

Plan Guide 2020

Take advantage of all your Prescription Drug plan has to offer.

ARLINGTON PUBLIC SCHOOLS

UnitedHealthcare® MedicareRx for Groups (PDP)

Effective: January 1, 2020 through December 31, 2020

Group Number: 23707



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Introducing the UnitedHealthcare® MedicareRxSM for Groups (PDP) prescription drug plan

Dear Retiree,

Your former employer or plan sponsor has selected UnitedHealthcare® to offer prescription drug coverage for all eligible retirees. We believe you should get more than a good plan and that's why we have the people, tools and resources in place to help you live a healthier life.

Let us help you:

- Get tools and resources to help you be in more control of your health
- Find ways to save money, so you can focus more on what matters most to you

In this book you will find:

- A description of this plan and how it works
- Information on benefits, programs and services — and how much they cost
- Details on how to enroll
- What you can expect after you enroll

Enrolling is easy:

- 1 Find the Enrollment Request Form(s) in the “Enrollment” section of this book
- 2 Fill out completely — make sure you sign and date the form(s)
- 3 Return your completed form(s) in the enclosed envelope before your enrollment deadline



GET A 3 MONTH SUPPLY¹



OVER 67,000 PHARMACIES



OPTUMRx[®] HOME DELIVERY

¹Your employer group or plan sponsor may provide coverage beyond 3 months. Please refer to the Benefit Highlights or Summary of Benefits for more information.

Visit us online anytime

www.UHCRetiree.com

Toll-free **1-877-558-4749**, TTY **711**
8 a.m. - 8 p.m. local time, 7 days a week

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Plan Information

Benefit Highlights

ARLINGTON PUBLIC SCHOOLS 23707

Effective January 1, 2020 to December 31, 2020

This is a short description of your plan benefits. For complete information, please refer to your Summary of Benefits or Evidence of Coverage. Limitations, exclusions, and restrictions may apply.

Prescription Drugs

	Your Cost	
Initial Coverage Stage	Network Pharmacy (30-day retail supply)	Mail Service Pharmacy (90-day supply)
Tier 1: Preferred Generic	\$10 copay	\$20 copay
Tier 2: Preferred Brand	\$25 copay	\$50 copay
Tier 3: Non-preferred Drug	\$40 copay	\$80 copay
Tier 4: Specialty Tier	\$40 copay	\$80 copay
Coverage gap stage	After your total drug costs reach \$4,020, the plan continues to pay its share of the cost of your drugs and you pay your share of the cost	
Catastrophic coverage stage	After your total out-of-pocket costs reach \$6,350, you will pay the greater of \$3.60 copay for generic (including brand drugs treated as generic), \$8.95 copay for all other drugs, or 5% coinsurance	

Your plan sponsor has elected to offer additional coverage on some prescription drugs that are normally excluded from coverage on your drug list (formulary). Please see your Additional Drug Coverage list for more information.

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare-approved Part D sponsor. Enrollment in the plan depends on the plan's contract renewal with Medicare.

Retiree plan prospects must meet the eligibility requirements to enroll for group coverage. This information is not a complete description of benefits. Contact the plan for more information.

Limitations, copayments, and restrictions may apply. Drug lists (formulary), pharmacy network, premium and/or copayments/coinsurance may change each plan year.

Plan Details

UnitedHealthcare® MedicareRxSM for Groups (PDP)

Your former employer or plan sponsor has selected a UnitedHealthcare® MedicareRxSM for Groups (PDP) plan for your prescription drug coverage. This is a plan designed just for a former employer or plan sponsor, like yours. Only eligible retirees of your former employer or plan sponsor can enroll in this plan. This plan is also known as a Medicare Part D plan.

Original Medicare (Parts A and B) helps pay for some of the costs of hospital stays and doctor visits, but it doesn't cover prescription drugs. Medicare Part D plans help with prescription drug costs. You can get Part D coverage through a private insurance company, like UnitedHealthcare®.

Make sure you are signed up for Medicare.



You must be entitled to Medicare Part A and/or enrolled in Medicare Part B to enroll in this plan.

- If you're not sure if you are enrolled, check with Social Security. Visit www.ssa.gov/locator or call **1-800-772-1213**, TTY **1-800-325-0778**, between 7 a.m. – 7 p.m. local time, Monday – Friday.
- If you are enrolled in Part B, you must continue to pay your Part B monthly premium to Social Security to keep your Part B coverage. If you stop paying your Medicare Part B premium, you will be disenrolled from Medicare Part B and this could affect your medical coverage.

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8 a.m. - 8 p.m. local time, 7 days a week

How your Group Medicare Part D plan works

Here are Medicare's rules about what types of coverage you can have either as an addition to or combined with a group-sponsored Medicare Part D prescription drug plan.



Rule 1: One plan at a time

- You may be enrolled in only one Medicare Part D prescription drug plan at a time. This means you may have one Medicare Part D plan or one Medicare Advantage plan that includes prescription drug coverage, but not both.
- The plan you enroll in last is the plan that Centers for Medicare & Medicaid Services (CMS) considers to be your final decision.
- If you enroll in another plan with prescription drug coverage after your enrollment in this group-sponsored plan, you will be disenrolled from this plan.
- Any eligible family members may also be disenrolled from their group-sponsored coverage and you and your family may not have drug coverage through your plan sponsor or former employer.



Rule 2: You must have employer group-sponsored coverage

Your group-sponsored Medicare Part D plan includes only drug coverage. It does not include medical care coverage.

- If you want a Medicare Advantage plan, it must come through a group like your former employer or plan sponsored Part D prescription drug plan.
- If you enroll in an individual medical plan, you may be disenrolled from this group-sponsored prescription drug plan.



Remember: If you drop or are disenrolled from your group-sponsored retiree drug coverage, you may not be able to re-enroll. Limitations and restrictions vary by your former employer or plan sponsor.

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8 a.m. - 8 p.m. local time, 7 days a week

Here are some of the highlights of your new prescription drug plan:

Dedicated service

We're here for you. Our Customer Service team has been specially trained to know all the ins and outs of your plan.

Complete drug list

The plan's drug list (formulary) includes all of the drugs covered by Medicare Part D in brand or generic form. Your plan may include additional drug coverage beyond what Medicare allows.

Filling your prescriptions is convenient

There are more than 67,000 national chain, regional and independent local retail pharmacies in the UnitedHealthcare network. Using a UnitedHealthcare network pharmacy can help make sure you are getting the lowest cost available through your plan.



**OVER 67,000
PHARMACIES¹**

¹2019 Optum Internal Report Data

Visit us online anytime

www.UHCRetiree.com

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8 a.m. - 8 p.m. local time, 7 days a week



What is IRMAA?

The Income-Related Monthly Adjustment Amount (IRMAA) is an amount Social Security determines you may need to pay in addition to your monthly plan premium if your modified adjusted gross income on your IRS tax return from two years ago is above a certain limit. This extra amount is paid directly to Social Security, not to your plan. Social Security will contact you if you have to pay IRMAA.



What is a Medicare Part D Late Enrollment Penalty (LEP)?

Most people first become eligible for Medicare when they turn 65. This is your Initial Enrollment Period. If, at any time after you first become eligible for Part D, there's a period of at least 63 days in a row when you don't have Part D or other creditable prescription drug coverage, a penalty may apply. Creditable coverage is prescription drug coverage that is at least as good as or better than what Medicare requires. The late enrollment penalty is an amount added to your monthly Medicare premium and billed to you separately by UnitedHealthcare.

When you become a member, your former employer or plan sponsor will be asked to confirm that you have had continuous Part D coverage. If your former employer or plan sponsor asks for information about your prescription drug coverage history, please respond as quickly as possible to avoid an unnecessary penalty. Once you become a member, more information will be available in your Evidence of Coverage (EOC). Your Quick Start Guide will include details on how to access your EOC.

Call Social Security to see if you qualify for Extra Help

If you have a limited income, you may be able to get Extra Help to pay for your prescription drug costs. If you qualify, Extra Help could pay up to 75% or more of your drug costs. Many people qualify and don't know it. There's no penalty for applying and you can re-apply every year.



Toll-free call **1-800-772-1213**, TTY **1-800-325-0778**, between 7 a.m. – 7 p.m. local time, Monday – Friday

How your prescription drug coverage works

Your Medicare Part D prescription drug coverage includes thousands of brand name and generic prescription drugs. Check your plan's drug list to see if your drugs are covered.



What pharmacies can I use?

You can choose from over 67,000 national chain, regional and independent local retail pharmacies.



What is a drug cost tier?

Drugs are divided into different cost levels or tiers. In general, the lower the tier, the less you pay.



What will I pay for my prescription drugs?

What you pay will depend on the coverage your former employer or plan sponsor has arranged and on what drug cost tier your prescription falls into. Your cost may also change during the year based on the total cost of the prescriptions you have filled.¹



EASY ACCESS TO PHARMACIES NATIONWIDE

¹Refer to the Summary of Benefits or Benefit Highlights for more information.

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8 a.m. - 8 p.m. local time, 7 days a week

The price you pay for a covered drug will depend on two factors:

1. The drug cost tier for your drug

Each covered drug is assigned to a tier. Generally, the lower the tier, the less you pay.

Tier	Cost	Description
Tier 1	Low	Most generic drugs.
Tier 2		Many common brand name drugs, called preferred brands, and some higher-cost generic drugs.
Tier 3		Non-preferred generic and non-preferred brand name drugs. In addition, Part D eligible compound medications are covered in tier 3.
Tier 4 (Specialty)		High

2. Your Medicare drug payment stages

Annual deductible: If your plan has a deductible, you pay the total cost of your drugs until you reach the deductible amount set by your plan. Then you move to the initial coverage stage. If you don't have a deductible, your coverage begins in the initial coverage stage.

Initial Coverage	Coverage Gap (Donut Hole)	Catastrophic Coverage
<p>In this drug payment stage:</p> <ul style="list-style-type: none"> You pay a copay or coinsurance (percentage of a drug's total cost) and the plan pays the rest You stay in this stage until your total drug costs reach \$4,020 	<p>Your plan provides additional coverage through the gap.</p> <ul style="list-style-type: none"> You continue to pay the same copay or coinsurance as you did in the initial coverage stage You stay in this stage until your out-of-pocket costs reach \$6,350 	<p>After your out-of-pocket costs reach \$6,350:</p> <ul style="list-style-type: none"> You pay a small copay or coinsurance amount You stay in this stage for the rest of the plan year

Total Drug Costs: The amount you pay (or others pay on your behalf) and the plan pays for prescription drugs starting January 2020. This does not include premiums.

Out-of-Pocket Costs: The amount you pay (or others pay on your behalf), including the deductible, for prescription drugs starting January 2020. This does not include premiums.


Ways to save on your prescription drugs

You may save on the medications you take regularly

If you prefer the convenience of mail order, you could save time and money by receiving your maintenance medications through OptumRx® Home Delivery. You'll get automatic refill reminders and access to licensed pharmacists if you have questions.

Get a 3 month¹ supply at retail pharmacies

In addition to OptumRx® home delivery, most retail pharmacies offer 3 month supplies for some prescription drugs.

