic of LOMOTIL)	Tier 2	
GATTEX KIT 5mg	Tier 2	NM LA PA
LINZESS CAPS 72mcg, 145mcg, 290mcg QL (30 caps / 30 days)	Tier 3	QL
loperamide hcl CAPS 2mg	Tier 2	
misoprostol (generic of CYTOTEC) TABS 100mcg, 200mcg	Tier 2	
MOVANTIK TABS 12.5mg QL (60 tabs / 30 days)	Tier 2	QL
MOVANTIK TABS 25mg QL (30 tabs / 30 days)	Tier 2	QL
RELISTOR SOLN 8mg/0.4ml, 12mg/0.6ml	Tier 2	PA
sucralfate (generic of CARAFATE) TABS 1gm	Tier 2	
ursodiol CAPS 300mg	Tier 2	
ursodiol (generic of URSO 250) TABS 250mg	Tier 3	
ursodiol (generic of URSO FORTE) TABS 500mg	Tier 3	
XERMELO TABS 250mg QL (90 tabs / 30 days)	Tier 2	QL NM LA PA
XIFAXAN TABS 550mg	Tier 2	PA
PANCREATIC ENZYMES		
CREON CAP 3000UNIT	Tier 2	
CREON CAP 6000UNIT	Tier 2	
CREON CAP 12000UNT	Tier 2	
CREON CAP 24000UNT	Tier 2	
CREON CAP 36000UNT	Tier 2	
ZENPEP CAP 3000UNIT	Tier 3	
ZENPEP CAP 5000UNIT	Tier 3	
ZENPEP CAP 10000UNT	Tier 3	
ZENPEP CAP 15000UNT	Tier 3	
ZENPEP CAP 20000UNT	Tier 3	
ZENPEP CAP 25000	Tier 3	
ZENPEP CAP 40000	Tier 3	
PROTON PUMP INHIBITORS		
DEXILANT CPDR 30mg, 60mg QL (30 caps / 30 days)	Tier 3	QL
lansoprazole CPDR 15mg QL (60 caps / 30 days)	Tier 2	QL
lansoprazole (generic of PREVACID) CPDR 30mg QL (60 caps / 30 days)	Tier 2	QL
omeprazole CPDR 10mg, 20mg, 40mg	Tier 1	
pantoprazole sodium (generic of PROTONIX) SOLR 40mg	Tier 2	
pantoprazole sodium (generic of PROTONIX) TBEC 20mg, 40mg	Tier 1	
GENITOURINARY		
BENIGN PROSTATIC HYPERPLASIA		
alfuzosin hcl (generic of UROXATRAL) TB24 10mg QL (30 tabs / 30 days)	Tier 1	QL
dutasteride (generic of AVODART) CAPS .5mg QL (30 caps / 30 days)	Tier 2	QL
finasteride (generic of PROSCAR) TABS 5mg	Tier 1	

Drug Name	Drug Tier	Requirements/ Limits
tamsulosin hcl (generic of FLOMAX) CAPS .4mg	Tier 1	
MISCELLANEOUS		
acetic acid SOLN .25%	Tier 1	
bethanechol chloride TABS 5mg, 10mg, 25mg, 50mg	Tier 2	
potassium citrate (alkalinizer) (generic of UROCIT-K 15) TBCR 15meq	Tier 3	
potassium citrate (alkalinizer) (generic of UROCIT-K 5) TBCR 540mg	Tier 3	
potassium citrate (alkalinizer) (generic of UROCIT-K 10) TBCR 1080mg	Tier 3	
URINARY ANTISPASMODICS		
MYRBETRIQ TB24 25mg, 50mg QL (30 tabs / 30 days)	Tier 3	QL
oxybutynin chloride SYRP 5mg/5ml; TABS 5mg	Tier 2	
oxybutynin chloride (generic of DITROPAN XL) TB24 5mg QL (30 tabs / 30 days)	Tier 2	QL
oxybutynin chloride (generic of DITROPAN XL) TB24 10mg QL (60 tabs / 30 days)	Tier 2	QL
oxybutynin chloride TB24 15mg QL (60 tabs / 30 days)	Tier 2	QL
solifenacin succinate (generic of VESICARE) TABS 5mg, 10mg QL (30 tabs / 30 days)	Tier 2	QL
tolterodine tartrate (generic of DETROL LA) CP24 2mg, 4mg QL (30 caps / 30 days)	Tier 3	QL ST
tolterodine tartrate (generic of DETROL) TABS 1mg, 2mg QL (60 tabs / 30 days)	Tier 3	QL ST
TOVIAZ TB24 4mg, 8mg QL (30 tabs / 30 days)	Tier 2	QL
trospium chloride TABS 20mg QL (60 tabs / 30 days)	Tier 2	QL
VAGINAL ANTI-INFECTIVES		
clindamycin phosphate vaginal (generic of CLEOCIN) CREA 2%	Tier 2	
metronidazole vaginal GEL .75%	Tier 2	
terconazole vaginal CREA .4%, .8%; SUPP 80mg	Tier 2	
vandazole GEL .75%	Tier 2	
HEMATOLOGIC		
ANTICOAGULANTS		
ELIQUIS TABS 2.5mg QL (60 tabs / 30 days)	Tier 2	QL
ELIQUIS TABS 5mg QL (74 tabs / 30 days)	Tier 2	QL
ELIQUIS STARTER PACK TBPK 5mg QL (74 tabs / 30 days)	Tier 2	QL
enoxaparin sodium (generic of LOVENOX) SOLN 30mg/0.3ml, 40mg/0.4ml, 60mg/0.6ml, 80mg/0.8ml, 100mg/ml, 120mg/0.8ml, 150mg/ml, 300mg/3ml	Tier 3	
fondaparinux sodium (generic of ARIXTRA) SOLN 2.5mg/0.5ml	Tier 3	
fondaparinux sodium (generic of ARIXTRA) SOLN 5mg/0.4ml, 7.5mg/0.6ml, 10mg/0.8ml	Tier 1	
HEP SOD/NACL INJ 25000UNT	Tier 2	
heparin sodium (porcine) SOLN 1000unit/ml, 5000unit/ml, 10000unit/ml, 20000unit/ml	Tier 2	B/D
heparin sodium (porcine) 100 unit/ml in d5w	Tier 2	
heparin sodium (porcine)-dextrose iv sol 20000 unit/500ml-5%	Tier 2	
heparin sodium (porcine)-dextrose iv sol 25000 unit/500ml-5%	Tier 2	

Drug Name	Drug Tier	Requirements/ Limits
HEPARIN/NACL INJ 25000UNT	Tier 2	
jantoven TABS 1mg, 2mg, 2.5mg, 3mg, 4mg, 5mg, 6mg, 7.5mg, 10mg	Tier 1	
PRADAXA CAPS 75mg, 150mg QL (60 caps / 30 days)	Tier 3	QL
PRADAXA CAPS 110mg QL (120 caps / 30 days)	Tier 3	QL
warfarin sodium TABS 1mg, 2mg, 2.5mg, 3mg, 4mg, 5mg, 6mg, 7.5mg, 10mg	Tier 1	
XARELTO TABS 2.5mg QL (60 tabs / 30 days)	Tier 2	QL
XARELTO TABS 10mg, 15mg, 20mg QL (30 tabs / 30 days)	Tier 2	QL
XARELTO STAR TAB 15/20MG QL (51 tabs / 30 days)	Tier 2	QL
HEMATOPOIETIC GROWTH FACTORS		
PROCRIT SOLN 2000unit/ml, 3000unit/ml, 4000unit/ml, 10000unit/ml	Tier 2	NM PA
PROCRIT SOLN 20000unit/ml, 40000unit/ml	Tier 2	NM PA
ZARXIO SOSY 300mcg/0.5ml, 480mcg/0.8ml	Tier 2	NM PA
MISCELLANEOUS		
anagrelide hcl CAPS 1mg	Tier 3	
anagrelide hcl (generic of AGRYLIN) CAPS .5mg	Tier 3	
BERINERT KIT 500unit QL (24 boxes / 30 days)	Tier 2	QL NM LA PA
cilostazol TABS 50mg, 100mg	Tier 1	
DOPTELET TABS 20mg	Tier 2	NM LA PA
DROXIA CAPS 200mg, 300mg, 400mg	Tier 2	
ENDARI PACK 5gm	Tier 2	NM LA PA
HAEGARDA SOLR 2000unit QL (30 vials / 30 days)	Tier 2	QL NM LA PA

Drug Name	Drug Tier	Requirements/ Limits
HAEGARDA SOLR 3000unit QL (20 vials / 30 days)	Tier 2	QL NM LA PA
icatibant acetate (generic of FIRAZYR) SOLN 30mg/3ml QL (9 syringes / 30 days)	Tier 1	QL NM PA
pentoxifylline TBCR 400mg	Tier 1	
PROMACTA PACK 12.5mg QL (360 packets / 30 days)	Tier 2	QL NM LA PA
PROMACTA PACK 25mg QL (180 packets / 30 days)	Tier 2	QL NM LA PA
PROMACTA TABS 12.5mg, 25mg QL (30 tabs / 30 days)	Tier 2	QL NM LA PA
PROMACTA TABS 50mg, 75mg QL (60 tabs / 30 days)	Tier 2	QL NM LA PA
tranexamic acid (generic of CYKLOKAPRON) SOLN 1000mg/10ml	Tier 3	
tranexamic acid (generic of LYSTEDA) TABS 650mg	Tier 2	
PLATELET AGGREGATION INHIBITORS		
aspirin-dipyridamole cap er 12hr 25-200 mg	Tier 3	
BRILINTA TABS 60mg, 90mg	Tier 3	
clopidogrel bisulfate (generic of PLAVIX) TABS 75mg	Tier 1	
dipyridamole TABS 25mg, 50mg, 75mg PA if 70 years and older	Tier 2	PA
prasugrel hcl (generic of EFFIENT) TABS 5mg, 10mg	Tier 2	
IMMUNOLOGIC AGENTS		
AUTOIMMUNE AGENTS		
ENBREL SOLN 25mg/0.5ml; SOLR 25mg QL (16 vials / 28 days)	Tier 2	QL NM PA
ENBREL SOSY 25mg/0.5ml QL (16 syringes / 28 days)	Tier 2	QL NM PA

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

Drug Name	Drug Tier	Requirements/ Limits
GAMMAKED SOLN 1gm/10ml, 5gm/50ml, 10gm/100ml, 20gm/200ml	Tier 2	NM PA
GAMMAPLEX SOLN 5gm/100ml, 5gm/50ml, 10gm/100ml, 10gm/200ml, 20gm/200ml, 20gm/400ml	Tier 2	NM PA
GAMUNEX-C SOLN 1gm/10ml, 2.5gm/25ml, 5gm/50ml, 10gm/100ml, 20gm/200ml, 40gm/400ml	Tier 2	NM PA
OCTAGAM SOLN 1gm/20ml, 2gm/20ml, 2.5gm/50ml, 5gm/100ml, 5gm/50ml, 10gm/100ml, 10gm/200ml, 20gm/200ml, 25gm/500ml, 30gm/300ml	Tier 2	NM PA
PANZYGA SOLN 1gm/10ml, 2.5gm/25ml, 5gm/50ml, 10gm/100ml, 20gm/200ml, 30gm/300ml	Tier 2	NM PA
PRIVIGEN SOLN 5gm/50ml, 10gm/100ml, 20gm/200ml, 40gm/400ml	Tier 2	NM PA
IMMUNOMODULATORS		
ACTIMMUNE SOLN 2000000unit/0.5ml	Tier 2	NM LA PA
ARCALYST SOLR 220mg	Tier 2	NM PA
INTRON A SOLN 10mu/ml, 6000000unit/ml; SOLR 50mu	Tier 2	B/D NM
INTRON A SOLR 10mu	Tier 2	B/D NM
INTRON A SOLR 18mu	Tier 3	B/D NM
IMMUNOSUPPRESSANTS		
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
BENLYSTA SOLR 120mg, 400mg	Tier 2	NM PA
cyclosporine (generic of SANDIMMUNE) CAPS 25mg, 100mg	Tier 3	B/D NM
cyclosporine modified (for microemulsion) (generic of NEORAL) CAPS 25mg, 100mg; SOLN 100mg/ml	Tier 3	B/D NM
cyclosporine modified (for microemulsion) CAPS 50mg	Tier 3	B/D NM
everolimus (immunosuppressant) (generic of ZORTRESS) TABS .5mg, .75mg	Tier 1	B/D NM
everolimus (immunosuppressant) (generic of ZORTRESS) TABS .25mg	Tier 3	B/D NM
gengraf (generic of NEORAL) CAPS 25mg, 100mg; SOLN 100mg/ml	Tier 3	B/D NM
mycophenolate mofetil (generic of CELLCEPT) CAPS 250mg; TABS 500mg	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 3	B/D NM
PROGRAF PACK .2mg, 1mg	Tier 3	B/D NM
SANDIMMUNE SOLN 100mg/ml	Tier 2	B/D NM
sirolimus (generic of RAPAMUNE) SOLN 1mg/ml	Tier 1	B/D NM
sirolimus (generic of RAPAMUNE) TABS .5mg, 1mg, 2mg	Tier 3	B/D NM
tacrolimus (generic of PROGRAF) CAPS .5mg, 1mg, 5mg	Tier 3	B/D NM
ZORTRESS TABS 1mg	Tier 2	B/D NM
VACCINES		
ACTHIB INJ	Tier 2	
ADACEL INJ	Tier 2	
BCG VACCINE INJ	Tier 3	
BEXSERO INJ	Tier 2	
BOOSTRIX INJ	Tier 2	
DAPTACEL INJ	Tier 2	

