bright HEALTH

In Collaboration with

bright HEALTH | Mount Sinai

Be happy.

It's included.

New York

Bright Advantage (HMO)
H2288-001

Bright Advantage Plus (HMO)
H2288-002

Bright Advantage Flex (PPO)
H9516-001

Bright Advantage Flex Plus (PPO)
H9516-002

Bright Advantage Assist (HMO)
H2288-005

Our Service Areas Include:
Kings, New York, and Queens Counties

Join. Save. Be happy.

Bright Health plans are HMO's and PPO's with a Medicare contract. Our SNP's also have contracts with state Medicaid programs. Our plans are issued through Bright Health Insurance Company or one of its affiliates. Enrollment in our plans depends on contract renewal. Other providers are available in our network. Most network providers participate through our Care Partner, Mount Sinai.

This information is not a complete description of benefits. Call Bright Health customer service for more information.

Y0127_TEMPL-MA-DIR-2306_M H2288, H9516 Accepted 09/09/2018

Medicare plans that give you a whole lot more.

At Bright Health, we're taking a new approach to healthcare, so you feel less confused and, well, better.

Happiness comes with all of our plans, along with coverage to help keep you healthy — **medical, dental, hearing, vision, prescription, and plenty of wellness extras — all included**. Choosing a Bright Health Medicare Advantage plan means you get a whole lot more benefits and could save hundreds of dollars every month as compared to what you pay with Original Medicare alone or a Medicare Supplement plan.

No hoops. No headaches. No nonsense.

Y0127_TEMPL-MA-FLR-2307_M Accepted 09/09/2018

Welcome.

One of the hardest things to do is to make something simple. But we were up for the challenge and have created a whole new level of health insurance. One where confusing jargon is a thing of the past. Welcome to your new reality.

Stress-free healthcare from a company who cares.

We provide so much more than great health plans that save our members hundreds. Your seamless experience includes complete transparency and fast issue resolution.

A great network of quality providers.

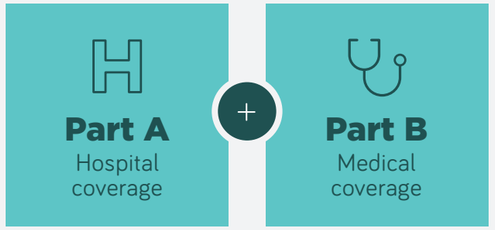
We connect you with a great network of providers who will get to know you. Our carefully chosen network of Care Partners will help make sure you get whole-body care.

Y0127_TEMPL-MA-FLR-2308_M Accepted 09/09/2018

Understanding Medicare basics

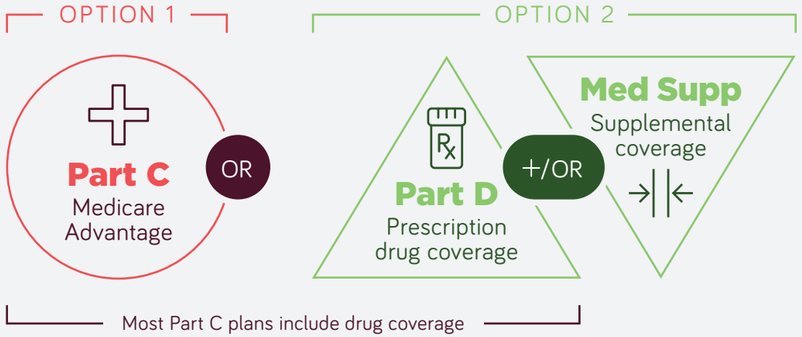
STEP 1:

Enroll in Original Medicare (offered by the federal government).



STEP 2:

Decide if you need additional coverage (offered by private insurers).



...and the care that's covered.

Part A covers

- Inpatient Hospital Stay
- Skilled Nursing Care
- Hospice Care
- Home Health Care

Part B covers

- Doctor Visits
- Outpatient Care
- Home Health Care
- Durable Medical Equipment
- Many Preventive Services

Part C covers

Everything that Original Medicare does, plus extras (depends on the plan):

- Dental & Eye Care
- Hearing Exams
- Fitness Discounts
- Prescription Drugs

Part D covers

- Prescription Drugs

Med Supp covers

- Parts A and B Gaps

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Let's dig a little deeper.