Check your UnitedHealthcare pharmacy directory to see if a retail pharmacy offers 3 month supplies noted with a  symbol. An online pharmacy directory is available at:

www.UHCRetiree.com

To request a printed directory, call Customer Service toll-free at:

1-877-558-4749, TTY 711, 8 a.m. - 8 p.m. local time, 7 days a week

Ask your doctor about trial supplies

A trial supply allows you to fill a prescription for less than 30 days. This way you can pay a reduced copay or coinsurance and make sure the medication works for you before getting a full month supply.

Explore lower cost options

Each covered drug in your drug list is assigned to a drug cost tier. Generally, the lower the tier, the less you pay. If you're taking a higher-tier drug, you may want to ask your doctor if there's a lower-tier drug you could take instead.

Have an annual medication review

Make an appointment to have an annual medication review with your doctor, to make sure you are only taking the drugs you need.

¹Your former employer or plan sponsor may provide coverage beyond 3 months. Please refer to the Benefit Highlights or Summary of Benefits for more information.

The UnitedHealthcare Savings Promise



UnitedHealthcare is committed to keeping your prescription drug costs down. As a UnitedHealthcare member, you have our Savings Promise that you'll get the lowest price available. That low price may be your plan copay, the pharmacy's retail price or our contracted price with the pharmacy.

Summary of Benefits 2020



Overview of your plan

UnitedHealthcare® MedicareRxSM for Groups (PDP)

Group Name (Plan Sponsor): ARLINGTON PUBLIC SCHOOLS
Group Number: 23707

S5820-803-000

Look inside to take advantage of the drug coverages the plan provides.
Call Customer Service or go online for more information about the plan.

 Toll-free **1-877-558-4749**, TTY **711**
8 a.m. - 8 p.m. local time, 7 days a week

 www.UHCRetiree.com



Summary of Benefits

January 1, 2020 - December 31, 2020

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. The Evidence of Coverage (EOC) provides a complete list of services we cover. You can see it online at www.UHCRetiree.com or you can call Customer Service for help. When you enroll in the plan you will get information that tells you where you can go online to view your Evidence of Coverage.

About this plan.

UnitedHealthcare® MedicareRxSM for Groups (PDP) is a Medicare Prescription Drug Plan plan with a Medicare contract.

To join UnitedHealthcare® MedicareRxSM for Groups (PDP), you must be entitled to Medicare Part A, and/or be enrolled in Medicare Part B, live in our service area as listed below be a United States citizen or lawfully present in the United States and meet the eligibility requirements of your former employer, union group or trust administrator (plan sponsor).

Our service area includes the 50 United States, the District of Columbia and all US territories.

Use network pharmacies.

UnitedHealthcare® MedicareRxSM for Groups (PDP) has a network of pharmacies. If you use out-of-network pharmacies, the plan may not pay for those drugs or you may pay more than you pay at a network pharmacy.

You can go to www.UHCRetiree.com to search for a network pharmacy using the online directory. You can also view the plan Drug List (Formulary) to see what drugs are covered, and if there are any restrictions.

UnitedHealthcare® MedicareRxSM for Groups (PDP)

Premiums and Benefits	Cost-Share
Monthly Plan Premium	Contact your group plan benefit administrator to determine your actual premium amount, if applicable.
Annual Prescription Drug Deductible	This plan does not have a deductible.

Prescription Drugs

If the actual cost for a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.

Your plan sponsor has chosen to make supplemental drug coverage available to you. This coverage is in addition to your Part D prescription drug benefit. The drug copays in this section are for drugs that are covered by both your Part D prescription drug benefit and your supplemental drug coverage. You can view the Certificate of Coverage at www.UHCRetiree.com or call Customer Service to have a hard copy sent to you.

Your plan sponsor has elected to offer additional coverage on some prescription drugs that are normally excluded from coverage on your Formulary. Please see your Additional Drug Coverage list for more information.

If you reside in a long-term care facility, you will pay the same for a 31-day supply as a 30-day supply at a retail pharmacy.

Stage 1: Annual Prescription Deductible	Since you have no deductible, this payment stage doesn't apply.	
Stage 2: Initial Coverage (After you pay your deductible, if applicable)	Retail Cost-Sharing	Mail Order Cost-Sharing
	One-month supply	Three-month supply
Tier 1: Preferred Generic	\$10 copay	\$20 copay
Tier 2: Preferred Brand	\$25 copay	\$50 copay
Tier 3: Non-preferred Drug	\$40 copay	\$80 copay
Tier 4: Specialty Tier	\$40 copay	\$80 copay
Stage 3: Coverage Gap Stage	After your total drug costs reach \$4,020, the plan continues to pay its share of the cost of your drugs and you pay your share of the cost.	
Stage 4: Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$6,350, you pay the greater of: <ul style="list-style-type: none"> □ 5% coinsurance, or □ \$3.60 copay for generic (including brand drugs treated as generic) and a \$8.95 copay for all other drugs. 	

Required Information

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare-approved Part D sponsor. Enrollment in the plan depends on the plan's contract renewal with Medicare.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at <https://www.medicare.gov> 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.

UnitedHealthcare Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-814-6894 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-814-6894 (TTY : 711)。

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

Premium and/or copayments/coinsurance may change each plan year.

Drugs and prices may vary between pharmacies and are subject to change during the plan year. Prices are based on quantity filled at the pharmacy. Quantities may be limited by pharmacy based on their dispensing policy or by the plan based on Quantity Limit requirements; if prescription is in excess of a limit, copay amounts may be higher.

You are not required to use OptumRx home delivery for a 90-day supply of your maintenance medication. If you have not used OptumRx home delivery, you must approve the first prescription order sent directly from your doctor to OptumRx before it can be filled. New prescriptions from OptumRx should arrive within ten business days from the date the completed order is received, and refill orders should arrive in about seven business days. Contact OptumRx anytime at 1-888-279-1828, TTY 711. OptumRx is an affiliate of UnitedHealthcare Insurance Company.

The Formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

You must continue to pay your Medicare Part B premium.

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The company does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the member toll-free phone number listed in the front of this booklet.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the member toll-free phone number listed in the front of this booklet.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en la portada de esta guía.

請注意：如果您說**中文 (Chinese)**，我們免費為您提供語言協助服務。請撥打本手冊封面所列的免付費會員電話號碼。

XIN LUU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Xin vui lòng gọi số điện thoại miễn phí dành cho hội viên trên trang bìa của tập sách này.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 이 책자 앞 페이지에 기재된 무료 회원 전화번호로 문의하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nakalista sa harapan ng booklet na ito.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русским (Russian)**. Позвоните по бесплатному номеру телефона, указанному на лицевой стороне данной брошюры.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يرجى الاتصال على رقم الهاتف المجاني للعضو الموجود في مقدمة هذا الكتيب.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo telefòn gratis pou manm yo ki sou kouvèti ti liv sa a.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone sans frais pour les affiliés figurant au début de ce guide.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny członkowski numer telefonu podany na okładce tej broszury.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número do membro encontrado na frente deste folheto.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero verde per i membri indicato all'inizio di questo libretto.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer für Mitglieder auf der Vorderseite dieser Broschüre an.

注意事項：日本語 (**Japanese**) を話される場合、無料の言語支援サービスをご利用いただけます。本冊子の表紙に記載されているメンバー用フリーダイヤルにお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگان اعضا که بر روی جلد این کتابچه قید شده تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते हैं, आपको भाषा सहायता सेवाएं, निःशुल्क उपलब्ध हैं। कृपया इस पुस्तिका के सामने के पृष्ठ पर सूचीबद्ध सदस्य टोल-फ्री फ़ोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu tus tswv cuab xov tooj hu dawb teev nyob ntawm sab xub ntiag ntawm phau ntawv no.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ (**Khmer**) សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខសមាជិកឥតចេញថ្លៃ បានកត់នៅខាងមុខនៃកូនសៀវភៅនេះ។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyanam. Pakitawagan iti miyembro toll-free nga number nga nakasurat iti sango ti libro.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíik'eh, bee ná'ahóót'i'. T'áá shòqdí díí naaltsoos bidáahgi t'áá jiik'eh naaltsoos báha'dít'éhígíí béesh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka xubinta ee telefonka bilaashka ah ee ku qoran xagga hore ee buugyaraha.



Drug List

Drug List

This is a partial alphabetical list of prescription drugs covered by the plan as of August 1, 2019. This list can change throughout the year. Call us or go online for the most complete, up-to-date information. Our phone number and website are listed on the back cover of this book.

- ☐ **Brand name** drugs are in **bold** type. Generic drugs are in plain type
- ☐ Covered drugs are placed in tiers. Each tier has a different cost
 - Tier 1: Preferred generic
 - Tier 2: Preferred brand
 - Tier 3: Non-preferred drug
 - Tier 4: Specialty tier
- ☐ Each tier has a copay or coinsurance amount
- ☐ See the Summary of Benefits in this book to find out what you'll pay for these drugs
- ☐ Some drugs have coverage requirements, such as Prior Authorization or Step Therapy. If your drug has any coverage rules or limits, there will be code(s) in the list. The codes and what they mean are shown below

PA Prior authorization	The plan needs more information from your doctor to make sure the drug is being used correctly for a medical condition covered by Medicare. If you don't get prior approval, it may not be covered.
QL Quantity limits	The plan only covers a certain amount of this drug for 1 copay. Limits help make sure the drug is used safely. If your doctor prescribes more than the limit, you or your doctor can ask the plan to cover the additional quantity.
ST Step therapy	You may need to try lower-cost drugs that treat the same condition before the plan will cover your drug. If you have tried other drugs or your doctor thinks they are not right for you, you or your doctor can ask the plan for coverage.
B/D Medicare Part B or Part D	Depending on how this drug is used, it may be covered by Medicare Part B or Part D. Your doctor may need to give the plan more information about how this drug will be used to make sure it's covered correctly.
HRM High-risk medication	This drug is known as a high-risk medication (HRM) for patients 65 years and older. This drug may cause side effects if taken on a regular basis. We suggest you talk with your doctor to see if an alternative drug is available to treat your condition.

T1 = Tier 1 T2 = Tier 2 T3 = Tier 3 T4 = Tier 4

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LA Limited access	The FDA only lets certain facilities or doctors give out this drug. It may require extra handling, doctor coordination or patient education.
MME Morphine milligram equivalent	Additional quantity limits may apply across all drugs in the opioid class used for the treatment of pain. This additional limit is called a cumulative morphine milligram equivalent (MME), and is designed to monitor safe dosing levels of opioids for individuals who may be taking more than 1 opioid drug for pain management. If your doctor prescribes more than this amount or thinks the limit is not right for your situation, you or your doctor can ask the plan to cover the additional quantity.
7D 7-Day limit	An opioid drug used for the treatment of acute pain may be limited to a 7-day supply for members with no recent history of opioid use. This limit is intended to minimize long-term opioid use. For members who are new to the plan, and have a recent history of using opioids, the limit may be overridden by having the pharmacy contact the plan.
DL Dispensing limit	Dispensing limits apply to this drug. This drug is limited to a 1 month supply per prescription.