Drug Name	Drug Tier	Requirements/ Limits
DIP/TET PED INJ 25-5LFU	Tier 2	B/D
ENGERIX-B SUSP 10mcg/0.5ml, 20mcg/ml	Tier 2	B/D
GARDASIL 9 INJ	Tier 3	
HAVRIX SUSP 720elu/0.5ml, 1440elu/ml	Tier 2	
HIBERIX SOLR 10mcg	Tier 2	
IMOVAX RABIES (H.D.C.V.) INJ 2.5unit/ml	Tier 3	B/D
INFANRIX INJ	Tier 2	
IPOL INJ INACTIVE	Tier 2	
IXIARO INJ	Tier 3	
KINRIX INJ	Tier 2	
M-M-R II INJ	Tier 2	
MENACTRA INJ	Tier 2	
MENQUADFI INJ	Tier 2	
MENVEO INJ	Tier 2	
PEDIARIX INJ 0.5ML	Tier 2	
PEDVAX HIB SUSP 7.5mcg/0.5ml	Tier 2	
PENTACEL INJ	Tier 3	
PROQUAD INJ	Tier 3	
QUADRACEL INJ	Tier 2	
RABAVERT INJ	Tier 3	B/D
RECOMBIVAX HB SUSP 5mcg/0.5ml, 10mcg/ml, 40mcg/ml	Tier 2	B/D
ROTARIX SUS	Tier 2	
ROTATEQ SOL	Tier 2	
SHINGRIX SUSR 50mcg/0.5ml QL (2 vials per lifetime)	Tier 2	QL
TDVAX INJ 2-2 LF	Tier 2	B/D
TENIVAC INJ 5-2LF	Tier 2	B/D
TRUMENBA INJ	Tier 2	
TWINRIX INJ	Tier 3	
TYPHIM VI SOLN 25mcg/0.5ml	Tier 3	
VAQTA SUSP 25unit/0.5ml, 50unit/ml	Tier 2	
VARIVAX INJ 1350pfu/0.5ml	Tier 2	
YF-VAX INJ	Tier 3	

Drug Name	Drug Tier	Requirements/ Limits
NUTRITIONAL/SUPPLEMENTS		
ELECTROLYTES/MINERALS, INJECTABLE		
D2.5W/NACL INJ 0.45%	Tier 2	
D5W/LYTES INJ #48	Tier 3	
D10W/NACL INJ 0.2%	Tier 2	
dextrose 2.5% w/ sodium chloride 0.45% (generic of DEXTROSE 2.5%/NACL 0.45%)	Tier 2	
dextrose 5% in lactated ringers	Tier 2	
dextrose 5% w/ sodium chloride 0.2%	Tier 2	
dextrose 5% w/ sodium chloride 0.9%	Tier 2	
dextrose 5% w/ sodium chloride 0.45%	Tier 2	
dextrose 10% w/ sodium chloride 0.45%	Tier 2	
ISOLYTE-P INJ /D5W	Tier 3	
ISOLYTE-S INJ	Tier 3	
ISOLYTE-S INJ PH 7.4	Tier 3	
kcl 10 meq/l (0.075%) in dextrose 5% & nacl 0.45% inj	Tier 2	
kcl 20 meq/l (0.15%) in dextrose 5% & nacl 0.2% inj	Tier 2	
kcl 20 meq/l (0.15%) in dextrose 5% & nacl 0.9% inj	Tier 2	
kcl 20 meq/l (0.15%) in dextrose 5% & nacl 0.45% inj	Tier 2	
kcl 20 meq/l (0.15%) in nacl 0.9% inj	Tier 2	
KCL 20 MEQ/L (0.15%) IN NACL 0.45% INJ	Tier 3	
kcl 20 meq/l (0.15%) in nacl 0.45% inj (generic of POTASSIUM CHLORIDE/SODIUM)	Tier 2	
kcl 30 meq/l (0.224%) in dextrose 5% & nacl 0.45% inj	Tier 2	
kcl 40 meq/l (0.3%) in dextrose 5% & nacl 0.45% inj	Tier 2	

Drug Name	Drug Tier	Requirements/ Limits
KCL 40 MEQ/L (0.3%) IN NACL 0.9% INJ	Tier 3	
KCL/D5W/NACL INJ 0.3/0.9%	Tier 3	
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	
MG SO4/D5W INJ 10MG/ML	Tier 2	
PLASMA-LYTE INJ -148	Tier 3	
PLASMA-LYTE INJ -A	Tier 3	
potassium chloride SOLN 2meq/ml	Tier 2	
POTASSIUM CHLORIDE SOLN 10meq/50ml, 20meq/50ml	Tier 3	
potassium chloride SOLN 10meq/100ml, 20meq/100ml, 40meq/100ml	Tier 3	
potassium chloride 20 meq/l (0.15%) in dextrose 5% inj	Tier 2	
sodium chloride SOLN .45%, .9%, 2.5meq/ml, 3%, 5%	Tier 2	
TPN ELECTROL INJ	Tier 3	B/D
ELECTROLYTES/MINERALS/VITAMINS, ORAL		
klor-con PACK 20meq	Tier 3	
klor-con 8 TBCR 8meq	Tier 1	
klor-con 10 TBCR 10meq	Tier 1	
klor-con m10 TBCR 10meq	Tier 1	
klor-con m15 TBCR 15meq	Tier 2	
klor-con m20 TBCR 20meq	Tier 1	
M-NATAL PLUS TAB	Tier 2	
potassium chloride CPCR 8meq, 10meq	Tier 2	
potassium chloride PACK 20meq; SOLN 10%, 20%	Tier 3	
potassium chloride TBCR 8meq	Tier 1	
potassium chloride (generic of K-TAB) TBCR 10meq, 20meq	Tier 1	
potassium chloride microencapsulated crystals er TBCR 10meq, 20meq	Tier 1	
PRENATAL TAB 27-1MG	Tier 2	
PRENATAL TAB PLUS	Tier 2	
PRENATAL VIT TAB LOW IRON	Tier 2	
sodium fluoride chew; tab; 1.1 (0.5 f) mg/ml soln	Tier 1	
TRICARE TAB PRENATAL	Tier 2	
IV NUTRITION		
AMINOSYN-PF INJ 7%	Tier 3	B/D
CLINIMIX INJ 4.25/D5W	Tier 3	B/D
CLINIMIX INJ 4.25/D10	Tier 3	B/D
CLINIMIX INJ 5%/D15W	Tier 3	B/D
CLINIMIX INJ 5%/D20W	Tier 3	B/D
CLINIMIX INJ 6/5	Tier 3	B/D
CLINIMIX INJ 8/10	Tier 3	B/D
CLINIMIX INJ 8/14	Tier 3	B/D
clinisol sf 15%	Tier 3	B/D
CLINOLIPID EMU 20%	Tier 3	B/D
dextrose SOLN 5%, 10%	Tier 2	
dextrose SOLN 50%, 70%	Tier 2	B/D
FREAMINE HBC INJ 6.9%	Tier 3	B/D
FREAMINE III INJ 10%	Tier 3	B/D
hepatamine	Tier 3	B/D
INTRALIPID EMUL 20gm/100ml, 30gm/100ml	Tier 3	B/D
NUTRILIPID EMUL 20gm/100ml	Tier 3	B/D
plenamine	Tier 3	B/D
PREMASOL SOL 10%	Tier 3	B/D
PROCALAMINE INJ 3%	Tier 3	B/D
PROSOL INJ 20%	Tier 3	B/D
TRAVASOL INJ 10%	Tier 3	B/D
TROPHAMINE INJ 10%	Tier 3	B/D

Drug Name	Drug Tier	Requirements/ Limits
OPHTHALMIC		
ANTI-INFECTIVE/ANTI-INFLAMMATORY		
bacitracin-polymyxin-neomycin-hc ophth oint 1%	Tier 2	
BLEPHAMIDE OIN S.O.P.	Tier 3	
neomycin-polymyxin-dexamethasone ophth oint 0.1% (generic of MAXITROL)	Tier 1	
neomycin-polymyxin-dexamethasone ophth susp 0.1% (generic of MAXITROL)	Tier 1	
sulfacetamide sodium-prednisolone ophth soln 10-0.23(0.25)%	Tier 1	
TOBRADEX OIN 0.3-0.1%	Tier 2	
tobramycin-dexamethasone ophth susp 0.3-0.1% (generic of TOBRADEX)	Tier 3	
ZYLET SUS 0.5-0.3%	Tier 2	
ANTI-INFECTIVES		
bacitracin (ophthalmic) OINT 500unit/gm	Tier 2	
bacitracin-polymyxin b ophth oint	Tier 1	
BESIVANCE SUSP .6%	Tier 2	
CILOXAN OINT .3%	Tier 2	
ciprofloxacin hcl (ophth) (generic of CILOXAN) SOLN .3%	Tier 1	
erythromycin (ophth) OINT 5mg/gm	Tier 1	
gentak OINT .3%	Tier 2	
gentamicin sulfate (ophth) SOLN .3%	Tier 1	
moxifloxacin hcl (ophth) (generic of VIGAMOX) SOLN .5%	Tier 2	
NATACYN SUSP 5%	Tier 3	
neomycin-bacitrac zn-polymyx 5(3.5)mg-400unt-10000unt op oin	Tier 2	
neomycin-polymy-gramicid op sol 1.75-10000-0.025mg-unt-mg/ml	Tier 2	
ofloxacin (ophth) (generic of OCUFLOX) SOLN .3%	Tier 1	
polymyxin b-trimethoprim ophth soln 10000 unit/ml-0.1% (generic of POLYTRIM)	Tier 1	
sulfacetamide sodium (ophth) OINT 10%	Tier 2	
sulfacetamide sodium (ophth) (generic of BLEPH-10) SOLN 10%	Tier 2	
tobramycin (ophth) (generic of TOBREX) SOLN .3%	Tier 1	
trifluridine SOLN 1%	Tier 3	
ZIRGAN GEL .15%	Tier 3	
ANTI-INFLAMMATORIES		
ALREX SUSP .2%	Tier 2	
BROMSITE SOLN .075%	Tier 3	
dexamethasone sodium phosphate (ophth) SOLN .1%	Tier 2	
diclofenac sodium (ophth) SOLN .1%	Tier 1	
DUREZOL EMUL .05%	Tier 2	
FLAREX SUSP .1%	Tier 3	
fluorometholone (ophth) SUSP .1%	Tier 2	
flurbiprofen sodium SOLN .03%	Tier 2	
ILEVRO SUSP .3%	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	
prednisolone acetate (ophth) (generic of PRED FORTE) SUSP 1%	Tier 2	
PREDNISOLONE SODIUM PHOSP SOLN 1%	Tier 2	
PROLENSA SOLN .07%	Tier 2	
ANTIALLERGICS		
azelastine hcl (ophth) SOLN .05%	Tier 2	