Parts A and B: Original Medicare

(offered through the federal government)

Part A: Hospital coverage
Covers inpatient hospital stays, skilled nursing care, hospice care, and home health care.

Part B: Medical coverage
Covers doctor visits, outpatient care, durable medical equipment, home health care, and many preventive services.

Part C: Medicare Advantage

(offered by private insurers)

Medicare Advantage plans combine the benefits of Parts A and B, and most come with Part D prescription drug coverage plus extra benefits and features. You must still be enrolled in Original Medicare to enroll in a Medicare Advantage plan, but you'll get your benefits through the Medicare Advantage plan instead.

Part D: Prescription Drug Coverage

(offered by private insurers)

Original Medicare does not include coverage for most prescription drugs. If you take prescriptions, you'll want to enroll in a Medicare Advantage plan that includes coverage for prescription drugs (like the Bright Health plans in this guide). Be sure to check the plan's formulary (drug list) before enrolling to be sure your medications are included.

Medicare Supplement Plans

(state-regulated and offered by private insurers)

Sometimes called, "Medigap," these plans help cover some of the out-of-pocket costs not covered by Original Medicare, like deductibles, copays and coinsurance. Medicare Supplement Plans are available from private insurers to be used with Original Medicare (Parts A and B).

Who's eligible for Medicare?

To be eligible for Medicare, you must be a U.S. citizen or legal resident who has lived in the U.S. for at least give years in a row. Most people become eligible for Medicare when they turn 65. Adults under the age of 65 with certain disabilities or medical conditions may also be eligible for Medicare.

When can you enroll?

Most are first eligible to enroll in a Medicare plan during the seven months surrounding your 65th birthday (three months before, the month of, and three months after). Then, you have another chance each fall to enroll in or switch to a new Medicare plan. This is called the Annual Enrollment Period, which runs from October 15 to December 7 each year. Your plan changes would go into effect on January 1.

Initial Enrollment Period

You're first eligible to enroll in a Medicare plan in the **seven months surrounding your 65th birthday** (three months before, the month of, and three months after).

Open Enrollment Period

You can make "like plan" changes from **January 1 to March 31, 2019**.

Annual Enrollment Period (AEP)

For 2019 coverage, AEP runs from **October 15 to December 7**. During this time, members can make changes or switch to a new health insurance provider.

Special Enrollment Period

Available when special circumstances happen that cause you to have to change your current plan.

Extra Help

If you have limited income, you may qualify for Extra Help, also known as Low-income Subsidy (LIS), to pay for prescription drug costs. If you qualify, Medicare could pay for 75% or more of your costs. You also won't experience the coverage gap or incur a late enrollment penalty. Many people are eligible and don't even know it.

For more information about this Extra Help, contact your certified Bright sales agent, visit 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**.

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2019 Bright Health Medicare Advantage Plans

Benefits at a Glance

New York

Bright Advantage (HMO)
H2288-001

Bright Advantage Plus (HMO)
H2288-002

Bright Advantage Assist (HMO)
H2288-005

Bright Advantage Flex (PPO)
H9516-001

Bright Advantage Flex Plus (PPO)
H9516-002

Y0127_TEMPL-MA-BKRG-2297_M
H2288, H9516 Accepted 09/09/2018

Compare and save.

Compare medical costs.