A

Abacavir Sulfate-Lamivudine (Oral Tablet),T3 - QL

Acamprosate Calcium (Oral Tablet Delayed Release),T3

Acetaminophen-Codeine (300-15MG Oral Tablet, 300-30MG Oral Tablet, 300-60MG Oral Tablet),T1 - 7D; MME; DL; QL

Acetazolamide (Oral Tablet),T2

Acetazolamide ER (Oral Capsule Extended Release 12 Hour),T2

Acyclovir (Oral Capsule),T1

Acyclovir (Oral Tablet),T1

Adacel (Intramuscular Suspension),T2

Advair Diskus (Inhalation Aerosol Powder Breath Activated),T2 - QL

Advair HFA (Inhalation Aerosol),T2 - QL

Aggrenox (Oral Capsule Extended Release 12 Hour),T3 - QL

Albendazole (Oral Tablet),T4 - QL

Alcohol Prep Pads,T2

Alendronate Sodium (Oral Tablet),T1

Alfuzosin HCl ER (Oral Tablet Extended Release 24 Hour),T1

Allopurinol (Oral Tablet),T1

Alosetron HCl (Oral Tablet),T4 - PA

Alprazolam (Oral Tablet Immediate Release),T1 - QL

Alrex (Ophthalmic Suspension),T3

Amantadine HCl (Oral Capsule),T2

Ambrisentan (Oral Tablet),T4 - PA; LA; QL

Amiloride HCl (Oral Tablet),T1

Amiodarone HCl (100MG Oral Tablet, 400MG

Bold type = Brand name drug

Plain type = Generic drug

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Oral Tablet),T3	0.42ML Injection Solution Prefilled Syringe, 40MCG/0.4ML Injection Solution Prefilled Syringe),T3 - PA
Amiodarone HCl (200MG Oral Tablet),T1	Aranesp (Albumin Free) (25MCG/ML Injection Solution, 40MCG/ML Injection Solution),T3 - PA
Amitiza (Oral Capsule),T2 - QL	Aripiprazole (Oral Tablet),T1 - QL
Amitriptyline HCl (Oral Tablet),T3 - HRM	Arnuity Ellipta (Inhalation Aerosol Powder Breath Activated),T2 - QL
Amlodipine Besylate (Oral Tablet),T1	Aspirin-Dipyridamole ER (Oral Capsule Extended Release 12 Hour),T3 - QL
Amlodipine-Benazepril (Oral Capsule),T1 - QL	Atazanavir Sulfate (Oral Capsule),T4 - QL
Ammonium Lactate (External Cream),T1	Atenolol (Oral Tablet),T1
Ammonium Lactate (External Lotion),T1	Atomoxetine HCl (Oral Capsule),T3
Amoxicillin (Oral Capsule),T1	Atorvastatin Calcium (Oral Tablet),T1 - QL
Amoxicillin (Oral Tablet),T1	Atovaquone-Proguanil HCl (Oral Tablet),T2
Amphetamine-Dextroamphetamine (Oral Tablet),T2 - QL	Atripla (Oral Tablet),T4 - QL
Amphetamine-Dextroamphetamine ER (Oral Capsule Extended Release 24 Hour),T2 - QL	Atrovent HFA (Inhalation Aerosol Solution),T3
Anagrelide HCl (Oral Capsule),T2	Aubagio (Oral Tablet),T4 - LA; QL
Anastrozole (Oral Tablet),T1	Auryxia (Oral Tablet),T4 - PA
Androderm (Transdermal Patch 24 Hour),T2	Avonex (30MCG Intramuscular Kit),T4
Anoro Ellipta (Inhalation Aerosol Powder Breath Activated),T2 - QL	Avonex Pen (Intramuscular Auto-Injector Kit),T4
Apriso (Oral Capsule Extended Release 24 Hour),T2 - QL	Avonex Prefilled (Intramuscular Prefilled Syringe Kit),T4
Aranesp (Albumin Free) (100MCG/0.5ML Injection Solution Prefilled Syringe, 150MCG/0.3ML Injection Solution Prefilled Syringe, 200MCG/0.4ML Injection Solution Prefilled Syringe, 300MCG/0.6ML Injection Solution Prefilled Syringe, 500MCG/ML Injection Solution Prefilled Syringe, 60MCG/0.3ML Injection Solution Prefilled Syringe),T4 - PA	Azathioprine (Oral Tablet),T1 - B/D,PA
Aranesp (Albumin Free) (100MCG/ML Injection Solution, 200MCG/ML Injection Solution, 300MCG/ML Injection Solution, 60MCG/ML Injection Solution),T4 - PA	Azelastine HCl (0.1% Nasal Solution, 0.15% Nasal Solution),T2
Aranesp (Albumin Free) (10MCG/0.4ML Injection Solution Prefilled Syringe, 25MCG/	Azelastine HCl (Ophthalmic Solution),T1
	Azithromycin (Oral Packet),T1
	Azithromycin (Oral Tablet),T1
	Azopt (Ophthalmic Suspension),T2
	B
	BRIVIACT (Oral Solution),T4 - PA; QL

T1 = Tier 1

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BRIVIACT (Oral Tablet),T4 - PA; QL

Baclofen (Oral Tablet),T1

Balsalazide Disodium (Oral Capsule),T3

Belsomra (Oral Tablet),T2 - QL

Benazepril HCl (Oral Tablet),T1 - QL

Benazepril-Hydrochlorothiazide (Oral Tablet),T2 - QL

Benzotropine Mesylate (Oral Tablet),T2 - PA; HRM

Bepreve (Ophthalmic Solution),T3

Berinert (Intravenous Kit),T4 - PA; LA

Betaseron (Subcutaneous Kit),T4

Bethanechol Chloride (Oral Tablet),T2

Betimol (Ophthalmic Solution),T3

Bevespi Aerosphere (Inhalation Aerosol),T3 - ST

Bicalutamide (Oral Tablet),T1

Binosto (Oral Tablet Effervescent),T3

Bisoprolol Fumarate (Oral Tablet),T1

Bisoprolol-Hydrochlorothiazide (Oral Tablet),T1 - QL

Breo Ellipta (Inhalation Aerosol Powder Breath Activated),T2 - QL

Brilinta (Oral Tablet),T2 - QL

Brimonidine Tartrate (0.15% Ophthalmic Solution),T3

Brimonidine Tartrate (0.2% Ophthalmic Solution),T1

Budesonide (Inhalation Suspension),T3 - B/D,PA

Budesonide (Oral Capsule Delayed Release Particles),T3

Bumetanide (Oral Tablet),T2

Buprenorphine (Transdermal Patch Weekly),T2 - 7D; DL; QL

Buprenorphine HCl (Tablet Sublingual),T1 - QL

Bupropion HCl (Oral Tablet Immediate Release),T1

Bupropion HCl ER (XL) (450MG Oral Tablet Extended Release 24 Hour),T3

Bupropion HCl SR (150MG Oral Tablet Extended Release 12 Hour Smoking-Deterrent),T1

Bupropion HCl SR (Oral Tablet Extended Release 12 Hour),T1

Bupropion HCl XL (150MG Oral Tablet Extended Release 24 Hour, 300MG Oral Tablet Extended Release 24 Hour),T1

Buspirone HCl (Oral Tablet),T1

Butrans (Transdermal Patch Weekly),T2 - 7D; DL; QL

Bydureon (Subcutaneous Pen-Injector),T3 - QL

Bydureon BCise (Subcutaneous Auto-Injector),T3 - QL

Byetta 10MCG Pen (Subcutaneous Solution Pen-Injector),T3 - ST; QL

Byetta 5MCG Pen (Subcutaneous Solution Pen-Injector),T3 - ST; QL

Bystolic (Oral Tablet),T2 - QL

C

Cabergoline (Oral Tablet),T2

Calcitriol (External Ointment),T3

Calcitriol (Oral Capsule),T1 - B/D,PA

Calcium Acetate (Phosphate Binder) (Oral Capsule),T2

Calcium Acetate (Phosphate Binder) (Oral Tablet),T2

Captopril (Oral Tablet),T2 - QL

Carafate (Oral Suspension),T3

Carafate (Oral Tablet),T3

Carbamazepine (Oral Tablet Immediate

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Release),T2	Clonidine (Transdermal Patch Weekly),T3
Carbidopa-Levodopa (Oral Tablet Immediate Release),T1	Clonidine HCl (Oral Tablet Immediate Release),T1
Carbidopa-Levodopa ER (Oral Tablet Extended Release),T2	Clopidogrel Bisulfate (75MG Oral Tablet),T1 - QL
Carbidopa-Levodopa-Entacapone (Oral Tablet),T3	Clozapine (100MG Oral Tablet, 200MG Oral Tablet, 25MG Oral Tablet, 50MG Oral Tablet),T2
Carvedilol (Oral Tablet),T1	Clozapine ODT (100MG Oral Tablet Dispersible, 150MG Oral Tablet Dispersible),T3
Cayston (Inhalation Solution Reconstituted),T4 - PA; LA	Clozapine ODT (12.5MG Oral Tablet Dispersible, 25MG Oral Tablet Dispersible),T2
Cefuroxime Axetil (Oral Tablet),T1	Clozapine ODT (200MG Oral Tablet Dispersible),T4
Celecoxib (Oral Capsule),T2 - QL	Colchicine (0.6MG Oral Capsule) (Brand Equivalent Mitigare),T2 - QL
Cephalexin (250MG Oral Capsule, 500MG Oral Capsule),T1	Colchicine (0.6MG Oral Tablet) (Brand Equivalent Colcrys),T2 - QL
Cephalexin (750MG Oral Capsule),T3	Combigan (Ophthalmic Solution),T2
Cephalexin (Oral Tablet),T2	Combivent Respimat (Inhalation Aerosol Solution),T2 - QL
Chantix (Oral Tablet),T2	Comtan (Oral Tablet),T4
Chlorhexidine Gluconate (Mouth Solution),T1	Copaxone (Subcutaneous Solution Prefilled Syringe),T4
Chlorthalidone (Oral Tablet),T1	Cosentyx 300 Dose (Subcutaneous Solution Prefilled Syringe),T4 - PA; LA
Cholestyramine Light (Oral Powder),T3	Cosopt PF (Ophthalmic Solution),T3
Cilostazol (Oral Tablet),T1	Creon (Oral Capsule Delayed Release Particles),T2
Cimetidine (Oral Tablet),T2	Crestor (Oral Tablet),T3 - QL
Ciprodex (Otic Suspension),T2	Crixivan (Oral Capsule),T2 - QL
Ciprofloxacin HCl (250MG Oral Tablet Immediate Release, 500MG Oral Tablet Immediate Release, 750MG Oral Tablet Immediate Release),T1	Cromolyn Sodium (Inhalation Nebulization Solution),T2 - B/D,PA
Citalopram Hydrobromide (Oral Tablet),T1	Cromolyn Sodium (Oral Concentrate),T3
Clarithromycin (Oral Tablet Immediate Release),T2	Cyclophosphamide (Oral Capsule),T2 - B/D,PA
Clenpiq (Oral Solution),T2	Cyproheptadine HCl (Oral Tablet),T3 - PA; HRM
Climara Pro (Transdermal Patch Weekly),T3 - PA; HRM	
Clonazepam (Oral Tablet),T1 - QL	