Drug Name	Drug Tier	Requirements/ Limits
bepotastine besilate (generic of BEPREVE) SOLN 1.5%	Tier 2	
BEPREVE SOLN 1.5%	Tier 2	
cromolyn sodium (ophth) SOLN 4%	Tier 1	
LASTACAFT SOLN .25%	Tier 3	
olopatadine hcl SOLN .1%	Tier 2	
ZERVIATE SOLN .24%	Tier 3	
ANTIGLAUCOMA		
ALPHAGAN P SOLN .1%	Tier 2	
betaxolol hcl (ophth) SOLN .5%	Tier 2	
BETOPTIC-S SUSP .25%	Tier 2	
brimonidine tartrate SOLN .2%	Tier 1	
brimonidine tartrate (generic of ALPHAGAN P) SOLN .15%	Tier 3	
brinzolamide (generic of AZOPT) SUSP 1%	Tier 3	
carteolol hcl (ophth) SOLN 1%	Tier 1	
COMBIGAN SOL 0.2/0.5%	Tier 2	
dorzolamide hcl (generic of TRUSOPT) SOLN 2%	Tier 1	
dorzolamide hcl-timolol maleate ophth soln 22.3-6.8 mg/ml (generic of COSOPT)	Tier 1	
latanoprost (generic of XALATAN) SOLN .005%	Tier 1	
levobunolol hcl SOLN .5%	Tier 1	
LUMIGAN SOLN .01%	Tier 2	
pilocarpine hcl (generic of ISOPTO CARPINE) SOLN 1%, 2%, 4%	Tier 2	
RHOPRESSA SOLN .02%	Tier 2	
SIMBRINZA SUS 1-0.2%	Tier 2	
timolol maleate (ophth) (generic of TIMOPTIC-XE) SOLG .25%, .5%	Tier 3	
timolol maleate (ophth) (generic of TIMOPTIC) SOLN .25%, .5%	Tier 1	
timolol maleate (ophth) once-daily (generic of ISTALOL) SOLN .5%	Tier 3	
VYZULTA SOLN .024%	Tier 3	
MISCELLANEOUS		
ATROPINE SULFATE SOLN 1%	Tier 2	
CYSTADROPS SOLN .37%	Tier 2	NM LA PA
CYSTARAN SOLN .44%	Tier 2	NM LA PA
ISOPTO ATROPINE SOLN 1%	Tier 2	
proparacaine hcl (generic of ALCAINE) SOLN .5%	Tier 2	
RESTASIS EMUL .05%	Tier 2	
RESTASIS MULTIDOSE EMUL .05%	Tier 2	
OTIC		
OTIC AGENTS		
acetic acid (otic) SOLN 2%	Tier 2	
ciprofloxacin-dexamethasone otic susp 0.3-0.1% (generic of CIPRODEX)	Tier 3	
neomycin-polymyxin-hc otic soln 1%	Tier 2	
neomycin-polymyxin-hc otic susp 3.5 mg/ml-10000 unit/ml-1%	Tier 2	
ofloxacin (otic) SOLN .3%	Tier 3	
RESPIRATORY		
ANTICHOLINERGIC/BETA AGONIST COMBINATIONS		
ANORO ELLIPT AER 62.5-25 QL (60 blisters / 30 days)	Tier 2	QL
BEVESPI AER 9-4.8MCG QL (1 inhaler / 30 days)	Tier 2	QL
BREZTRI AERO AER SPHERE QL (1 inhaler / 30 days)	Tier 2	QL
BREZTRI AERO AER SPHERE (INSTITUTIONAL PACK) QL (4 inhalers / 28 days)	Tier 2	QL

Drug Name	Drug Tier	Requirements/ Limits
COMBIVENT AER 20-100 QL (2 inhalers / 30 days)	Tier 3	QL
ipratropium-albuterol nebu soln 0.5-2.5(3) mg/3ml	Tier 2	B/D
TRELEGY AER ELLIPTA 100-62.5-25 MCG QL (60 blisters / 30 days)	Tier 2	QL
TRELEGY AER ELLIPTA 200-62.5-25 MCG QL (60 blisters / 30 days)	Tier 2	QL
ANTICHOLINERGICS		
ATROVENT HFA AERS 17mcg/act QL (2 inhalers / 30 days)	Tier 3	QL
INCRUSE ELLIPTA AEPB 62.5mcg/inh QL (30 blisters / 30 days)	Tier 2	QL
ipratropium bromide SOLN .02%	Tier 1	B/D
ipratropium bromide (nasal) SOLN .03%, .06%	Tier 2	
ANTIHISTAMINES		
azelastine hcl SOLN .1%, .15%	Tier 2	
cetirizine hcl SOLN 1mg/ml	Tier 1	
cyproheptadine hcl SYRP 2mg/5ml; TABS 4mg PA if 70 years and older	Tier 2	PA
diphenhydramine hcl SOLN 50mg/ml	Tier 2	
hydroxyzine hcl SOLN 25mg/ml, 50mg/ml PA if 70 years and older	Tier 3	PA
hydroxyzine hcl SYRP 10mg/5ml PA if 70 years and older	Tier 2	PA
hydroxyzine hcl TABS 10mg, 25mg, 50mg PA if 70 years and older	Tier 1	PA
hydroxyzine pamoate (generic of VISTARIL) CAPS 25mg, 50mg PA if 70 years and older	Tier 1	PA
levocetirizine dihydrochloride TABS 5mg	Tier 2	
BETA AGONISTS		
albuterol sulfate AERS 108mcg/act QL (2 inhalers / 30 days) (generic of Ventolin HFA)	Tier 2	QL
albuterol sulfate (generic of PROAIR HFA) AERS 108mcg/act QL (2 inhalers / 30 days) (generic of Proair HFA)	Tier 2	QL
albuterol sulfate (generic of PROVENTIL HFA) AERS 108mcg/act QL (2 inhalers / 30 days) (generic of Proventil HFA)	Tier 2	QL
albuterol sulfate NEBU .63mg/3ml, 1.25mg/3ml, 2.5mg/0.5ml	Tier 2	B/D
albuterol sulfate NEBU .083%	Tier 1	B/D
albuterol sulfate SYRP 2mg/5ml	Tier 1	
albuterol sulfate TABS 2mg, 4mg	Tier 3	
levalbuterol tartrate AERO 45mcg/act QL (2 inhalers / 30 days)	Tier 2	QL
SEREVENT DISKUS AEPB 50mcg/dose QL (60 inhalations / 30 days)	Tier 2	QL
terbutaline sulfate TABS 2.5mg, 5mg	Tier 3	
VENTOLIN HFA AERS 108mcg/act QL (2 inhalers / 30 days)	Tier 2	QL
VENTOLIN HFA (INSTITUTIONAL PACK) AERS 108mcg/act QL (6 inhalers / 30 days)	Tier 2	QL

Drug Name	Drug Tier	Requirements/ Limits
LEUKOTRIENE MODULATORS		
montelukast sodium (generic of SINGULAIR) CHEW 4mg, 5mg	Tier 2	
montelukast sodium (generic of SINGULAIR) PACK 4mg	Tier 3	
montelukast sodium (generic of SINGULAIR) TABS 10mg	Tier 1	
zafirlukast (generic of ACCOLATE) TABS 10mg, 20mg	Tier 2	
MISCELLANEOUS		
acetylcysteine SOLN 10%, 20%	Tier 2	B/D
ARALAST NP SOLR 500mg, 1000mg	Tier 2	NM LA PA
cromolyn sodium NEBU 20mg/2ml	Tier 2	B/D
DALIRESP TABS 250mcg, 500mcg	Tier 3	
epinephrine (anaphylaxis) (generic of EPIPEN 2-PAK) SOAJ .3mg/0.3ml (generic of EpiPen)	Tier 2	
epinephrine (anaphylaxis) (generic of EPIPEN-JR 2-PAK) SOAJ .15mg/0.3ml (generic of EpiPen)	Tier 2	
epinephrine (anaphylaxis) SOAJ .15mg/0.15ml, .3mg/0.3ml (generic of Adrenaclick)	Tier 2	
ESBRIET CAPS 267mg QL (270 caps / 30 days)	Tier 2	QL NM PA
ESBRIET TABS 267mg QL (270 tabs / 30 days)	Tier 2	QL NM PA
ESBRIET TABS 801mg QL (90 tabs / 30 days)	Tier 2	QL NM PA
FASENRA SOSY 30mg/ml	Tier 2	NM LA PA
FASENRA PEN SOAJ 30mg/ml	Tier 2	NM LA PA
KALYDECO PACK 25mg, 50mg, 75mg QL (56 packs / 28 days)	Tier 2	QL NM PA
KALYDECO TABS 150mg QL (60 tabs / 30 days)	Tier 2	QL NM PA
OFEV CAPS 100mg, 150mg QL (60 caps / 30 days)	Tier 2	QL NM PA
ORKAMBI GRA 100-125 QL (56 packs / 28 days)	Tier 2	QL NM PA
ORKAMBI GRA 150-188 QL (56 packs / 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
PROLASTIN-C SOLN 1000mg/20ml; SOLR 1000mg	Tier 2	NM LA PA
PULMOZYME SOLN 1mg/ml	Tier 2	NM PA
SYMDEKO TAB 50-75MG QL (56 tabs / 28 days)	Tier 2	QL NM LA PA
SYMDEKO TAB 100-150 QL (56 tabs / 28 days)	Tier 2	QL NM LA PA
SYMJEPI SOSY .15mg/0.3ml, .3mg/0.3ml	Tier 3	
theophylline TB12 300mg, 450mg	Tier 3	
theophylline TB24 400mg, 600mg	Tier 2	
TRIKAFTA TAB 50-25-37.5MG & 75MG QL (84 tabs / 28 days)	Tier 2	QL NM LA PA
TRIKAFTA TAB 100-50-75MG & 150MG QL (84 tabs / 28 days)	Tier 2	QL NM LA PA
XOLAIR SOLR 150mg; SOSY 75mg/0.5ml, 150mg/ml	Tier 2	NM LA PA
ZEMAIRA SOLR 1000mg	Tier 2	NM LA PA

Drug Name	Drug Tier	Requirements/ Limits
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
STEROID INHALANTS		
ARNUITY ELLIPTA AEPB 50mcg/act, 100mcg/act, 200mcg/act QL (30 inhalations / 30 days)	Tier 2	QL
budesonide (inhalation) (generic of PULMICORT) SUSP .25mg/2ml, .5mg/2ml	Tier 3	B/D
FLOVENT DISKUS AEPB 50mcg/blist QL (180 inhalations / 30 days)	Tier 2	QL
FLOVENT DISKUS AEPB 100mcg/blist, 250mcg/blist QL (240 inhalations / 30 days)	Tier 2	QL
FLOVENT HFA AERO 44mcg/act, 110mcg/act, 220mcg/act QL (2 inhalers / 30 days)	Tier 2	QL
PULMICORT FLEXHALER AEPB 90mcg/act QL (3 inhalers / 30 days)	Tier 3	QL
PULMICORT FLEXHALER AEPB 180mcg/act QL (2 inhalers / 30 days)	Tier 3	QL
STEROID/BETA-AGONIST COMBINATIONS		
ADVAIR DISKU AER 100/50 QL (60 inhalations / 30 days)	Tier 2	QL
ADVAIR DISKU AER 250/50 QL (60 inhalations / 30 days)	Tier 2	QL
ADVAIR DISKU AER 500/50 QL (60 inhalations / 30 days)	Tier 2	QL
ADVAIR HFA AER 45/21 QL (1 inhaler / 30 days)	Tier 2	QL
ADVAIR HFA AER 115/21 QL (1 inhaler / 30 days)	Tier 2	QL
ADVAIR HFA AER 230/21 QL (1 inhaler / 30 days)	Tier 2	QL
BREO ELLIPTA INH 100-25 QL (60 blisters / 30 days)	Tier 2	QL
BREO ELLIPTA INH 200-25 QL (60 blisters / 30 days)	Tier 2	QL
SYMBICORT AER 80-4.5 QL (1 inhaler / 30 days)	Tier 2	QL
SYMBICORT AER 160-4.5 QL (1 inhaler / 30 days)	Tier 2	QL
TOPICAL *DERMATOLOGY, ACNE*		
accutane CAPS 20mg, 30mg, 40mg	Tier 3	PA
amnesteem CAPS 10mg, 20mg, 40mg	Tier 3	PA
avita (generic of RETIN-A) CREA .025% QL (45 gm / 30 days)	Tier 3	QL PA
avita GEL .025% QL (45 gm / 30 days)	Tier 3	QL PA
claravis CAPS 10mg, 20mg, 30mg, 40mg	Tier 3	PA
clindamycin phosphate (topical) GEL 1% QL (75 gm / 30 days)	Tier 3	QL
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	QL