	Bright Advantage (HMO) H2288-001	Bright Advantage Plus (HMO) H2288-002	Bright Advantage Assist (HMO) H2288-005	Bright Advantage Flex (PPO) H9516-001	Bright Advantage Flex Plus (PPO) H9516-002
OVERVIEW					
Monthly Premium	$0	$55	$39	$0	$110
Annual Out-Of-Pocket Maximum (not including Rx)	$6,200	$4,900	$6,500	$6,500	$4,900
Annual Medical Deductible	$0	$0	$0	$250	$0
Annual Prescription Drug (Rx) Deductible	$200	$0	$0, $85, or $415 depending on level of Extra Help	$200	$0
Plan Includes Out-of-Network (OON) Benefits	N/A	N/A	N/A	Yes	Yes
Coinsurance for Most OON Services	N/A	N/A	N/A	40%	35%
Combined Annual Out-of-Pocket Maximum (INN & OON services)	N/A	N/A	N/A	$10,000	$10,000
DOCTOR VISITS					
Primary Care Office Visits	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Specialist Office Visits	$25 copay	$20 copay	$30 copay	$25 copay	$20 copay
Annual Routine Physical	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Preventive Care	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
FACILITY-BASED SERVICES					
Inpatient Hospitalization	$295/day for days 1-5; $0/day for days 6 and beyond	$250/day for days 1-5; $0/day for days 6 and beyond	$300/day for days 1-5; $0/day for days 6 and beyond	$295/day for days 1-5; $0/day for days 6 and beyond	$250/day for days 1-5; $0/day for days 6 and beyond
Outpatient Surgery (ASC)	$200 copay	$150 copay	$300 copay	$200 copay	$150 copay
Outpatient Surgery (Outpatient Hospital Facility)	$300 copay	$250 copay	$350 copay	$300 copay	$250 copay
EMERGENT & URGENTLY NEEDED SERVICES					
Emergency Room	$90 copay	$90 copay	$90 copay	$90 copay	$90 copay
Urgent Care	$25 copay	$25 copay	$30 copay	$25 copay	$25 copay
DIAGNOSTIC SERVICES/LABS/IMAGING					
Diagnostic Radiology Service (e.g., MRI)	$50 copay for ultrasound; 20% coinsurance for all other diagnostic radiological services	$50 copay for ultrasound; 20% coinsurance for all other diagnostic radiological services	$50 copay for ultrasound; 20% coinsurance for all other diagnostic radiological services	$50 copay for ultrasounds; 20% coinsurance for all other diagnostic radiological services	$50 copay for ultrasounds; 20% coinsurance for all other diagnostic radiological services
Lab Services	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Outpatient X-Rays	$10 copay	$10 copay	$15 copay	$10 copay	$10 copay

Compare benefit extras.

	Bright Advantage (HMO) H2288-001	Bright Advantage Plus (HMO) H2288-002	Bright Advantage Assist (HMO) H2288-005	Bright Advantage Flex (PPO) H9516-001	Bright Advantage Flex Plus (PPO) H9516-002
HEARING SERVICES					
Routine Hearing Exam & Hearing Aid Fitting/Evaluation	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Hearing Aid Allowance	$3,000 hearing aid allowance every 3 years	$3,000 hearing aid allowance every 3 years	$3,000 hearing aid allowance every 3 years	$3,000 hearing aid allowance every 3 years	$3,000 hearing aid allowance every 3 years
DENTAL SERVICES					
Preventive Dental: X-rays	$0 copay; 2 every 3 years	$0 copay; 2 every 3 years	$0 copay; 2 every 3 years	$0 copay; 2 every 3 years	$0 copay; 2 every 3 years
Preventive Dental: Oral Exams	$0 copay; 2 every year	$0 copay; 2 every year	$0 copay; 2 every year	$0 copay; 2 every year	$0 copay; 2 every year
Preventive Dental: Cleaning (prophylaxis)	$0 copay; 2 every year	$0 copay; 2 every year	$0 copay; 2 every year	$0 copay; 2 every year	$0 copay; 2 every year
Preventive Dental: Fluoride Treatment	$0 copay; 1 every year	$0 copay; 1 every year	$0 copay; 1 every year	$0 copay; 1 every year	$0 copay; 1 every year
Dental Benefit Maximum	N/A	$1,000 annual benefit maximum	$1,000 annual benefit maximum	N/A	$1,000 annual benefit maximum
Comprehensive Dental	Available for an additional monthly premium	Coinsurance varies depending on the services you receive	Coinsurance varies depending on the services you receive	Available for an additional monthly premium	Coinsurance varies depending on the services you receive
VISION SERVICES					
Routine Eye Exam	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Materials Allowance	$130 vision materials allowance every 2 years	$130 vision materials allowance every 2 years	$130 vision materials allowance every 2 years	$130 vision materials allowance every 2 years	$130 vision materials allowance every 2 years
OTHER SUPPLEMENTAL BENEFITS					
Fitness Benefit	Includes an annual fitness or gym membership at no copay/cost share to the member	Includes an annual fitness or gym membership at no copay/cost share to the member	Includes an annual fitness or gym membership at no copay/cost share to the member	Includes an annual fitness or gym membership at no copay/cost share to the member	Includes an annual fitness or gym membership at no copay/cost share to the member
Acupuncture	$20 copay per visit, up to 12 visits per year	$20 copay per visit, up to 12 visits per year	$20 copay per visit, up to 12 visits per year	$20 copay per visit, up to 12 visits per year	$20 copay per visit, up to 12 visits per year
Over-The-Counter (OTC) Debit Card	Not covered	$30 OTC credit every 3 months	Not covered	Not covered	Not covered
OPTIONAL SUPPLEMENTAL BENEFITS (FOR ADDITIONAL MONTHLY PREMIUM)					
Comprehensive Dental Premium	$13	Already included in your plan	Already included in your plan	$18	Already included in your plan
Comprehensive Dental Benefits	Coinsurance varies depending on the services you receive	Already included in your plan	Already included in your plan	Coinsurance varies depending on the services you receive	Already included in your plan
Comprehensive Dental Benefit Maximum	$1,000 annual benefit maximum	N/A	N/A	$1,000 annual benefit maximum	N/A
Comprehensive Vision Premium	Already included in your plan	Already included in your plan	Already included in your plan	Already included in your plan	Already included in your plan
Comprehensive Vision Benefits	Already included in your plan	Already included in your plan	Already included in your plan	Already included in your plan	Already included in your plan