T1 = Tier 1

T2 = Tier 2

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T4 = Tier 4

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D

Daliresp (Oral Tablet),T3 - PA

Dapsone (External Gel),T3

Dapsone (Oral Tablet),T2

Deferasirox (Oral Tablet Soluble),T4 - PA

Desmopressin Acetate (Oral Tablet),T2

Dexilant (Oral Capsule Delayed Release),T3 - QL

Diazepam (Oral Tablet),T1 - QL

Diclofenac Potassium (Oral Tablet),T2

Diclofenac Sodium (Oral Tablet Delayed Release),T1

Dicyclomine HCl (Oral Capsule),T1 - HRM

Dicyclomine HCl (Oral Tablet),T1 - HRM

Digoxin (125MCG Oral Tablet),T3 - HRM; QL

Digoxin (250MCG Oral Tablet),T3 - PA; HRM

Dihydroergotamine Mesylate (Nasal Solution),T4

Diltiazem HCl (Oral Tablet Immediate Release),T1

Diltiazem HCl ER (Oral Capsule Extended Release 12 Hour),T2

Diltiazem HCl ER Beads (360MG Oral Capsule Extended Release 24 Hour, 420MG Oral Capsule Extended Release 24 Hour),T1

Diltiazem HCl ER Coated Beads (120MG Oral Capsule Extended Release 24 Hour, 180MG Oral Capsule Extended Release 24 Hour, 240MG Oral Capsule Extended Release 24 Hour, 300MG Oral Capsule Extended Release 24 Hour),T1

Diphenoxylate-Atropine (Oral Tablet),T3 - PA; HRM

Disulfiram (Oral Tablet),T2

Divalproex Sodium (Oral Capsule Delayed Release Sprinkle),T2

Divalproex Sodium (Oral Tablet Delayed

Release),T1

Divalproex Sodium ER (Oral Tablet Extended Release 24 Hour),T1

Donepezil HCl (10MG Oral Tablet, 5MG Oral Tablet),T1 - QL

Donepezil HCl ODT (Oral Tablet Dispersible),T1 - QL

Dorzolamide HCl-Timolol Maleate (Ophthalmic Solution),T1

Doxazosin Mesylate (Oral Tablet),T1

Doxycycline Hyclate (100MG Oral Tablet Immediate Release, 20MG Oral Tablet Immediate Release),T2

Doxycycline Hyclate (150MG Oral Tablet Immediate Release, 75MG Oral Tablet Immediate Release),T3

Doxycycline Hyclate (Oral Capsule),T2

Dronabinol (Oral Capsule),T3 - PA

Duavee (Oral Tablet),T3 - PA; HRM

Duloxetine HCl (20MG Oral Capsule Delayed Release Particles, 30MG Oral Capsule Delayed Release Particles, 60MG Oral Capsule Delayed Release Particles),T1 - QL

Durezol (Ophthalmic Emulsion),T2

Dutasteride (Oral Capsule),T2

Dymista (Nasal Suspension),T3

E

Edarbi (Oral Tablet),T3 - QL

Edarbyclor (Oral Tablet),T3 - QL

Eliquis (Oral Tablet),T2 - QL

Elmiron (Oral Capsule),T4

Embeda (Oral Capsule Extended Release),T2 - 7D; MME; DL; QL

Enalapril Maleate (Oral Tablet),T1 - QL

Enalapril-Hydrochlorothiazide (Oral Tablet),T1 -

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QL	Fentanyl (100MCG/HR Transdermal Patch 72 Hour, 75MCG/HR Transdermal Patch 72 Hour),T3 - 7D; MME; DL; QL
Enbrel (Subcutaneous Solution Prefilled Syringe),T4 - PA	Fentanyl (12MCG/HR Transdermal Patch 72 Hour, 25MCG/HR Transdermal Patch 72 Hour, 50MCG/HR Transdermal Patch 72 Hour),T2 - 7D; MME; DL; QL
Enbrel (Subcutaneous Solution Reconstituted),T4 - PA	Finasteride (5MG Oral Tablet) (Generic Proscar),T1
Entacapone (Oral Tablet),T3	Flovent Diskus (Inhalation Aerosol Powder Breath Activated),T2
Entecavir (Oral Tablet),T3	Flovent HFA (Inhalation Aerosol),T2 - QL
Epclusa (Oral Tablet),T4 - PA; QL	Fluconazole (Oral Tablet),T1
Eplerenone (Oral Tablet),T2	Fluocinolone Acetonide (External Cream),T2
Epzicom (Oral Tablet),T4 - QL	Fluocinolone Acetonide (External Ointment),T2
Equetro (Oral Capsule Extended Release 12 Hour),T3	Fluocinolone Acetonide (Otic Oil),T2
Ergotamine-Caffeine (Oral Tablet),T2	Fluphenazine HCl (Oral Tablet),T1
Ertapenem Sodium (Injection Solution Reconstituted),T3	Fluticasone Propionate (External Cream),T2
Escitalopram Oxalate (Oral Tablet),T1	Fluticasone Propionate (External Lotion),T3
Estradiol (Oral Tablet),T3 - PA; HRM	Fluticasone Propionate (External Ointment),T2
Estradiol (Transdermal Patch Twice Weekly),T3 - PA; HRM; QL	Fluticasone Propionate (Nasal Suspension),T1
Estradiol (Transdermal Patch Weekly),T3 - PA; HRM; QL	Forteo (Subcutaneous Solution),T4 - PA
Estradiol (Vaginal Cream),T3	Furosemide (Oral Tablet),T1
Eszopiclone (Oral Tablet),T3 - PA; HRM; QL	Fuzeon (Subcutaneous Solution Reconstituted),T4 - QL
Ethosuximide (Oral Capsule),T3	Fycompa (Oral Suspension),T4
Extavia (Subcutaneous Kit),T4	Fycompa (Oral Tablet),T4
Ezetimibe (Oral Tablet),T1	
F	G
Famotidine (20MG Oral Tablet, 40MG Oral Tablet),T1	Gabapentin (Oral Capsule),T1
Farxiga (Oral Tablet),T3 - ST; QL	Gabapentin (Oral Tablet),T1
Fenofibrate (145MG Oral Tablet, 48MG Oral Tablet),T2	Gammagard (2.5GM/25ML Injection Solution),T4 - PA
Fenofibrate (160MG Oral Tablet, 54MG Oral Tablet),T1	Gemfibrozil (Oral Tablet),T1
	Genotropin (Subcutaneous Solution

T1 = Tier 1

T2 = Tier 2

T3 = Tier 3

T4 = Tier 4

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Reconstituted),T4 - PA	Kit),T4 - PA
Genotropin MiniQuick (Subcutaneous Solution Reconstituted),T4 - PA	Humulin 70/30 (Subcutaneous Suspension),T2
Gentamicin Sulfate (Ophthalmic Solution),T1	Humulin N (Subcutaneous Suspension),T2
Gilenya (0.5MG Oral Capsule),T4 - QL	Humulin R (Injection Solution),T2
Glatiramer Acetate (Subcutaneous Solution Prefilled Syringe),T4	Hydralazine HCl (Oral Tablet),T1
Glimepiride (Oral Tablet),T1 - QL	Hydrochlorothiazide (Oral Capsule),T1
Glipizide (Oral Tablet Immediate Release),T1 - QL	Hydrochlorothiazide (Oral Tablet),T1
Glipizide ER (Oral Tablet Extended Release 24 Hour),T1 - QL	Hydrocodone-Acetaminophen (10-325MG Oral Tablet, 5-325MG Oral Tablet, 7.5-325MG Oral Tablet),T2 - 7D; MME; DL; QL
Glucagen HypoKit (Injection Solution Reconstituted),T3	Hydromorphone HCl (Oral Tablet Immediate Release),T1 - 7D; MME; DL; QL
Glucagon Emergency (Injection Kit),T2	Hydroxychloroquine Sulfate (Oral Tablet),T1
Glyxambi (Oral Tablet),T2 - QL	Hydroxyurea (Oral Capsule),T1
Guanidine HCl (Oral Tablet),T2	Hydroxyzine HCl (Oral Tablet),T3 - PA; HRM
H	Hysingla ER (Oral Tablet ER 24 Hour Abuse-Deterrent),T2 - 7D; MME; DL; QL
Haegarda (Subcutaneous Solution Reconstituted),T4 - PA; LA	I
Haloperidol (Oral Tablet),T1	Ibandronate Sodium (Oral Tablet),T2
Harvoni (Oral Tablet),T4 - PA; QL	Ibuprofen (400MG Oral Tablet, 600MG Oral Tablet, 800MG Oral Tablet),T1
Humalog (Subcutaneous Solution Cartridge),T2	Ilievro (Ophthalmic Suspension),T2
Humalog (Subcutaneous Solution),T2	Imatinib Mesylate (Oral Tablet),T4 - PA; QL
Humalog Mix 50/50 (Subcutaneous Suspension),T2	Imiquimod (5% External Cream),T2
Humalog Mix 50/50 KwikPen (Subcutaneous Suspension Pen-Injector),T2	Imiquimod Pump (3.75% External Cream),T4 - PA
Humalog Mix 75/25 KwikPen (Subcutaneous Suspension Pen-Injector),T2	Imvexxy Maintenance Pack (Vaginal Insert),T2 - PA; QL
Humira (10MG/0.1ML Subcutaneous Prefilled Syringe Kit, 10MG/0.2ML Subcutaneous Prefilled Syringe Kit, 20MG/0.2ML Subcutaneous Prefilled Syringe Kit, 40MG/0.4ML Subcutaneous Prefilled Syringe	Imvexxy Starter Pack (Vaginal Insert),T2 - PA; QL
	Incruse Ellipta (Inhalation Aerosol Powder Breath Activated),T2 - QL
	Intelligence (100MG Oral Tablet, 200MG Oral Tablet),T4 - QL

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Invokamet (Oral Tablet Immediate Release),T2 - QL