Drug Name	Drug Tier	Requirements/ Limits
erythromycin (acne aid) SOLN 2% QL (60 mL / 30 days)	Tier 2	QL
isotretinoin CAPS 10mg, 20mg, 30mg, 40mg	Tier 3	PA
myorisan CAPS 10mg, 20mg, 30mg, 40mg	Tier 3	PA
sulfacetamide sodium (acne) (generic of KLARON) LOTN 10% QL (118 mL / 30 days)	Tier 3	QL
tretinoin (generic of RETIN-A) CREA .025%, .05%, .1%; GEL .01%, .025% QL (45 gm / 30 days)	Tier 3	QL PA
zenatane CAPS 10mg, 20mg, 30mg, 40mg	Tier 3	PA
DERMATOLOGY, ANTIBIOTICS		
gentamicin sulfate (topical) CREA .1% QL (30 gm / 30 days)	Tier 3	QL
gentamicin sulfate (topical) OINT .1% QL (30 gm / 30 days)	Tier 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	
SULFAMYLON CREA 85mg/gm QL (453.6 gm / 30 days)	Tier 3	QL
DERMATOLOGY, ANTIFUNGALS		
clotrimazole (topical) CREA 1% QL (45 gm / 30 days)	Tier 2	QL
clotrimazole w/ betamethasone cream 1-0.05% QL (45 gm / 30 days)	Tier 2	QL
ketoconazole (topical) CREA 2% QL (60 gm / 30 days)	Tier 2	QL
nyamyc POWD 100000unit/gm QL (60 gm / 30 days)	Tier 2	QL
nystatin (topical) CREA 100000unit/gm; OINT 100000unit/gm QL (30 gm / 30 days)	Tier 2	QL
nystatin (topical) POWD 100000unit/gm QL (60 gm / 30 days)	Tier 2	QL
nystop POWD 100000unit/gm QL (60 gm / 30 days)	Tier 2	QL
DERMATOLOGY, ANTIPSORIATICS		
acitretin (generic of SORIATANE) CAPS 10mg, 25mg	Tier 3	PA
acitretin CAPS 17.5mg	Tier 3	PA
calcipotriene SOLN .005% QL (120 mL / 30 days)	Tier 3	QL PA
tazarotene (generic of TAZORAC) CREA .1% QL (60 gm / 30 days)	Tier 2	QL PA
TAZORAC CREA .05% QL (60 gm / 30 days)	Tier 3	QL PA
DERMATOLOGY, ANTISEBORRHEICS		
ketoconazole (topical) SHAM 2% QL (120 mL / 30 days)	Tier 1	QL
selenium sulfide LOTN 2.5%	Tier 1	
DERMATOLOGY, CORTICOSTEROIDS		
ala-cort CREA 1%, 2.5%	Tier 1	
alclometasone dipropionate CREA .05%; OINT .05% QL (60 gm / 30 days)	Tier 2	QL
betamethasone dipropionate (topical) CREA .05% QL (120 gm / 30 days)	Tier 2	QL
betamethasone dipropionate (topical) LOTN .05% QL (120 mL / 30 days)	Tier 2	QL
betamethasone dipropionate (topical) OINT .05% QL (120 gm / 30 days)	Tier 3	QL
betamethasone dipropionate augmented (generic of DIPROLENE AF) CREA .05% QL (120 gm / 30 days)	Tier 1	QL

Drug Name	Drug Tier	Requirements/ Limits
betamethasone dipropionate augmented GEL .05% QL (120 gm / 30 days)	Tier 3	QL
betamethasone dipropionate augmented LOTN .05% QL (120 mL / 30 days)	Tier 3	QL
betamethasone dipropionate augmented (generic of DIPROLENE) OINT .05% QL (120 gm / 30 days)	Tier 3	QL
betamethasone valerate CREA .1%; OINT .1% QL (120 gm / 30 days)	Tier 2	QL
betamethasone valerate LOTN .1% QL (120 mL / 30 days)	Tier 2	QL
clobetasol propionate (generic of TEMOVATE) CREA .05%; OINT .05% QL (60 gm / 30 days)	Tier 2	QL
clobetasol propionate GEL .05% QL (60 gm / 30 days)	Tier 3	QL
clobetasol propionate SOLN .05% QL (50 mL / 30 days)	Tier 2	QL
clobetasol propionate e CREA .05% QL (60 gm / 30 days)	Tier 2	QL
ENSTILAR AER QL (120 gm / 30 days)	Tier 3	QL PA
fluocinolone acetonide CREA .01% QL (60 gm / 30 days)	Tier 3	QL
fluocinolone acetonide (generic of SYNALAR) CREA .025% QL (120 gm / 30 days)	Tier 3	QL
fluocinolone acetonide (generic of DERMA-SMOOTHE/FS BODY) OIL .01% QL (118.28 mL / 30 days)	Tier 2	QL
fluocinolone acetonide (generic of DERMA-SMOOTHE/FS SCALP) OIL .01% QL (118.28 mL / 30 days)	Tier 2	QL
fluocinolone acetonide (generic of SYNALAR) OINT .025% QL (120 gm / 30 days)	Tier 2	QL
fluocinolone acetonide (generic of SYNALAR) SOLN .01% QL (90 mL / 30 days)	Tier 3	QL
fluocinonide CREA .05% QL (120 gm / 30 days)	Tier 2	QL
fluocinonide GEL .05%; OINT .05% QL (60 gm / 30 days)	Tier 3	QL
fluocinonide SOLN .05% QL (60 mL / 30 days)	Tier 2	QL
fluocinonide emulsified base CREA .05% QL (120 gm / 30 days)	Tier 2	QL
fluticasone propionate CREA .05%; OINT .005%	Tier 2	
halobetasol propionate CREA .05%; OINT .05% QL (50 gm / 30 days)	Tier 3	QL
hydrocortisone (topical) CREA 1%, 2.5%; LOTN 2.5%; OINT 2.5%	Tier 1	
mometasone furoate CREA .1%; OINT .1%; SOLN .1%	Tier 2	
triamcinolone acetonide (topical) CREA .1% QL (454 gm / 30 days)	Tier 1	QL
triamcinolone acetonide (topical) CREA .025%, .5%; OINT .025%, .1%, .5%	Tier 1	
triamcinolone acetonide (topical) LOTN .025%, .1%	Tier 2	
triderm CREA .5%	Tier 1	
DERMATOLOGY, LOCAL ANESTHETICS		
glydo PRSY 2% QL (60 mL / 30 days)	Tier 3	QL PA
lidocaine OINT 5% QL (50 gm / 30 days)	Tier 3	QL PA

Drug Name	Drug Tier	Requirements/ Limits
lidocaine (generic of LIDODERM) PTCH 5% QL (3 patches / 1 day)	Tier 3	QL PA
lidocaine hcl GEL 2% QL (30 mL / 30 days)	Tier 3	QL PA
lidocaine hcl SOLN 4% QL (50 mL / 30 days)	Tier 2	QL PA
lidocaine-prilocaine cream 2.5-2.5% QL (30 gm / 30 days)	Tier 2	QL PA
DERMATOLOGY, MISCELLANEOUS SKIN AND MUCOUS MEMBRANE		
diclofenac sodium (topical) (generic of VOLTAREN) GEL 1% QL (1000 gm / 30 days)	Tier 2	QL PA
fluorouracil (topical) (generic of EFUDEX) CREA 5% QL (40 gm / 30 days)	Tier 3	QL
fluorouracil (topical) SOLN 2%, 5% QL (10 mL / 30 days)	Tier 2	QL
hydrocortisone (rectal) (generic of ANUSOL-HC) CREA 2.5%	Tier 1	
imiquimod (generic of ALDARA) CREA 5% QL (24 packets / 30 days)	Tier 2	QL
lactic acid (ammonium lactate) CREA 12%	Tier 1	
lactic acid (ammonium lactate) LOTN 12%	Tier 2	
metronidazole (topical) (generic of METROCREAM) CREA .75% QL (45 gm / 30 days)	Tier 3	QL
metronidazole (topical) GEL .75% QL (45 gm / 30 days)	Tier 2	QL
podofilox SOLN .5% QL (7 mL / 28 days)	Tier 2	QL
procto-med hc (generic of ANUSOL-HC) CREA 2.5%	Tier 2	
procto-pak (generic of PROCTOCORT) CREA 1%	Tier 2	
proctozone-hc (generic of ANUSOL-HC) CREA 2.5%	Tier 2	
RECTIV OINT .4% QL (30 gm / 30 days)	Tier 3	QL
rosadan (generic of METROCREAM) CREA .75% QL (45 gm / 30 days)	Tier 3	QL
tacrolimus (topical) (generic of PROTOPIC) OINT .03%, .1% QL (100 gm / 30 days)	Tier 3	QL
TARGRETIN GEL 1% QL (60 gm / 30 days)	Tier 2	QL NM PA
VALCHLOR GEL .016% QL (60 gm / 30 days)	Tier 2	QL NM LA PA
DERMATOLOGY, SCABICIDES AND PEDICULIDES		
malathion LOTN .5% QL (59 mL / 30 days)	Tier 3	QL
permethrin CREA 5% QL (60 gm / 30 days)	Tier 2	QL
DERMATOLOGY, WOUND CARE AGENTS		
REGRANEX GEL .01% QL (30 gm / 30 days)	Tier 2	QL PA
SANTYL OINT 250unit/gm QL (180 gm / 30 days)	Tier 3	QL
sodium chloride (gu irrigant) SOLN .9%	Tier 2	
water for irrigation, sterile irrigation soln	Tier 1	
MOUTH/THROAT/DENTAL AGENTS		
chlorhexidine gluconate (mouth-throat) (generic of PERIDEX) SOLN .12%	Tier 1	
clotrimazole TROC 10mg QL (150 lozenges / 30 days)	Tier 3	QL
lidocaine hcl (mouth-throat) SOLN 2%	Tier 1	
nystatin (mouth-throat) SUSP 100000unit/ml	Tier 2	
periogard (generic of PERIDEX) SOLN .12%	Tier 1	
pilocarpine hcl (oral) (generic of SALAGEN) TABS 5mg, 7.5mg	Tier 2	

Drug Name	Drug Tier	Requirements/ Limits
triamcinolone acetonide (mouth) PSTE .1%	Tier 2	

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

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

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

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

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

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

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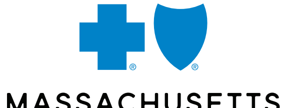

EVERYTHING YOU NEED TO LIVE A HEALTHIER LIFE

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

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

1 Start with your health assessment

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

2 Take a wellness workshop

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

Learn about:

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

3 Stay motivated and stick to your goals

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

Get Started Now

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

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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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NURSES RIGHT NOW. NO IFS, ANDS, OR BUTS.

Call our 24/7 Nurse Line **1-888-247-BLUE (2583).**

Speak to a registered nurse, when you need to, day or night. Because guidance and advice should happen round the clock.

YES, YOUR PLAN COVERS IT!

Nurses are ready around the clock to answer your questions. Call our Nurse Line 24/7 to determine if you need immediate care.

GET CONNECTED DIRECTLY TO A NURSE

Immediate advice, no waiting for a callback.

365 DAYS A YEAR

Including holidays. For access that's ready when you are.

THERE'S NO ADDITIONAL COST

Because your health comes first.

EMAIL* A NURSE 24/7, TOO

Create an account to email a nurse for general questions or advice, day or night.

*We partner with Carenet Health", an independent health care engagement company, to administer this service. You'll need to create a Carenet Health account or sign in to their secure website. When creating your account, you'll need to enter your nine-digit Blue Cross member ID number. Please don't include the letter prefix.

Questions?

Visit **myblue.bluecrossma.com** and select **Find a Doctor & Estimate Costs** to find a provider near you. Download the MyBlue App from the App Store®´ or Google Play™.

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FITNESS REIMBURSEMENT

Get rewarded for your healthy habits!

Save up to

$150

Qualified for Reimbursement:

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

Not Qualified for Reimbursement:

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

Get Started

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

Your reimbursement is waiting!

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FITNESS REIMBURSEMENT REQUEST

Please print all information clearly. To verify that this reimbursement is offered within your plan, or for more information, you can sign in to MyBlue at **bluecrossma.org** or call the Member Service number on your ID card.
All fitness reimbursement requests must be submitted by March 31 of the following year.

Subscriber Information (Policyholder)

Identification Number on Subscriber ID Card (including first 3 characters)	**Subscriber's Last Name**	**First Name**	**Middle Initial**
Address – Number and Street	**City**	**State**	**ZIP Code**
Employer's Name			

Claim Information

Member's Last Name	**First Name**	**Middle Initial**	**Date of Birth** ___/___/____

Claim is for (choose one and color in the entire box):
- ❑ Subscriber (policyholder)
- ❑ Spouse (of policyholder)
- ❑ Ex-Spouse
- ❑ Dependent (up to age 26)
- ❑ Other (specify): ______________

Name, Address, and Phone Number of Qualified Fitness Expense

Total Dollars requested for Qualified Fitness Expense: $ _______________

Calendar year that fees were paid: _______________

Blue Cross Blue Shield of Massachusetts will make a reimbursement decision within 30 calendar days of receiving a completed request form. Reimbursement is sent to the member's address on file with Blue Cross. Reimbursement may be considered taxable income, so you should consult your tax advisor.

Certification and Authorization (This form must be signed and dated below.)
I certify that the information provided in support of this submission is complete and correct, and that I have not previously submitted for these services. I enrolled in the qualified program with the full intention of using such program. I understand that Blue Cross Blue Shield of Massachusetts may require proof of payment for a reimbursement decision. I authorize the release of any information about my qualified fitness program to Blue Cross Blue Shield of Massachusetts.

Subscriber's or Member's Signature: **Date:** ___/___/____

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

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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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WEIGHT-LOSS REIMBURSEMENT

Your reward for healthy behavior:
Receive up to $150 annually when you participate in a qualified weight-loss program.[1]

Qualified for Weight-Loss Reimbursement

Participation fees for:

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

Not Qualified for Weight-Loss Reimbursement

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

GET REIMBURSED IN THREE EASY STEPS

1

Choose
Start by picking a qualified weight-loss program.

2

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

3

Mail
Send the completed form to the address listed.

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

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

Questions?

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

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WEIGHT-LOSS REIMBURSEMENT REQUEST

Please Print All Information Clearly: To verify this reimbursement is offered within your plan, or for more information, please sign in to MyBlue at **bluecrossma.com/myblue** or call the Member Service number on your ID card. All weight-loss reimbursement requests must be submitted by March 31 of the following year.

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

Subscriber Information (Policyholder)

Identification Number on Subscriber ID Card (including first 3 characters)	**Subscriber's Last Name**	**First Name**	**Middle Initial**
Address – Number and Street	**City**	**State**	**Zip Code**
Employer's Name			

Claim Information

Member Last Name	**First Name**	**Middle Initial**	**Gender** (color in the entire box) ❑ Male ❑ Female	**Date of Birth** ___/___/____

Claim is for (choose one and color in the entire box):
- ❑ Subscriber (policyholder)
- ❑ Spouse (of policyholder)
- ❑ Ex-Spouse
- ❑ Dependent (up to age 26)
- ❑ Other (specify):

Name, Address, and Phone Number of Qualified Weight-Loss Program

Total dollars requested: $ ________________

Monthly program participation fee: $ ________________

Calendar Year: ___/___/____

Blue Cross Blue Shield of Massachusetts will make a reimbursement decision within 30 calendar days of receiving a completed request form. Reimbursement is sent to the member's address on file with Blue Cross. Reimbursement may be considered taxable income, so consult your tax advisor.

Certification and Authorization (This form must be signed and dated below.)
I certify that the information provided in support of this submission is complete and correct and that I have not previously submitted for these services. I understand that Blue Cross Blue Shield of Massachusetts may require proof of payment for a reimbursement decision. I authorize the release of any information about my qualified weight-loss program to Blue Cross Blue Shield of Massachusetts.

Subscriber's or Member's Signature: **Date:** ___/___/____

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

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Thank you for choosing a Blue Cross Blue Shield plan.

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

Before You Begin

Please carefully read the instructions below.

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

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

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

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

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

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

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163537 36-3630 (11/17)

Instructions

Section 1 To Be Filled Out By Your Employer

Your employer will fill out this section.

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

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

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

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

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

If your new hires are subject to a probationary period, please indicate the time frame in the "Remarks" section, as well as the qualifying events for new enrollees.

If a subscriber is being moved from an active group to a retiree group (within the same account), this is a transfer and not a termination. Please include the Medical or Dental Group # transferring to.

Cancellation date will be the first day of no coverage.

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

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

Section 2 Yourself (Member 1)

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

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

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

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

Section 3 Member 2

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

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

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

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

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

Section 5 Personal Savings Account

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

For each option:

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

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

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

Section 6 Signatures (Employer & Employee)

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

Please mail to:

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

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

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Please Read the Instructions Before Filling Out This Form.

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

Enrollment and Change Form

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

1. To Be Filled Out by Your Employer

Company Name	Current Medical Group #:	Medical Group # Transfering To:		
Current BCBS ID #, If any	Requested Effective Date MM DD YYYY	Date of Hire MM DD YYYY	Current Dental Group #:	Dental Group # Transferring To

Type of Transaction

☐ ADD ☐ CANCEL
☐ CHANGE Three digit
☐ TRANSFER termination code ☐ ☐ ☐

Remarks: (i.e., qualifying event for a new add, change to family or other instruction)

☐ Open Enrollment
☐ New Hire
☐ COBRA

Change to Family
☐ Add Spouse
☐ Add Dependent

☐ Loss of Coverage (HIPAA Continuation of Coverage Letter required)
☐ Other: ______________________________

2. Yourself (Member 1)

What products? ☐ Access Blue ☐ Blue Choice ☐ Blue Choice New England ☐ Blue Medicare Rx (Part D) ☐ Dental Blue ☐ HMO Blue ☐ HMO Blue New England ☐ Managed Blue for Seniors ☐ Medex (Group) ☐ Network Blue ☐ PPO ☐ Saver Blue

Membership Type (Medical) ☐ Individual ☐ Family

Membership Type (Dental) ☐ Individual ☐ Family

First Name	M.I.	Last Name	Sex	Date of Birth
Street Address/ P.O. Box #	Apt. #	City/ Town	State	Zip Code

Home Phone ( )	Cell Phone ( )	Email	
Social Security # (REQUIRED)[1]	Other Insurance?[2] Y ☐ / N ☐	Other Insurance Company Name	Member Identification Number
PCP ID # (see instructions)	Name of PCP	City / State	Is this your current PCP? Y ☐ / N ☐

Are you covered by Medicare?[2] Y ☐ / N ☐	Part A Effective Date MM DD YYYY	Part B Effective Date MM DD YYYY	Part D Effective Date MM DD YYYY	Medicare #	☐ 65+ ☐ Disabled ☐ ESRD
				Actively Working? Y ☐ / N ☐	If Retired, Date

3. Member 2

Please Check One: ☐ Spouse ☐ Domestic Partner ☐ Divorced Spouse (court ordered) Plan Type: ☐ Medical ☐ Dental

First Name	M.I.	Last Name	Sex	Date of Birth

Social Security # (REQUIRED)[1]	Phone ( )	Other Insurance?[1] Y ☐ / N ☐	Other Insurance Company Name	Member Identification Number
PCP ID # (see instructions)	Name of PCP	City / State	Is this your current PCP? Y ☐ / N ☐	

Are you covered by Medicare?[2] Y ☐ / N ☐	Part A Effective Date MM DD YYYY	Part B Effective Date MM DD YYYY	Part D Effective Date MM DD YYYY	Medicare #	☐ 65+ ☐ Disabled ☐ ESRD
				Actively Working? Y ☐ / N ☐	If Retired, Date

4. Your Eligible Dependents (Member 3, 4 and 5)

Dependent's First Name 3.)	M.I.	Last Name	Sex	Date of Birth
Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP		
Is this your current PCP? Y ☐ / N ☐	Full-time student and aged 19 or older ☐	Disabled and aged 26 or older ☐	Plan Type: ☐ Medical ☐ Dental	
Dependent's First Name 4.)	M.I.	Last Name	Sex	Date of Birth
Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP		
Is this your current PCP? Y ☐ / N ☐	Full-time student and aged 19 or older ☐	Disabled and aged 26 or older ☐	Plan Type: ☐ Medical ☐ Dental	
Dependent's First Name 5.)	M.I.	Last Name	Sex	Date of Birth
Social Security # (REQUIRED)[1]	PCP ID # (see instructions)	Name of PCP		
Is this your current PCP? Y ☐ / N ☐	Full-time student and aged 19 or older ☐	Disabled and aged 26 or older ☐	Plan Type: ☐ Medical ☐ Dental	

Please check if you are using separate forms for additional dependent children ☐ Total # of dependents: ______________

5. Personal Savings Account

☐ **HSA: Health Savings Account**	Start Date	End Date	FSA Goal Amount (Please see instructions for limits.): $
☐ **FSA: Health Flexible Spending Account**	Start Date	End Date	Health: $
☐ **FSA: Dependent Care Reimbursement Account**	Start Date	End Date	Dependent Care: $

6. Signature (Employer & Employee)

The information here is complete and true. I understand that Blue Cross and Blue Shield will rely on this information to enroll me and my dependents or to make changes to my membership. I understand that I should read the subscriber certificate or benefit booklet provided by my employer to understand my benefits and any restrictions that apply to my health care plan. I understand that Blue Cross and Blue Shield may obtain personal and medical information about me to carry out its business, and that it may use and disclose that information in accordance with law. I acknowledge that I may obtain further information about the collection, use, and disclosure of my information in "Our Commitment to Confidentiality," Blue Cross and Blue Shield's notice of privacy practices.

Employee's Signature ______________________ Date __________ Employer's Signature ______________________ Date __________

1. REQUIRED: Under the Affordable Care Act, we are required to collect the Social Security number for you and any dependent enrolling in your plan.

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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.

An Association of Independent Blue Cross and Blue Shield Plans

Take this reference card with you when you travel.
When you need care, you'll be prepared.

TEAR HERE

Urgent Care

1. 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

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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 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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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.

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- **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 you authorized (among others). An example of a disclosure that would be reported to you is our disclosure of your information in response to a court order.
- **You have the right to ask us to correct or amend information you believe to be incorrect.** Your request to correct or amend information must be in writing. Please complete the Members Request to Amend Protected Health Information form. If we deny your request, you may ask us to make your request part of your records.