Invokamet XR (Oral Tablet Extended Release 24 Hour),T2 - QL

Invokana (Oral Tablet),T2 - QL

Ipratropium Bromide (Inhalation Solution),T1 - B/D,PA

Ipratropium Bromide (Nasal Solution),T2

Ipratropium-Albuterol (Inhalation Solution),T1 - B/D,PA

Irbesartan (Oral Tablet),T1 - QL

Irbesartan-Hydrochlorothiazide (Oral Tablet),T1 - QL

Isentress (Oral Tablet),T4 - QL

Isoniazid (Oral Tablet),T1

Isosorbide Dinitrate (Oral Tablet Immediate Release),T1

Isosorbide Dinitrate ER (Oral Tablet Extended Release),T1

Isosorbide Mononitrate (Oral Tablet Immediate Release),T1

Isosorbide Mononitrate ER (Oral Tablet Extended Release 24 Hour),T1

Ivermectin (Oral Tablet),T1

J

Janumet (Oral Tablet Immediate Release),T2 - QL

Janumet XR (Oral Tablet Extended Release 24 Hour),T2 - QL

Januvia (Oral Tablet),T2 - QL

Jardiance (Oral Tablet),T2 - QL

Jentadueto (Oral Tablet Immediate Release),T2 - QL

Jentadueto XR (Oral Tablet Extended Release 24 Hour),T2 - QL

Jublia (External Solution),T3

K

Kalydeco (50MG Oral Packet, 75MG Oral Packet),T4 - PA; LA

Kalydeco (Oral Tablet),T4 - PA; LA

Kazano (Oral Tablet),T3 - ST; QL

Ketoconazole (External Cream),T1 - QL

Ketorolac Tromethamine (Ophthalmic Solution),T2

Ketorolac Tromethamine (Oral Tablet),T3 - PA; HRM

Klor-Con 10 (Oral Tablet Extended Release),T1

Klor-Con 8 (Oral Tablet Extended Release),T1

Klor-Con M20 (Oral Tablet Extended Release),T1

Kombiglyze XR (Oral Tablet Extended Release 24 Hour),T3 - QL

Korlym (Oral Tablet),T4 - PA; LA

L

Lactulose (10GM/15ML Oral Solution),T1

Lactulose (Oral Packet),T3

Lamivudine (100MG Oral Tablet),T2

Lamivudine (150MG Oral Tablet, 300MG Oral Tablet),T2 - QL

Lamotrigine (Oral Tablet Immediate Release),T1

Lantus (Subcutaneous Solution),T2

Lantus SoloStar (Subcutaneous Solution Pen-Injector),T2

Lastacaft (Ophthalmic Solution),T2

Latanoprost (Ophthalmic Solution),T1

Latuda (Oral Tablet),T4 - QL

Ledipasvir-Sofosbuvir (Oral Tablet),T4 - PA; QL

Leflunomide (Oral Tablet),T2

T1 = Tier 1

T2 = Tier 2

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Letrozole (Oral Tablet),T1	Losartan Potassium (Oral Tablet),T1 - QL
Leucovorin Calcium (10MG Oral Tablet, 15MG Oral Tablet),T2	Losartan Potassium-HCTZ (Oral Tablet),T1 - QL
Leucovorin Calcium (25MG Oral Tablet),T3	Lotemax (Ophthalmic Gel),T3
Leucovorin Calcium (5MG Oral Tablet),T1	Lotemax (Ophthalmic Ointment),T3
Leukeran (Oral Tablet),T4	Lotemax (Ophthalmic Suspension),T3
Levemir (Subcutaneous Solution),T2	Lovastatin (Oral Tablet),T1 - QL
Levemir FlexTouch (Subcutaneous Solution Pen-Injector),T2	Lumigan (Ophthalmic Solution),T2
Levetiracetam (Oral Tablet Immediate Release),T1	Lupron Depot (1-Month) (Intramuscular Kit),T4 - PA
Levocarnitine (Oral Tablet),T2	Lupron Depot (3-Month) (Intramuscular Kit),T4 - PA
Levocetirizine Dihydrochloride (Oral Tablet),T1	Lupron Depot (4-Month) (Intramuscular Kit),T4 - PA
Levofloxacin (Oral Tablet),T1	Lupron Depot (6-Month) (Intramuscular Kit),T4 - PA
Levothyroxine Sodium (Oral Tablet),T1	Luzu (External Cream),T3 - QL
Lidocaine (5% External Ointment),T3 - QL	Lysodren (Oral Tablet),T4
Lidocaine (5% External Patch),T3 - PA; QL	M
Lidocaine HCl (4% External Solution),T1	Mavyret (Oral Tablet),T4 - PA; QL
Lidocaine Viscous (2% Mouth/Throat Solution),T1	Meclizine HCl (Oral Tablet),T1 - HRM
Lidocaine-Prilocaine (External Cream),T2	Medroxyprogesterone Acetate (Intramuscular Suspension),T1
Lindane (External Shampoo),T3	Medroxyprogesterone Acetate (Oral Tablet),T1
Linzess (Oral Capsule),T2 - QL	Meloxicam (Oral Tablet),T1
Liothyronine Sodium (Oral Tablet),T1	Memantine HCl (10MG Oral Tablet, 5MG Oral Tablet),T1 - PA; QL
Lisinopril (Oral Tablet),T1 - QL	Memantine HCl ER (Oral Capsule Extended Release 24 Hour),T3 - PA; QL
Lisinopril-Hydrochlorothiazide (Oral Tablet),T1 - QL	Mercaptopurine (Oral Tablet),T2
Lithium Carbonate (Oral Capsule),T1	Meropenem (1GM Intravenous Solution Reconstituted),T3
Lithium Carbonate ER (Oral Tablet Extended Release),T1	Meropenem (500MG Intravenous Solution Reconstituted),T2
Lokelma (Oral Packet),T3 - QL	Mesalamine (1.2GM Oral Tablet Delayed
Loperamide HCl (Oral Capsule),T1	
Lorazepam (Oral Tablet),T1 - QL	

Bold type = Brand name drug

Plain type = Generic drug

This is a partial alphabetical list. This is not a complete list of the prescription drugs we cover.

Release) (Generic Lialda),T3 - QL	Misoprostol (Oral Tablet),T2
Metformin HCl (Oral Tablet Immediate Release),T1 - QL	Modafinil (Oral Tablet),T3 - PA; QL
Metformin HCl ER (Oral Tablet Extended Release 24 Hour) (Generic Glucophage XR),T1 - QL	Mometasone Furoate (Nasal Suspension),T3
Methadone HCl (Oral Tablet),T1 - 7D; MME; DL; QL	Montelukast Sodium (Oral Tablet),T1 - QL
Methazolamide (Oral Tablet),T3	Morphine Sulfate ER (100MG Oral Capsule Extended Release 24 Hour, 10MG Oral Capsule Extended Release 24 Hour, 20MG Oral Capsule Extended Release 24 Hour, 30MG Oral Capsule Extended Release 24 Hour, 50MG Oral Capsule Extended Release 24 Hour, 60MG Oral Capsule Extended Release 24 Hour, 80MG Oral Capsule Extended Release 24 Hour),T3 - 7D; MME; DL; QL
Methimazole (Oral Tablet),T1	Morphine Sulfate ER (100MG Oral Tablet Extended Release, 15MG Oral Tablet Extended Release, 30MG Oral Tablet Extended Release, 60MG Oral Tablet Extended Release) (Generic MS Contin),T2 - 7D; MME; DL; QL
Methotrexate (Oral Tablet),T1	Morphine Sulfate ER (200MG Oral Tablet Extended Release) (Generic MS Contin),T3 - 7D; MME; DL; QL
Methscopolamine Bromide (Oral Tablet),T3	Morphine Sulfate ER Beads (Oral Capsule Extended Release 24 Hour) (Generic Avinza),T3 - 7D; MME; DL; QL
Methyldopa (Oral Tablet),T3 - PA; HRM	Multaq (Oral Tablet),T2
Methylphenidate HCl (Oral Tablet Chewable),T3 - QL	Myrbetriq (Oral Tablet Extended Release 24 Hour),T2
Methylphenidate HCl (Oral Tablet Immediate Release) (Generic Ritalin),T2 - QL	N
Metoclopramide HCl (Oral Tablet),T1	Nadolol (Oral Tablet),T2
Metoprolol Succinate ER (Oral Tablet Extended Release 24 Hour),T1	Naftin (External Cream),T3
Metoprolol Tartrate (100MG Oral Tablet, 25MG Oral Tablet, 50MG Oral Tablet),T1	Naftin (External Gel),T3
Metronidazole (0.75% External Cream),T2	Naloxone HCl (0.4MG/ML Injection Solution),T1
Metronidazole (0.75% External Gel, 1% External Gel),T3	Naloxone HCl (Injection Solution Cartridge),T1
Metronidazole (0.75% External Lotion),T3	Naloxone HCl (Injection Solution Prefilled Syringe),T1
Metronidazole (250MG Oral Tablet, 500MG Oral Tablet),T1	Naltrexone HCl (Oral Tablet),T2
Metronidazole (375MG Oral Capsule),T3	
Minocycline HCl (Oral Capsule),T1	
Minocycline HCl (Oral Tablet Immediate Release),T3	
Minoxidil (Oral Tablet),T1	
Mirtazapine (Oral Tablet),T1	
Mirtazapine ODT (Oral Tablet Dispersible),T2	

T1 = Tier 1

T2 = Tier 2

T3 = Tier 3

T4 = Tier 4

This is a partial alphabetical list. This is not a complete list of the prescription drugs we cover.

Namzarcic (Oral Capsule ER 24 Hour Therapy Pack),T2 - PA; QL	Solution),T4 - PA
Namzarcic (Oral Capsule Extended Release 24 Hour),T2 - PA; QL	Nutropin AQ NuSpin 5 (Subcutaneous Solution),T4 - PA
Naproxen (Oral Tablet Immediate Release),T1	Nystatin (External Cream),T1
Narcan (Nasal Liquid),T2	Nystatin (External Ointment),T1
Neomycin-Polymyxin-HC (Ophthalmic Suspension),T3	Nystatin (External Powder),T1
Neomycin-Polymyxin-HC (Otic Suspension),T2	
Nesina (Oral Tablet),T3 - ST; QL	Ofloxacin (Ophthalmic Solution),T1
Neulasta (Subcutaneous Solution Prefilled Syringe),T4 - PA	Ofloxacin (Otic Solution),T2
Nevanac (Ophthalmic Suspension),T3	Olanzapine (Oral Tablet),T1 - QL
Niacin ER (Antihyperlipidemic) (1000MG Oral Tablet Extended Release, 750MG Oral Tablet Extended Release),T3	Olmesartan Medoxomil (Oral Tablet),T1 - QL
Niacin ER (Antihyperlipidemic) (500MG Oral Tablet Extended Release),T1	Olmesartan Medoxomil-HCTZ (Oral Tablet),T1 - QL
Nicotrol (Inhalation Inhaler),T3	Olmesartan-Amlodipine-HCTZ (Oral Tablet),T3 - QL
Nitrofurantoin Macrocrystal (100MG Oral Capsule, 50MG Oral Capsule) (Generic Macrochantin),T2 - HRM	Olopatadine HCl (0.1% Ophthalmic Solution),T2
Nitrofurantoin Monohydrate (Generic Macrobid),T2 - HRM	Omega-3-Acid Ethyl Esters (Oral Capsule) (Generic Lovaza),T3
Nitroglycerin (Tablet Sublingual),T1	Omeprazole (10MG Oral Capsule Delayed Release),T1 - QL
Nitrostat (Tablet Sublingual),T3	Omeprazole (20MG Oral Capsule Delayed Release, 40MG Oral Capsule Delayed Release),T1
Nizatidine (Oral Capsule),T2	Ondansetron HCl (Oral Tablet),T1 - B/D,PA
Norethindrone Acetate (5MG Oral Tablet),T1	Ondansetron ODT (Oral Tablet Dispersible),T1 - B/D,PA
Nortriptyline HCl (Oral Capsule),T1 - PA; HRM	Onglyza (Oral Tablet),T3 - QL
Nucynta ER (Oral Tablet Extended Release 12 Hour),T2 - 7D; MME; DL; QL	Opsumit (Oral Tablet),T4 - PA; LA
Nuedexta (Oral Capsule),T3 - PA	Orenitram (0.125MG Oral Tablet Extended Release),T3 - PA; LA
Nutropin AQ NuSpin 10 (Subcutaneous Solution),T4 - PA	Orenitram (0.25MG Oral Tablet Extended Release, 1MG Oral Tablet Extended Release, 2.5MG Oral Tablet Extended Release, 5MG Oral Tablet Extended Release),T4 - PA; LA
Nutropin AQ NuSpin 20 (Subcutaneous	Oseltamivir Phosphate (Oral Capsule),T2

Bold type = Brand name drug

Plain type = Generic drug

This is a partial alphabetical list. This is not a complete list of the prescription drugs we cover.