- **You have the right to ask that we restrict or refuse the disclosure of information about you and that we direct communications to you by alternative means or to alternative locations.** While we may not always be able to agree to your request, we will make reasonable efforts to accommodate requests. Unless you've notified us to request a different mailing address, Summary of Health Plan Payments statements for the subscriber, and all members listed on the subscriber's plan, are generally delivered to the subscriber's address. Under certain circumstances, you can request to not receive statements for a particular service, or to have statements delivered through an alternate method or to an alternate address, when required by state law. If you have concerns about protecting the privacy of your medical information in your statements, you can have these statements delivered to an address other than the plan subscriber's address, or have them delivered only via electronic means. For help understanding your delivery options, please call Member Service at the number listed on your member ID card. Your request and any subsequent revocation must be in writing.

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

ABOUT THIS NOTICE

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

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

WHCRA NOTICE

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

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

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

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

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

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

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

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Glossary of Health Coverage and Medical Terms

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

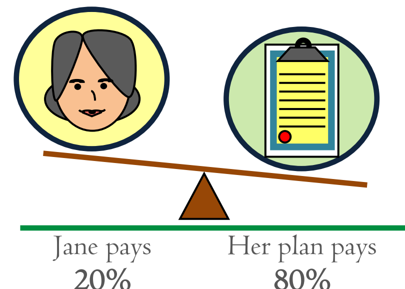
Allowed Amount
This is the maximum payment the plan will pay for a covered health care service. May also be called "eligible expense", "payment allowance", or "negotiated rate".

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

Balance Billing
When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. 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 out-of-network provider (non-preferred provider). A network provider (preferred provider) may not 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 provider to your health insurer or plan 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 owe. (For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)



(See page 6 for a detailed example.)

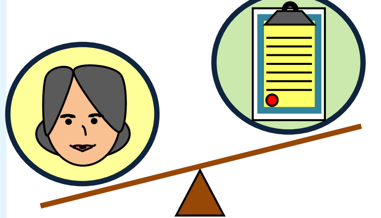
Complications of Pregnancy
Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren't complications of pregnancy.

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

Cost Sharing
Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay, or the cost of care a plan 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 plan you buy through the Marketplace. 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



Jane pays 100%

Her plan pays 0%

(See page 6 for a detailed example.)

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 also have separate deductibles that apply to specific services or groups of services. A plan 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 provider 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: 1) 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 emergency medical condition. Types of emergency medical transportation may include transportation by air, land, or sea. Your plan 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 emergency medical condition and treat you to keep an emergency medical condition from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for emergency medical conditions.

Excluded Services

Health care services that your plan doesn't pay for or cover.

Formulary

A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost sharing 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 premium. A health insurance contract may also be called a "policy" or "plan".

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 providers. 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 plans 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.

Individual Responsibility Requirement

Sometimes called the "individual mandate", the duty you may have to be enrolled in health coverage that provides minimum essential coverage. If you don't have minimum essential coverage, you may have to pay a penalty when you file your federal income tax return unless you qualify for a health coverage exemption.

In-network Coinsurance

Your share (for example, 20%) of the allowed amount for covered healthcare 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 providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

Marketplace

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

Maximum Out-of-pocket Limit

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

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

Health coverage that will meet the individual responsibility requirement. 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.

Minimum Value Standard

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

Network

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

Network Provider (Preferred Provider)

A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. 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 allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

Out-of-network Copayment

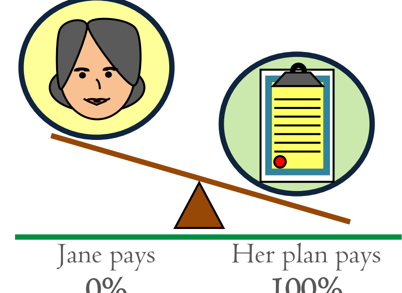
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

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

A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-particiapting" 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 plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.



(See page 6 for a detailed example.)

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 health insurance or plan. 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 health insurance. You can get this help if you get health insurance through the Marketplace and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly premium costs.

Prescription Drug Coverage

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

Prescription Drugs

Drugs and medications that by law require a prescription.

Preventive Care (Preventive Service)

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

Primary Care Physician

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

Primary Care Provider

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

Provider

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

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

Referral
A written order from your primary care provider for you to see a specialist 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 primary care provider. If you don't get a referral first, the plan 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 preventive care 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 provider 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 prescription drug 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 formulary.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

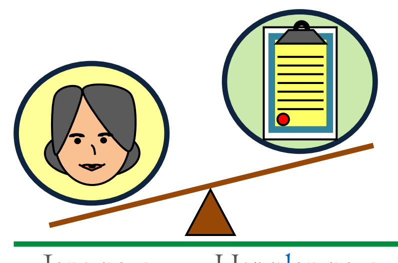
Urgent Care
Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

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

January 1st
Beginning of Coverage Period

December 31st
End of Coverage Period

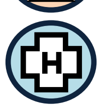


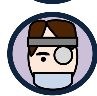
Jane pays 100% | Her plan pays 0%

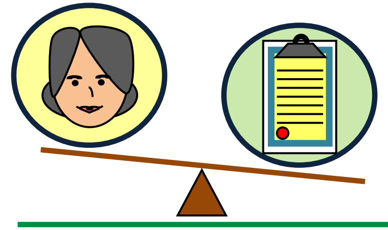
Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: $125
Jane pays: $125
Her plan pays: $0





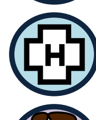


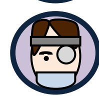
Jane pays 20% | Her plan pays 80%

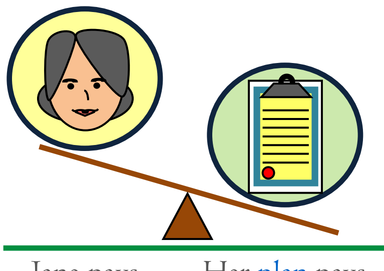
Jane reaches her $1,500 deductible, coinsurance begins

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 pays 0% | Her plan pays 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

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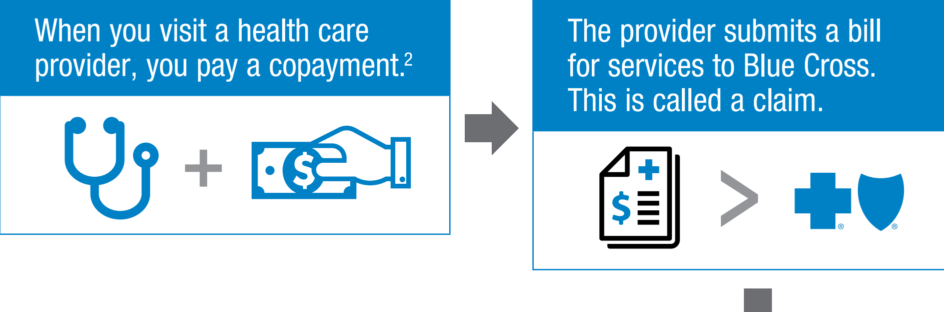
A Guide to Your Summary of Health Plan Payments[1]

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

When you visit a health care provider, you pay a copayment.[2]

The provider submits a bill for services to Blue Cross. This is called a claim.



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.

This is not a bill.

Payment overview*

Allowed amount	**$5,000.00**
Amount covered	**$3,700.00**

What you owe

Copayments	$0.00
Deductible	$1,000.00
Co-insurance	$0.00
Not Covered	$300.00
	$1,300.00

*See the glossary on the previous page to find out more about the terms included in the payment overview and payment details pages.

Amount covered by Blue Cross

Amount you owe (if any)

Copayments

Your copayments (also known as a copay) are the fixed dollar amount you pay each time you see a provider[2] or fill a prescription. Look for your copay amount on your member ID card.

Deductible

If your plan has a deductible, this is the amount of money you pay out-of-pocket for health care services, such as blood tests and x-rays, before Blue Cross starts to pay for them.

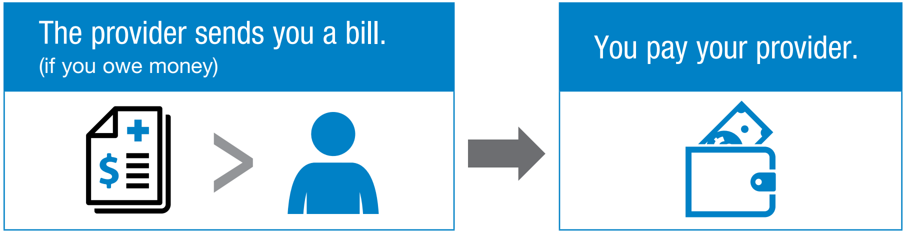
Co-insurance

If your plan has co-insurance, you're responsible for paying a predetermined percentage of your medical expenses once your deductible has been met.

Tip: See the glossary on page 2 of your statement for the meaning of any unfamiliar terms.

The provider sends you a bill.
(if you owe money)

You pay your provider.



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.

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

MASSACHUSETTS

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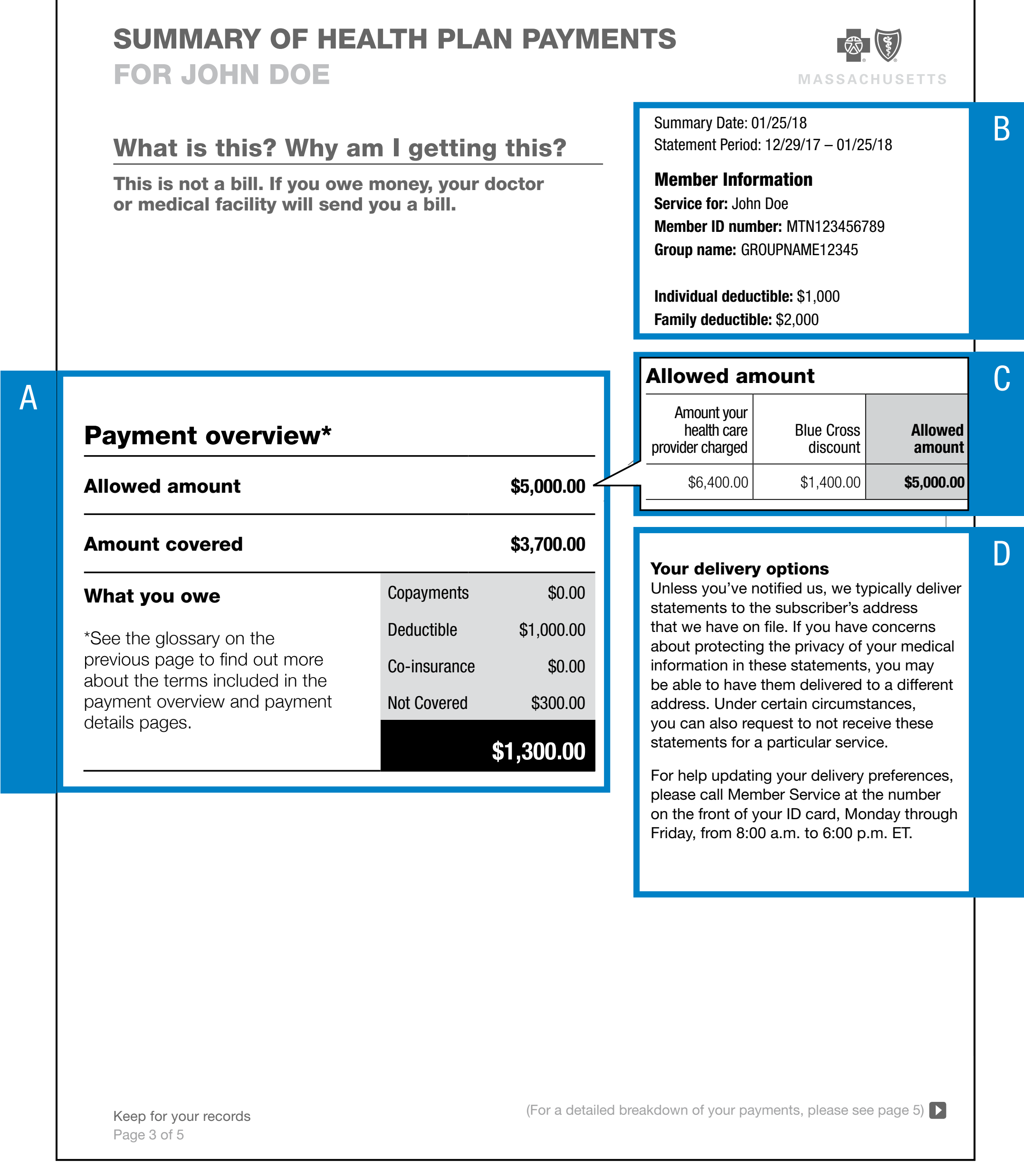
Your Summary of Health Plan Payments

Payment Overview Page



SUMMARY OF HEALTH PLAN PAYMENTS
FOR JOHN DOE

MASSACHUSETTS

What is this? Why am I getting this?

This is not a bill. If you owe money, your doctor or medical facility will send you a bill.

B

Summary Date: 01/25/18
Statement Period: 12/29/17 – 01/25/18

Member Information
Service for: John Doe
Member ID number: MTN123456789
Group name: GROUPNAME12345

Individual deductible: $1,000
Family deductible: $2,000

A

Payment overview*

Allowed amount		**$5,000.00**
Amount covered		**$3,700.00**
What you owe	Copayments	$0.00
	Deductible	$1,000.00
	Co-insurance	$0.00
	Not Covered	$300.00
		$1,300.00

*See the glossary on the previous page to find out more about the terms included in the payment overview and payment details pages.

C

Allowed amount

Amount your health care provider charged	Blue Cross discount	**Allowed amount**
$6,400.00	$1,400.00	**$5,000.00**

D

Your delivery options
Unless you've notified us, we typically deliver statements to the subscriber's address that we have on file. If you have concerns about protecting the privacy of your medical information in these statements, you may be able to have them delivered to a different address. Under certain circumstances, you can also request to not receive these statements for a particular service.

For help updating your delivery preferences, please call Member Service at the number on the front of your ID card, Monday through Friday, from 8:00 a.m. to 6:00 p.m. ET.

Keep for your records
Page 3 of 5

(For a detailed breakdown of your payments, please see page 5)

A 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.

C This section shows how the allowed amount was calculated.

D Your delivery options describes how these statements are delivered and how you can update your preferences.

Your Summary of Health Plan Payments

Payment Details Page

HEALTH PLAN PAYMENT DETAILS

E | F | G: Breakdown of what you owe | H

Service date	Service type	Amount charged: Amount your health care provider charged	Amount charged: Blue Cross discount	Allowed amount	Other insurance	Amount covered	What you owe	Copayments	Deductible	Co-insurance	Not covered (see notes)	What you owe	See notes
Dr. Josephine Smith, ABC Hospital Patient Name: John Doe Claim #: 11111111111111 (In-Network)													
1/15/18	Routine Services	$400.00	–$180.00	$220.00	$0.00	–$220.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	
1/15/18	X-ray	$180.35	–$60.35	$120.00	$0.00	$0.00	$120.00	$0.00	$120.00	$0.00	$0.00	$120.00	
1/15/18	Lab	$350.00	–$120.00	$230.00	$0.00	$0.00	$230.00	$0.00	$230.00	$0.00	$0.00	$230.00	
1/15/18	Room & board	$5,000.00	–$980.00	$4,020.00	$0.00	–$3,370.00	$650.00	$0.00	$650.00	$0.00	$0.00	$650.00	
Subtotal		$5,930.35	–$1,340.35	$4,590.00	$0.00	–$3,590.00	$1,000.00	$0.00	$1,000.00	$0.00	$0.00	$1,000.00	
Dr. Jake Giovanni, ABC Hospital Patient Name: John Doe Claim #: 2222222222222 (In-Network)													
1/15/18	Lab	$300.00	$0.00	$300.00	$0.00	$0.00	$300.00	$0.00	$0.00	$0.00	$300.00	$300.00	A
Subtotal		$300.00	$0.00	$300.00	$0.00	$0.00	$300.00	$0.00	$0.00	$0.00	$300.00	$300.00	
Grand total		$6,230.35	–$1,340.35	$4,890.00	$0.00	–$3,590.00	$1,300.00	$0.00	$1,000.00	$0.00	$300.00	$1,300.00	

I: This provider will bill you this amount.

J

Deductible

Allowed amount as of 11/1/16*

$0 — $1,000

Individual: Met ($1,000 of $1,000)

$0 — $2,000

Family: $1,000 of $2,000

Out-of-pocket maximum

Amount applied as of 11/1/16*

$0 — $5,000

Individual: $1,000 of $5,000

$0 — $10,000

Family: $1,000 of $10,000

HAVE QUESTIONS?

Call the number on your ID card.

Or log in to your account at bluecrossma.com/myblue.

For TTY, call 711

* Includes charges from this coverage period only.
Log in to your account at **www.bluecrossma.com/myblue** for your plan effective date.

E Your recent claims, including dates of service, names of providers, the amounts charged, and payment details.

F The amount you owe for each service.

G How we determined what you owe, including copayments, deductible, and co-insurance.

H Additional information on how we processed your claims.

I 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.

J A detailed breakdown of your deductible and out-of-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.

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184294M
55-1305 (04/18)

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Thank you for choosing a Blue Cross Blue Shield plan.

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

Before You Begin

Please carefully read the instructions below.

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

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

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

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

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

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

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163537 36-3630 (11/17)

Instructions

Section 1 To Be Filled Out By Your Employer

Your employer will fill out this section.

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

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

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

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

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

If your new hires are subject to a probationary period, please indicate the time frame in the "Remarks" section, as well as the qualifying events for new enrollees.

If a subscriber is being moved from an active group to a retiree group (within the same account), this is a transfer and not a termination. Please include the Medical or Dental Group # transferring to.

Cancellation date will be the first day of no coverage.

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

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

Section 2 Yourself (Member 1)

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

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

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

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

Section 3 Member 2

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

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

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

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

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

Section 5 Personal Savings Account

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

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

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

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

Section 6 Signatures (Employer & Employee)

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

Please mail to:

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

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

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Please Read the Instructions Before Filling Out This Form.

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

Enrollment and Change Form

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

1. To Be Filled Out by Your Employer

Company Name | Current Medical Group #: | Medical Group # Transfering To:

Current BCBS ID #, If any | Requested Effective Date MM DD YYYY | Date of Hire MM DD YYYY | Current Dental Group #: | Dental Group # Transferring To

Type of Transaction
❒ ADD ❒ CANCEL
❒ CHANGE Three digit
❒ TRANSFER termination code ☐ ☐ ☐

Remarks: (i.e., qualifying event for a new add, change to family or other instruction)
❒ Open Enrollment ❒ New Hire ❒ COBRA
Change to Family ❒ Add Spouse ❒ Add Dependent
❒ Loss of Coverage (HIPAA Continuation of Coverage Letter required)
❒ Other: ______________________________

2. Yourself (Member 1)

What products? ❒ Access Blue ❒ Blue Choice ❒ Blue Choice New England ❒ Blue Medicare Rx (Part D) ❒ Dental Blue ❒ HMO Blue ❒ HMO Blue New England ❒ Managed Blue for Seniors ❒ Medex (Group) ❒ Network Blue ❒ PPO ❒ Saver Blue

Membership Type (Medical) ❒ Individual ❒ Family | Membership Type (Dental) ❒ Individual ❒ Family

First Name | M.I. | Last Name | Sex | Date of Birth

Street Address/ P.O. Box # | Apt. # | City/ Town | State | Zip Code

Home Phone ( ) | Cell Phone ( ) | Email

Social Security # (REQUIRED)[1] | Other Insurance?[2] Y ❒ / N ❒ | Other Insurance Company Name | Member Identification Number

PCP ID # (see instructions) | Name of PCP | City / State | Is this your current PCP? Y❒ / N❒

Are you covered by Medicare?[2] Y❒ / N❒ | Part A Effective Date MM DD YYYY | Part B Effective Date MM DD YYYY | Part D Effective Date MM DD YYYY | Medicare # | Actively Working? Y❒ / N❒ | ❒ 65+ ❒ Disabled ❒ ESRD | If Retired, Date

3. Member 2

Please Check One: ❒ Spouse ❒ Domestic Partner ❒ Divorced Spouse (court ordered) | Plan Type: ❒ Medical ❒ Dental

First Name | M.I. | Last Name | Sex | Date of Birth

Social Security # (REQUIRED)[1] | Phone ( ) | Other Insurance?[1] Y ❒ / N ❒ | Other Insurance Company Name | Member Identification Number

PCP ID # (see instructions) | Name of PCP | City / State | Is this your current PCP? Y❒ / N❒

Are you covered by Medicare?[2] Y❒ / N❒ | Part A Effective Date MM DD YYYY | Part B Effective Date MM DD YYYY | Part D Effective Date MM DD YYYY | Medicare # | Actively Working? Y❒ / N❒ | ❒ 65+ ❒ Disabled ❒ ESRD | If Retired, Date

4. Your Eligible Dependents (Member 3, 4 and 5)

Dependent's First Name 3.) | M.I. | Last Name | Sex | Date of Birth

Social Security # (REQUIRED)[1] | PCP ID # (see instructions) | Name of PCP

Is this your current PCP? Y❒ / N❒ | Full-time student and aged 19 or older ❒ | Disabled and aged 26 or older ❒ | Plan Type: ❒ Medical ❒ Dental

Dependent's First Name 4.) | M.I. | Last Name | Sex | Date of Birth

Social Security # (REQUIRED)[1] | PCP ID # (see instructions) | Name of PCP

Is this your current PCP? Y❒ / N❒ | Full-time student and aged 19 or older ❒ | Disabled and aged 26 or older ❒ | Plan Type: ❒ Medical ❒ Dental

Dependent's First Name 5.) | M.I. | Last Name | Sex | Date of Birth

Social Security # (REQUIRED)[1] | PCP ID # (see instructions) | Name of PCP

Is this your current PCP? Y❒ / N❒ | Full-time student and aged 19 or older ❒ | Disabled and aged 26 or older ❒ | Plan Type: ❒ Medical ❒ Dental

Please check if you are using separate forms for additional dependent children ❒ Total # of dependents: ______________

5. Personal Savings Account

☐ **HSA: Health Savings Account**	Start Date	End Date	FSA Goal Amount (Please see instructions for limits.): $
☐ **FSA: Health Flexible Spending Account**	Start Date	End Date	Health: $
☐ **FSA: Dependent Care Reimbursement Account**	Start Date	End Date	Dependent Care: $

6. Signature (Employer & Employee)

The information here is complete and true. I understand that Blue Cross and Blue Shield will rely on this information to enroll me and my dependents or to make changes to my membership. I understand that I should read the subscriber certificate or benefit booklet provided by my employer to understand my benefits and any restrictions that apply to my health care plan. I understand that Blue Cross and Blue Shield may obtain personal and medical information about me to carry out its business, and that it may use and disclose that information in accordance with law. I acknowledge that I may obtain further information about the collection, use, and disclosure of my information in "Our Commitment to Confidentiality," Blue Cross and Blue Shield's notice of privacy practices.

Employee's Signature ______________ Date ________ Employer's Signature ______________ Date ________

1. REQUIRED: Under the Affordable Care Act, we are required to collect the Social Security number for you and any dependent enrolling in your plan.