Oseni (Oral Tablet),T3 - ST; QL

Osphena (Oral Tablet),T2 - PA; QL

Oxcarbazepine (Oral Tablet),T2

OxyContin (Oral Tablet ER 12 Hour Abuse-Deterrent),T2 - 7D; MME; DL; QL

Oxybutynin Chloride ER (Oral Tablet Extended Release 24 Hour),T2

Oxycodone HCl (10MG Oral Tablet Immediate Release, 15MG Oral Tablet Immediate Release, 20MG Oral Tablet Immediate Release, 30MG Oral Tablet Immediate Release, 5MG Oral Tablet Immediate Release),T1 - 7D; MME; DL; QL

Oxycodone HCl (5MG Oral Capsule),T2 - 7D; MME; DL; QL

Oxycodone-Acetaminophen (Oral Tablet),T2 - 7D; MME; DL; QL

Ozempic (Subcutaneous Solution Pen-Injector),T2 - QL

P

Pantoprazole Sodium (Oral Tablet Delayed Release),T1 - QL

Pazeo (Ophthalmic Solution),T2

Pegasys (Subcutaneous Solution),T4 - PA

Pegasys ProClick (Subcutaneous Solution),T4 - PA

Penicillin V Potassium (Oral Tablet),T1

Perforomist (Inhalation Nebulization Solution),T3 - B/D,PA; QL

Permethrin (External Cream),T2

Phenytoin Sodium Extended (Oral Capsule),T1

Phoslyra (Oral Solution),T2

Picato (External Gel),T2

Pilocarpine HCl (Oral Tablet),T3

Pimecrolimus (External Cream),T3 - ST

Pioglitazone HCl (Oral Tablet),T1 - QL

Pomalyst (Oral Capsule),T4 - PA

Potassium Chloride CR (Oral Tablet Extended Release),T1

Potassium Chloride ER (Oral Capsule Extended Release),T1

Potassium Citrate ER (Oral Tablet Extended Release),T3

Pradaxa (Oral Capsule),T3 - ST; QL

Pramipexole Dihydrochloride (Oral Tablet Immediate Release),T1

Pravastatin Sodium (Oral Tablet),T1 - QL

Prazosin HCl (Oral Capsule),T1

Prednisolone Acetate (Ophthalmic Suspension),T2

Prednisone (Oral Tablet),T1

Premarin (Oral Tablet),T3 - PA; HRM; QL

Premarin (Vaginal Cream),T2

Premphase (Oral Tablet),T3 - PA; HRM; QL

Prempro (Oral Tablet),T3 - PA; HRM; QL

Prezista (150MG Oral Tablet, 75MG Oral Tablet),T3 - QL

Prezista (600MG Oral Tablet, 800MG Oral Tablet),T4 - QL

Prezista (Oral Suspension),T4 - QL

Privigen (20GM/200ML Intravenous Solution),T4 - PA

ProAir HFA (Inhalation Aerosol Solution),T2

ProAir RespiClick (Inhalation Aerosol Powder Breath Activated),T2

Proctosol HC (Rectal Cream),T1

Progesterone Micronized (Oral Capsule),T2

Prolensa (Ophthalmic Solution),T3

Prolia (Subcutaneous Solution Prefilled

T1 = Tier 1

T2 = Tier 2

T3 = Tier 3

T4 = Tier 4

This is a partial alphabetical list. This is not a complete list of the prescription drugs we cover.

Syringe),T3 - QL

Propranolol HCl (Oral Tablet),T1
 Propranolol HCl ER (Oral Capsule Extended Release 24 Hour),T2
 Propylthiouracil (Oral Tablet),T1

Pulmicort Flexhaler (Inhalation Aerosol Powder Breath Activated),T3 - ST

Pyridostigmine Bromide (60MG Oral Tablet Immediate Release),T2

Q

Quetiapine Fumarate (Oral Tablet Immediate Release),T1 - QL
 Quinapril HCl (Oral Tablet),T1 - QL
 Quinapril-Hydrochlorothiazide (Oral Tablet),T1 - QL

R

Raloxifene HCl (Oral Tablet),T2
 Ramipril (Oral Capsule),T1 - QL
 Ranitidine HCl (150MG Oral Capsule, 300MG Oral Capsule),T2
 Ranitidine HCl (150MG Oral Tablet, 300MG Oral Tablet),T1
 Rasagiline Mesylate (Oral Tablet),T3
Rasuvo (Subcutaneous Solution Auto-Injector),T3 - PA
Rebif (Subcutaneous Solution Prefilled Syringe),T4
Renagel (Oral Tablet),T4
Restasis (Ophthalmic Emulsion),T2 - QL
Retacrit (10000UNIT/ML Injection Solution, 2000UNIT/ML Injection Solution, 3000UNIT/ML Injection Solution, 4000UNIT/ML Injection Solution),T3 - PA
Retacrit (40000UNIT/ML Injection Solution),T4 - PA

Revlimid (Oral Capsule),T4 - PA; LA

Reyataz (Oral Capsule),T4 - QL
Reyataz (Oral Packet),T4 - QL
 Ribavirin (Oral Tablet),T2
 Rifabutin (Oral Capsule),T3
 Rifampin (Oral Capsule),T2
 Riluzole (Oral Tablet),T2
 Risperidone (Oral Tablet),T1
 Ritonavir (Oral Tablet),T2 - QL
 Rivastigmine Tartrate (Oral Capsule),T2
 Rizatriptan Benzoate (Oral Tablet),T2 - QL
 Rizatriptan Benzoate ODT (Oral Tablet Dispersible),T2 - QL
 Ropinirole HCl (Oral Tablet Immediate Release),T1
 Rosuvastatin Calcium (Oral Tablet),T1 - QL

S

Sancuso (Transdermal Patch),T4
Santyl (External Ointment),T3
Saphris (Tablet Sublingual),T4
Savella (Oral Tablet),T2
 Selegiline HCl (Oral Capsule),T2
 Selegiline HCl (Oral Tablet),T2
Selzentry (150MG Oral Tablet, 300MG Oral Tablet, 75MG Oral Tablet),T4 - QL
Serevent Diskus (Inhalation Aerosol Powder Breath Activated),T2 - QL
 Sertraline HCl (Oral Tablet),T1
 Sevelamer Carbonate (Oral Packet),T4
 Sevelamer Carbonate (Oral Tablet) (Generic Renvela),T3
Shingrix (Intramuscular Suspension Reconstituted),T2 - PA

Bold type = Brand name drug

Plain type = Generic drug

This is a partial alphabetical list. This is not a complete list of the prescription drugs we cover.

Sildenafil Citrate (20MG Oral Tablet) (Generic Revatio),T2 - PA

Silodosin (Oral Capsule),T3 - QL

Silver Sulfadiazine (External Cream),T1

Simbrinza (Ophthalmic Suspension),T2

Simvastatin (Oral Tablet),T1 - QL

Sodium Polystyrene Sulfonate (Oral Powder),T2

Sofosbuvir-Velpatasvir (Oral Tablet),T4 - PA; QL

Solifenacin Succinate (Oral Tablet),T2 - QL

Sotalol HCl (Oral Tablet),T1

Spiriva HandiHaler (Inhalation Capsule),T2 - QL

Spironolactone (Oral Tablet),T1

Sprycel (Oral Tablet),T4 - PA

Stiolto Respimat (Inhalation Aerosol Solution),T2

Suboxone (Sublingual Film),T3 - QL

Sucralfate (Oral Tablet),T1

Sulfamethoxazole-Trimethoprim (800-160MG Oral Tablet),T1

Sulfasalazine (Oral Tablet Delayed Release),T1

Sulfasalazine (Oral Tablet Immediate Release),T1

Sumatriptan Succinate (Oral Tablet),T1 - QL

Suprax (100MG/5ML Oral Suspension Reconstituted, 200MG/5ML Oral Suspension Reconstituted),T3

Suprax (500MG/5ML Oral Suspension Reconstituted),T3

Suprax (Oral Capsule),T2

Suprax (Oral Tablet Chewable),T2

Suprep Bowel Prep Kit (Oral Solution),T2

Symbicort (Inhalation Aerosol),T2 - QL

SymlinPen 120 (Subcutaneous Solution Pen-Injector),T4 - PA

SymlinPen 60 (Subcutaneous Solution Pen-Injector),T4 - PA

Synjardy (Oral Tablet Immediate Release),T2 - QL

Synjardy XR (Oral Tablet Extended Release 24 Hour),T2 - QL

Synthroid (Oral Tablet),T2

T

Tamoxifen Citrate (Oral Tablet),T1

Tamsulosin HCl (Oral Capsule),T1

Targretin (External Gel),T4 - PA

Targretin (Oral Capsule),T4 - PA

Tasigna (Oral Capsule),T4 - PA

Tecfidera (Oral Capsule Delayed Release),T4 - LA; QL

Telmisartan (Oral Tablet),T1 - QL

Telmisartan-HCTZ (Oral Tablet),T3 - QL

Temazepam (15MG Oral Capsule, 30MG Oral Capsule),T2 - HRM; QL

Tenofovir Disoproxil Fumarate (Oral Tablet),T3 - QL

Terazosin HCl (Oral Capsule),T1

Testosterone (20.25MG/1.25GM 1.62% Transdermal Gel, 25MG/2.5GM 1% Transdermal Gel, 40.5MG/2.5GM 1.62% Transdermal Gel, 50MG/5GM 1% Transdermal Gel), Testosterone Pump (1% Transdermal Gel, 1.62% Transdermal Gel),T3

Testosterone Cypionate (Intramuscular Solution),T1

Theophylline ER (100MG Oral Tablet Extended Release 12 Hour, 200MG Oral Tablet Extended Release 12 Hour, 300MG Oral Tablet Extended Release 12 Hour),T1

Theophylline ER (Oral Tablet Extended Release 24 Hour),T1

T1 = Tier 1

T2 = Tier 2

T3 = Tier 3

T4 = Tier 4

This is a partial alphabetical list. This is not a complete list of the prescription drugs we cover.

Timolol Maleate (0.25% Ophthalmic Solution, 0.5% Ophthalmic Solution) (Generic Timoptic),T1

Timolol Maleate (0.5% (DAILY) Ophthalmic Solution) (Generic Istalol),T3

Timolol Maleate Ophthalmic Gel Forming (Ophthalmic Solution) (Generic Timoptic-XE),T2

Timoptic Ocudose (Ophthalmic Solution),T3

Tivicay (25MG Oral Tablet, 50MG Oral Tablet),T4 - QL

Tizanidine HCl (Oral Tablet),T1

Tobramycin (Ophthalmic Solution),T1

Tobramycin-Dexamethasone (Ophthalmic Suspension),T2

Topiramate (Oral Capsule Sprinkle Immediate Release),T2

Topiramate (Oral Tablet),T1

Toremifene Citrate (Oral Tablet),T4

Toujeo SoloStar (Subcutaneous Solution Pen-Injector),T2

Tradjenta (Oral Tablet),T2 - QL

Tramadol HCl (Oral Tablet Immediate Release),T1 - 7D; MME; DL; QL

Tranexamic Acid (Oral Tablet),T2

Transderm-Scop (1.5MG) (Transdermal Patch 72 Hour),T3 - PA; HRM

Trazodone HCl (100MG Oral Tablet, 150MG Oral Tablet, 50MG Oral Tablet),T1

Trelegy Ellipta (Inhalation Aerosol Powder Breath Activated),T2 - QL

Tresiba FlexTouch (Subcutaneous Solution Pen-Injector),T2

Tretinoin (External Cream),T3 - PA

Tretinoin (External Gel),T3 - PA

Tretinoin (Oral Capsule),T4

Triamcinolone Acetonide (External Cream),T1

Triamcinolone Acetonide (External Ointment),T1

Triamterene-HCTZ (Oral Capsule),T1

Triamterene-HCTZ (Oral Tablet),T1

Trihexyphenidyl HCl (Oral Tablet),T3 - PA; HRM

Trintellix (Oral Tablet),T3

Trulicity (Subcutaneous Solution Pen-Injector),T2 - QL

Truvada (Oral Tablet),T4 - QL

Tymlos (Subcutaneous Solution Pen-Injector),T4 - PA; QL

U

Udenyca (Subcutaneous Solution Prefilled Syringe),T4 - PA

Ursodiol (Oral Capsule),T2

Ursodiol (Oral Tablet),T3

V

Valacyclovir HCl (Oral Tablet),T2 - QL

Valganciclovir HCl (Oral Tablet),T4 - QL

Valproic Acid (Oral Capsule),T2

Valsartan (Oral Tablet),T1 - QL

Valsartan-Hydrochlorothiazide (Oral Tablet),T1 - QL

Vascepa (Oral Capsule),T3

Velphoro (Oral Tablet Chewable),T4

Veltassa (Oral Packet),T4 - QL

Ventolin HFA (Inhalation Aerosol Solution),T3 - PA

Verapamil HCl (Oral Tablet Immediate Release),T1

Verapamil HCl ER (Oral Capsule Extended Release 24 Hour),T2

Verapamil HCl ER (Oral Tablet Extended Release),T1

Bold type = Brand name drug

Plain type = Generic drug

This is a partial alphabetical list. This is not a complete list of the prescription drugs we cover.

Victoza (Subcutaneous Solution Pen-Injector),T2 - QL

Viibryd (Oral Tablet),T3

Vimpat (Oral Solution),T3 - QL

Vimpat (Oral Tablet),T3 - QL

Vosevi (Oral Tablet),T4 - PA; QL

Vyvanse (Oral Capsule),T3

Vyvanse (Oral Tablet Chewable),T3

W

Warfarin Sodium (Oral Tablet),T1

Wixela Inhub (Inhalation Aerosol Powder Breath Activated) (Generic Advair),T2 - QL

X

Xarelto (Oral Tablet),T2 - QL

Xigduo XR (Oral Tablet Extended Release 24 Hour),T3 - ST; QL

Xiidra (Ophthalmic Solution),T3 - QL

Xofluza (Oral Tablet Therapy Pack),T2 - QL

Xolair (Subcutaneous Solution Prefilled Syringe),T4 - PA; LA

Xtampza ER (Oral Capsule ER 12 Hour Abuse-Deterrent),T3 - ST; 7D; MME; DL; QL

Xtandi (Oral Capsule),T4 - PA; LA

Z

Zafirlukast (Oral Tablet),T2

Zaleplon (Oral Capsule),T2 - HRM; QL

Zarxio (Injection Solution Prefilled Syringe),T4

Zenpep (Oral Capsule Delayed Release Particles),T2

Zioptan (Ophthalmic Solution),T3

Zirgan (Ophthalmic Gel),T3

Zolpidem Tartrate (Oral Tablet Immediate Release),T3 - PA; HRM; QL

Zonisamide (Oral Capsule),T1

T1 = Tier 1

T2 = Tier 2

T3 = Tier 3

T4 = Tier 4

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Additional Drug Coverage

Bonus Drug List

Your employer group or plan sponsor offers a bonus drug list. The prescription drugs on this list are covered in addition to the drugs on the plan’s drug list (formulary).

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

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

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

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

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

QL Quantity limits	The plan only covers a certain amount of this drug for one copay or over a certain number of days. These limits may be in place to ensure safe and effective use of the drug.
DL Dispensing limit	Dispensing limits apply to this drug. This drug is limited to a one month supply per prescription.

Drug	Tier	Coverage Rules or Limits on use
Analgesics - drugs to treat pain, inflammation, and muscle and joint conditions		
Inflammation		
Salsalate	1	
Urinary Tract Pain		

Bold type = Brand name drug Plain type = Generic drug

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Drug	Tier	Coverage Rules or Limits on use
Phenazopyridine	1	
Anorexiant - drugs to promote weight loss		
Phentermine	1	QL (maximum of 1 capsule/tablet per day)
Anticoagulants - drugs to prevent clotting		
Heparin Lock Flush	1	
Dermatological agents - drugs to treat skin conditions		
Dry, Itchy Scalp		
Sulfacetamide Sodium Liquid Wash 10%	1	
Sulfacetamide Sodium w/Sulfur in Urea Emulsion 10-5%	1	
Dry Skin		
Urea 40% Cream	1	
Gastrointestinal agents - drugs to treat bowel, intestine and stomach conditions		
Hemorrhoids		
Hydrocortisone Acetate Suppository 25 mg	1	
Lidocaine/Hydrocortisone Acetate	1	
Irritable Bowel or Ulcers		
Clidinium & Chlordiazepoxide	1	
Hyoscyamine Sulfate	1	
Levbid	3	
Genitourinary agents - drugs to treat bladder, genital and kidney conditions		
Erectile Dysfunction		
Edex	3	QL (maximum of 6 cartridges per month)
Sildenafil (25 mg, 50 mg, 100 mg)	1	QL (maximum of 6 tablets per month)

Bold type = Brand name drug Plain type = Generic drug

Drug	Tier	Coverage Rules or Limits on use
Tadalafil	1	QL (maximum of 6 tablets per month)
Vardenafil	1	QL (maximum of 6 tablets per month)
Sexual Desire Disorder		
Addyi	3	QL (maximum of 1 tablet per day)
Urinary Tract Infection		
Methenamine/Hyoscamine/Methyl Blue/Sod Phosphate/Phenyl Salicylate	1	
Methenamine/Hyoscamine/Methylene Blue/Sodium Phosphate	1	
Hormonal agents - hormone replacement/modifying drugs		
Thyroid Supplement		
Armour Thyroid	3	
Nutritional supplements - drugs to treat vitamin & mineral deficiencies		
Potassium Supplement		
Effer-K	3	
K-Phos Tab	3	
Vitamins and Minerals		
Cyanocobalamin Injection (Vitamin B12)	1	
Folic Acid 1 mg (Rx only)	1	
Folic Acid-Vitamin B6-Vitamin B12 Tablet 2.5-25-1 mg	1	
Nephro-Vite Rx	3	
Phytonadione	1	
Renal Cap	1	
Vitamin D 50,000 unit (Rx only)	1	
Respiratory tract agents - drugs to treat allergies, cough, cold and lung conditions		

Bold type = Brand name drug Plain type = Generic drug

Drug	Tier	Coverage Rules or Limits on use
Cough and Cold		
Benzonatate (100 mg, 200 mg)	1	
Brompheniramine/Pseudoephedrine/ Dextromethorphan Syrup	1	
Guaifenesin/Codeine Syrup	1	DL
Hydrocodone Polst/Chlorpheniramine ER Susp (generic for Tussionex)	1	DL
Hydrocodone/Homatropine	1	DL
Promethazine/Codeine Syrup	1	DL
Promethazine/Dextromethorphan Syrup	1	

Bold type = Brand name drug Plain type = Generic drug

BDL: U

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

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

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

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a Medicare-approved Part D sponsor. Enrollment in the plan depends on the plan's contract renewal with Medicare.

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What's Next

Here's What You Can Expect Next

UnitedHealthcare® will process your enrollment





This chart shows you what we'll be sending and how we'll be contacting you after your enrollment.

Item	Description	Delivery Method
UnitedHealthcare Member ID Card	Watch for your UnitedHealthcare Member ID card in the mail.	
Quick Start Guide	Once you're enrolled, you will get a Quick Start Guide to review to help you start using your new plan.	
Website Access	After you receive your UnitedHealthcare Member ID card, you can register online at the website listed below to get access to plan information.	

Start using your plan on your effective date. Remember to use your UnitedHealthcare Member ID card.

We're here for you

When you call, be sure to let Customer Service know that you're calling about a group-sponsored plan. In addition, it will be helpful to have:

-  **Your group number on the front of this book**
-  **Name and address of your pharmacy**
-  **Medicare number and Medicare effective date — you can find this on your red, white and blue Medicare card**
-  **Please have a list of your current prescriptions and dosages ready**

Visit us online anytime

www.UHCRetiree.com

Toll-free **1-877-558-4749**, TTY **711**,
8 a.m. - 8 p.m. local time, 7 days a week

How to Enroll

You can enroll by phone, mail or fax. Simply choose the way that is easiest for you and follow the Enrollment Request Form Checkpoints below.



By phone

Contact us at toll-free **1-877-558-4749**, TTY **711**, 8 a.m. - 8 p.m. local time, 7 days a week to enroll over the phone.



By mail

UnitedHealthcare
P.O. Box 30770
Salt Lake City, UT 84130-0770



By fax

Fill out the Enrollment Request Form and fax it to:
888-950-1170

Incomplete information may delay your enrollment.

Enrollment Request Form Checkpoints

- ✓ Print your name exactly as it appears on your red, white and blue Medicare card.
- ✓ Make sure your permanent address is complete and accurate.
- ✓ Sign and date your name where indicated.
- ✓ Confirm the Plan Sponsor and Group Numbers are correct.
- ✓ Include the date you expect your proposed coverage to begin.

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2020 Enrollment Request Form

Please contact the plan if you need this information in another language or format (Braille).

1. Plan information

Plan Sponsor

ARLINGTON PUBLIC SCHOOLS

GPS Employer ID

23707

GPS Branch Number

001

Effective Date Requested: MM – DD – YYYY

(i.e., your proposed effective date, or on what day your coverage should begin)

Plan Sponsor use ONLY: Please date stamp this document to indicate when you received the completed and signed form.

To enroll in the UnitedHealthcare® MedicareRx for Groups (PDP) plan, please provide the following:

2. Information about you. (Please type or print in black or blue ink.)

<input type="checkbox"/> Mr.	Last Name	First Name	Middle Initial
<input type="checkbox"/> Mrs.			
<input type="checkbox"/> Ms.			