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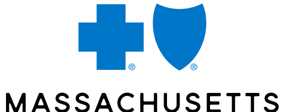
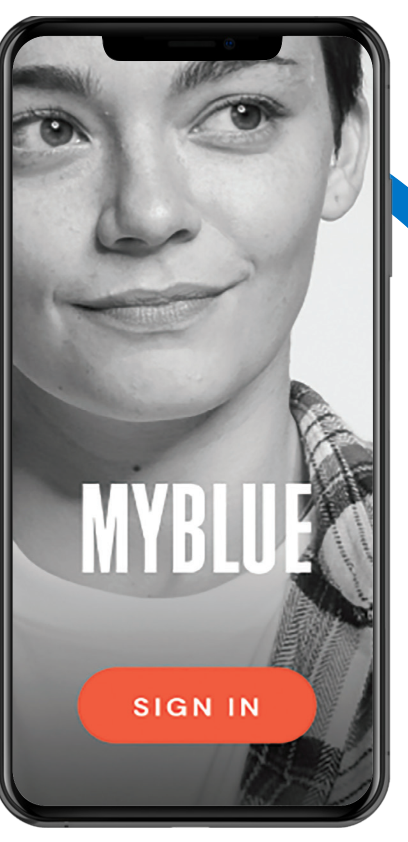


GETTING MORE. NOW THERE'S A PLAN.



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

MyBlue 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

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

COVERAGE AND BENEFITS

CLAIMS AND BALANCES

FITNESS AND WEIGHT-LOSS REIMBURSEMENT

MEDICATION LOOKUP

Sign In

Download the app, or create an account at **bluecrossma.com**.

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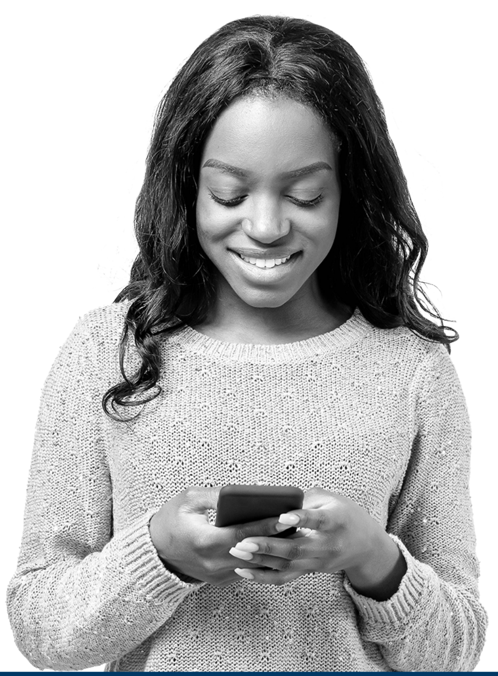
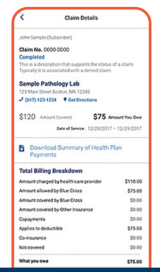
STAY ON TOP OF YOUR COVERAGE

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

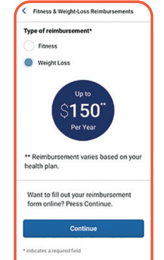
YOUR PLAN IN YOUR HAND



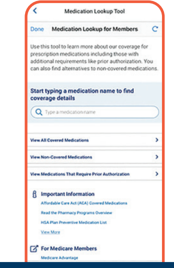
Once you sign in or create a MyBlue App account, you can see all of your benefits, all in one place. Track your claims, medications, account balances, and more from your device. And, you can easily keep track of reimbursements and savings.



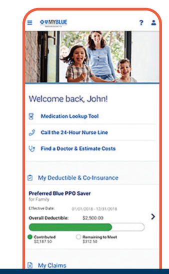
Track claims and benefits
Keep up to date on benefits and coverage.



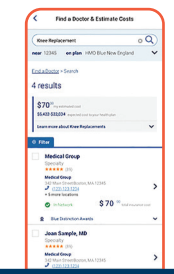
Fitness and weight-loss reimbursement
The online forms are here, along with other savings and offers.



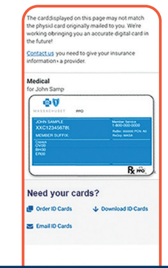
Your medications at a glance
Their names, costs, and prescriptions at your fingertips.



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



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



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**).
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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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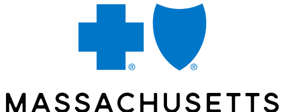

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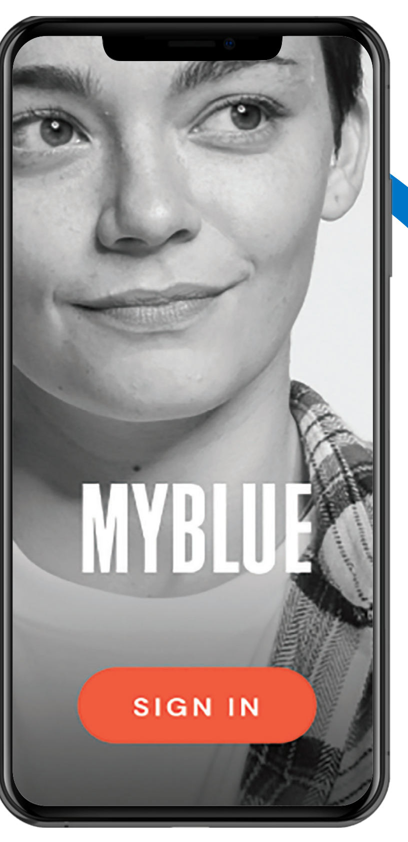

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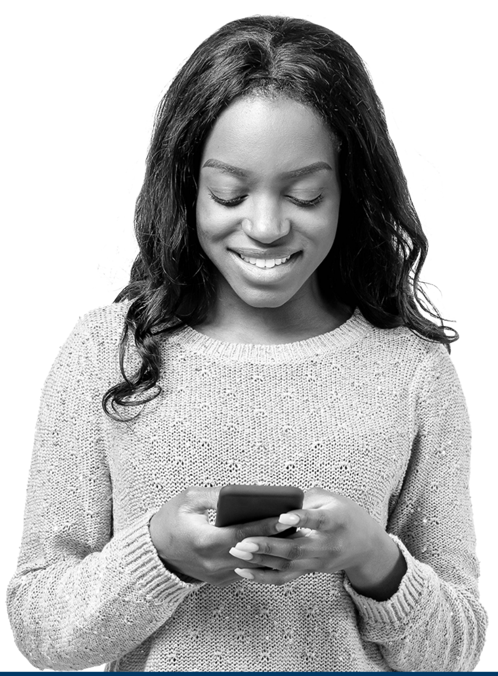

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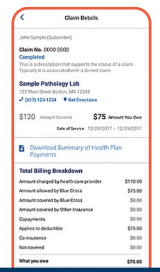

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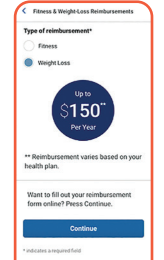

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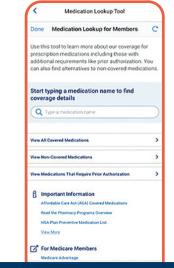

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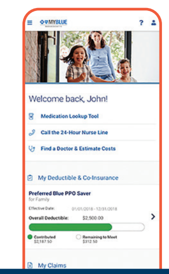

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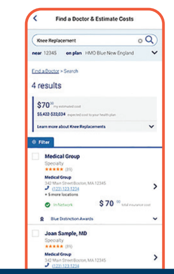

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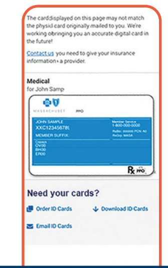

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Coordination of Benefits

What Is Coordination of Benefits?

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

You May Need Coordination of Benefits If:

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

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

If You Have More Than One Medical and Dental Plan

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

If You Have Questions

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

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

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

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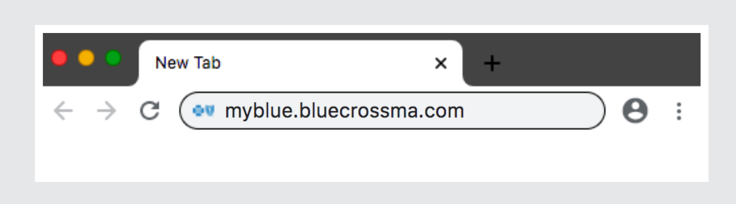
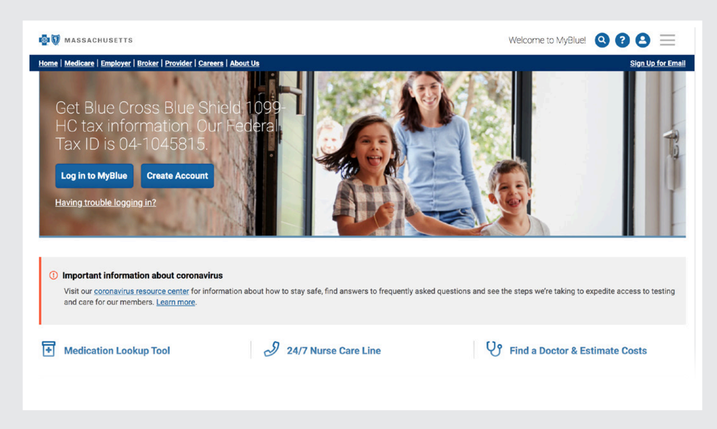
How to Find Your Primary Care Provider's ID Number

Instructions for Using Our Find a Doctor & Estimate Costs Tool

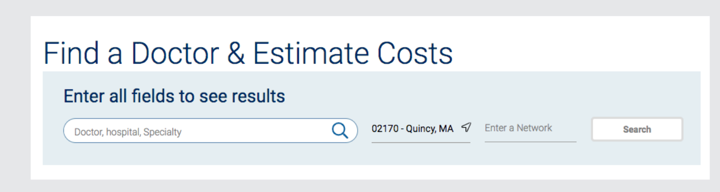
If your plan requires you to choose a primary care provider (PCP), you'll need to enter your PCP's ID number on your enrollment form. You can find this number in your plan's provider directory, or by following these steps:



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



2. Click Find a Doctor & Estimate Costs.



3. 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.

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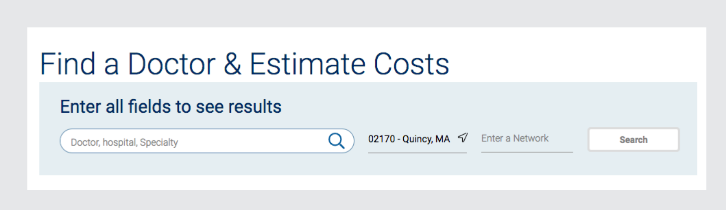
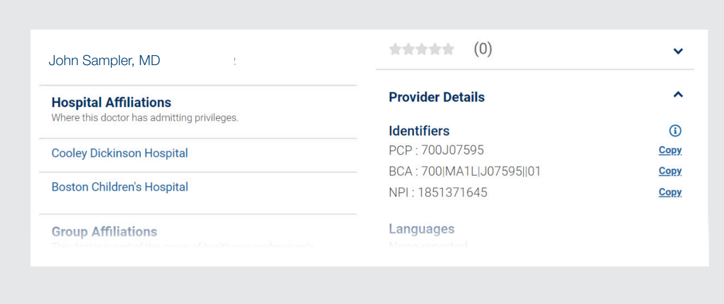
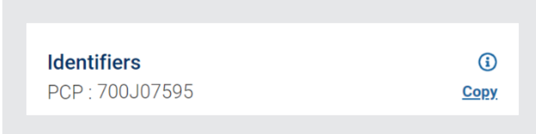


4. If you don't have a PCP, you can search for one by entering Primary Care in the Specialty field. You can then sort based on location, ratings, languages spoken, or other attributes listed along the left-hand side of the page.



5. 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.



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.

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NONDISCRIMINATION NOTICE

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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**.

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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 ID 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/ةيبرعلا:

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

Mon-Khmer, Cambodian/ខ្មែរ: ការជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសា ខ្មែរ សេវាជំនួយភាសាឥតគិតថ្លៃ គឺអាចរកបានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅផ្នែកសេវាសមាជិកតាមលេខនៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នក (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**).

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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**).

Persian/پارسیان:
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, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທຫາຝ່າຍບໍລິການສະມາຊິກທີ່ໝາຍເລກໂທລະສັບຢູ່ໃນບັດຂອງທ່ານ (TTY: **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**).

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