Birth Date MM – DD – YYYY

Sex: Male Female

Daytime Phone Number

() –

Mobile Phone Number

() –

Permanent Residence Street Address (P.O. Box is not allowed)

City	State	ZIP Code	County
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Mailing Address (Only if it's different from above. You can give a P.O. Box)

City	State	ZIP Code
------	-------	----------

Email Address

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Last Name	First Name	Medicare Number
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Emergency Contact

Contact Phone Number () -	Contact Relationship to You
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3. Information about your Medicare

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

-OR-

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card): _____

Medicare Number: _____

Sex: Male Female

Is Entitled to _____ Effective Date

Hospital (Part A) **MM - DD - YYYY**

Medical (Part B) **MM - DD - YYYY**

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

4. A few questions to help us manage your plan

I prefer to receive materials in the following language:

Spanish Other _____

If you don't see the language or format you want, please call us toll-free at **1-877-558-4749**, (TTY **711**) during 8 a.m. - 8 p.m. local time, 7 days a week.

Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits or State Pharmaceutical Assistance Programs.

Will you have other **prescription drug coverage** in addition to our plan? Yes No

If **"yes"**, please list your other coverage and your identification (ID) number for this coverage

Name of the Coverage _____

Member Number for Coverage	Group Number for Coverage
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Last Name	First Name	Medicare Number
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Do you, on your own or through your spouse, have any additional primary, supplemental or liability plan other than Medicare that includes prescription drug coverage? Yes No

If **“yes”**, please list your other coverage and your identification (ID) number(s) for this coverage:

Name of the Coverage

Member Number for Coverage	Group Number for Coverage
----------------------------	---------------------------

Are you a resident in a long-term care facility, such as a nursing home? Yes No

If **“yes,”** Name of Institution

Address of Institution

City	State	ZIP Code
------	-------	----------

Phone Number of Institution () -	Date of Admission MM - DD - YYYY
--	---

5. Please read this important information

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify won't have a coverage gap or a Late Enrollment Penalty. Many people are eligible for these savings and don't even know it. For more information about this Extra Help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for Extra Help online at www.socialsecurity.gov/prescriptionhelp.

If you are a member of a Medicare Advantage plan (like an HMO or PPO), you may already have prescription drug coverage through your Medicare Advantage plan that will meet your needs. By joining UnitedHealthcare® MedicareRx for Groups (PDP), your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug coverage. Read the information that your Medicare Advantage plan and your plan sponsor send you, and if you have questions, contact your Medicare Advantage plan or your plan sponsor.

UnitedHealthcare® MedicareRx for Groups (PDP) is a Medicare Prescription Drug plan available through your plan sponsor. If you enroll in an individual Prescription Drug plan in the future, you could lose your group sponsored coverage and you may not be able to re-enroll. Before you decide to change your coverage, ask your plan sponsor about your options. Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, medical assistance through the state Medicaid program, and the Medicare Savings Program.

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Last Name First Name Medicare Number

6. ATTENTION – please sign and date

I understand that my signature on this Enrollment Request Form means that I have read and understood the contents of this Enrollment Request Form, including the Statements of Understanding, and that the information provided by me is accurate and complete. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

This Enrollment Request Form must be signed, dated and received prior to your desired effective date. Upon receipt, the plan will process the form according to Medicare guidelines.

Signature of applicant/member/authorized representative **Today's Date**
 _____ MM - DD - YYYY

7. Authorized representative information

If I sign as an authorized representative, it means I have the legal right under state law to sign. I can show written proof (Power of attorney, guardianship, etc.) of this right if Medicare asks for it. I understand that I will need to submit written proof of this right, to the plan, if I wish to take action on behalf of the member beyond this application. After this application has been approved and you have received your UnitedHealthcare member ID card, please call Customer Service at the number on the back of your UnitedHealthcare member ID card to update your authorization information on file.

Signature **Today's Date**
 _____ MM - DD - YYYY

8. If someone assisted you in completing this form, please have that person complete the information below

Signature (of individual who assisted in completing this form) **Today's Date**
 _____ MM - DD - YYYY

<input type="checkbox"/> Plan Representative, check here if you signed above and assisted in completing this form.	Relationship to Applicant
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What's Next

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Last Name First Name Medicare Number

9. UnitedHealthcare® MedicareRx for Groups use only

Plan ID Number

Effective Coverage Date

MM-DD-YYYY

IEP _____ AEP _____

SEP (type) _____

GPS Employer ID Number

GPS Branch Number

Licensed Sales Representative Signature

Today's Date

MM-DD-YYYY

Print Name

Agent ID Number

Phone Number

() -

10. Employer use only

Enrollee is Eligible for Retiree Coverage

Effective Date

MM-DD-YYYY

Initials

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Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract. Enrollment in the plan depends on the plan's contract renewal with Medicare. UnitedHealthcare Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-555-5757 (TTY: 711). 注意：如果您說中文，您可以免費獲得語言援助服務。請致電 1-800-555-5757 (TTY: 711).

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Outpatient Prescription Drug Plan Enrollment Form

(Please Print)

Underwritten by
UnitedHealthcare Insurance Company

Required Information

Employer/Former Employer Name: ARLINGTON PUBLIC SCHOOLS	
Employer ID #: 23707	Employer Subsidy Group #: 23707
Employer Billing #: 001	

Please complete the entire form. Incomplete information can delay the enrollment process. (Please Print – If you need more room for your answers to any questions, please use a separate sheet of paper.)

Date of Retiree's Retirement MM - DD - YYYY	Source of Enrollment <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Newly Eligible <input type="checkbox"/> Special Enrollment
---	--

1. Personal Information

Applicant Last Name	Applicant First Name	MI	Suffix
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Date of Birth MM - DD - YYYY	Marital Status of Applicant: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow	<input type="checkbox"/> Male <input type="checkbox"/> Female
--	---	--

Name of Retiree	Relation to Retiree: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child
-----------------	--

Medicare #	Part A Effective Date MM - DD - YYYY	Part B Effective Date MM - DD - YYYY	Part D Effective Date MM - DD - YYYY
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Permanent Residence Street Address (P.O. Box is not allowed)

City	State	Zip
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E-mail Address

Home Telephone # ()	Alternate Telephone # ()
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In the future, would you be willing to receive materials through electronic means? Yes No

If you are currently a resident of an institution (e.g., skilled nursing facility, rehabilitation hospital, etc.), please provide the requested information on the next three lines. Providing this information will not affect your eligibility to enroll.

Institution Name	Date of Admission MM - DD - YYYY	Telephone # ()
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Address

City	State	Zip
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Doctor's Name	Doctor's Telephone # ()
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Applicant Last Name

Applicant First Name

MI

Medicare #

2. Benefit Coordination / Other Insurance Carrier Information

1. Do you have other health insurance? Yes No If Yes, complete Section 1a. – 1e. below.

2. Are you permanently disabled? Yes No If Yes, complete the following:

2a. Date disability began: **MM - DD - YYYY**

3. Do you have a disability affecting your ability to communicate or read? Yes No

If you have special needs, this document may be available in other formats or languages upon request. Please contact us at **1-877-558-4749**, TTY users should call **711**. Our office hours are 8 a.m. - 8 p.m. local time, 7 days a week.

Do you work or plan to work? Yes No

1a. Name	1b. Insurance Company Name	1c. Policy #	1d. Effective Date	1e. Other Employer Name and Address
			MM - DD - YYYY	
			MM - DD - YYYY	

FOR OFFICE USE ONLY

Retiree

Yes No

Group # _____

Plan Code _____

Spouse or child

Yes No

Verification _____

Date ____ - ____ - ____

Initial _____

FOR EMPLOYER USE ONLY

Enrollee is eligible for retiree coverage

Effective Date

____ - ____ - ____

Initial _____

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What's Next

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Applicant Last Name

Applicant First Name

MI

Medicare #

3. Terms and Conditions

I am requesting enrollment under the UnitedHealthcare Insurance Company (“UnitedHealthcare”) Group Retiree Policy. By signing this Enrollment Form, I agree to and understand the following:

1. All coverage is subject to the terms and conditions of the UnitedHealthcare Group Policy.
2. UnitedHealthcare or its designee shall have access and use of my medical records for purposes of utilization review surveys, processing of claims, financial audit or other purposes reasonably related to the performance of this Enrollment Form.
3. Any material omission or intentional misrepresentation in answering the questions on this Enrollment Form may result in the denial of benefits and the termination of my coverage.
4. Coverage shall not begin until acceptance of this Enrollment Form by UnitedHealthcare. Acceptance will not occur until after UnitedHealthcare validates Medicare coverage and eligibility for coverage under the group retiree plan. Upon acceptance of this Enrollment Form, UnitedHealthcare shall be bound by the terms of my UnitedHealthcare Group Policy and the Amendments thereto (if applicable).
5. My current prescription drug coverage under Part D is provided by a UnitedHealthcare plan. I understand that if my coverage under the Part D plan ends, this coverage will also end.
6. All statements and descriptions in this enrollment form are deemed to be representations and not warranties.

I certify that I have read the Terms and Conditions printed on this Enrollment Form and that I accept them and will abide by them. I further certify that the information provided in the Enrollment Form is true and complete to the best of my knowledge and belief.

Print Name of Applicant:

Signature of Applicant or Authorized Representative:

Today’s Date:

MM - DD - YYYY



Authorized Representative Information

If you are the authorized representative (Responsible Party, Power of Attorney, Family Member, etc.), you must sign above and provide the following information:

Name _____ Date _____

Address _____ City _____ State _____ Zip code _____

Relationship to Enrollee _____

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Statements of Understanding

By enrolling in this plan, I agree to the following:

PART D  **UnitedHealthcare® MedicareRx for Groups (PDP) is a Medicare Prescription Drug plan and has a contract with the federal government.**

This prescription drug coverage is in addition to my coverage under Medicare. I need to keep my Medicare Part A and/or Part B, and I must continue to pay my Medicare Part B premium if not paid for by Medicaid or a third party.



UnitedHealthcare MedicareRx for Groups (PDP) is available in all U.S. states, the District of Columbia and all U.S. territories.

I understand that I must use network pharmacies except in an emergency when I cannot use the plan's network pharmacies.



I can only be in one Prescription Drug Plan at a time.

- By enrolling in this plan, I will automatically be disenrolled from any other Medicare Part D Prescription Drug Plan.
- If I have prescription drug coverage or if I get it from somewhere other than this plan, I will inform UnitedHealthcare.
- Enrollment in this plan is generally for the entire plan year. I may leave this plan only at certain times of the year or under special conditions.



I may have to pay a late enrollment penalty for Medicare's prescription drug coverage.

This applies if I did not sign up for and maintain creditable prescription drug coverage when I first became eligible for Medicare, or if I leave this plan and don't have or get other prescription drug coverage. If I have a late enrollment penalty, I will get a letter making me aware of the penalty and what the next steps are.



I will receive information on how to get an Evidence of Coverage (EOC).

- The EOC will have more information about the drug coverage offered by the plan, as well as the terms and conditions.
- I have the right to appeal plan decisions about payment or services if I disagree.



My information will be released to Medicare and other plans, only as necessary, for treatment, payment and health care operations.

Medicare may also release my information for research and other purposes that follow all applicable Federal statutes and regulations.

Questions? We're here to help.



1-877-558-4749, TTY 711
8 a.m. - 8 p.m. local time, 7 days a week



Learn more at
www.UHCRetiree.com