Compare drug costs.

	Bright Advantage (HMO) H2288-001	Bright Advantage Plus (HMO) H2288-002	Bright Advantage Assist (HMO) H2288-005	Bright Advantage Flex (PPO) H9516-001	Bright Advantage Flex Plus (PPO) H9516-002
PART D PRESCRIPTION DRUGS					
Annual Prescription Drug (Rx) Deductible (Tiers 3-5)	$200 deductible	$0 deductible	$0, $85, or $415 deductible depending on level of Extra Help	$200 deductible	$0 deductible
RETAIL (30-DAY) SUPPLY					
Tier 1: Preferred Generic	$0 copay	$0 copay	N/A	$0 copay	$0 copay
Tier 2: Generic	$10 copay	$8 copay	N/A	$10 copay	$8 copay
Tier 3: Preferred Brand	$45 copay	$45 copay	N/A	$45 copay	$45 copay
Tier 4: Non-Preferred Drug	$95 copay	$95 copay	N/A	$95 copay	$95 copay
Tier 5: Specialty Tier	29% coinsurance	33% coinsurance	N/A	29% coinsurance	33% coinsurance
MAIL ORDER (90-DAY) SUPPLY					
Tier 1: Preferred Generic	$0 copay	$0 copay	N/A	$0 copay	$0 copay
Tier 2: Generic	$30 copay	$0 copay	N/A	$30 copay	$0 copay
Tier 3: Preferred Brand	$135 copay	$135 copay	N/A	$135 copay	$135 copay
Tier 4: Non-Preferred Drug	$285 copay	$285 copay	N/A	$285 copay	$285 copay
Tier 5: Specialty Tier	29% coinsurance	33% coinsurance	N/A	29% coinsurance	33% coinsurance
D-SNP AND NY LIS PART D					
Generic (including brand drugs treated as generic)	N/A	N/A	$0, $1.25, $3.40 copay, 15%, or 25%	N/A	N/A
All other drugs	N/A	N/A	$0, $3.80, $8.50 copay, 15%, or 25%	N/A	N/A

Bright Health plans are HMO's and PPO's with a Medicare contract. Our SNP's also have contracts with state Medicaid programs. Our plans are issued through Bright Health Insurance Company or one of its affiliates. Enrollment in our plans depends on contract renewal. Other providers are available in our network.

This information is not a complete description of benefits. Call (844) 706-9381 for more information.

Bright Health Plan Materials

Y0127_TEMPL-MA-MARC-2310_C

Notes:

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2019

Bright Health Summary of Benefits

Bright Advantage (HMO)
H2288-001

Bright Advantage Plus (HMO)
H2288-002

Bright Advantage Assist (HMO)
H2288-005

H2288_MA-DIR-2441_M Accepted 9/9/2018

Welcome to Bright Health.

Enclosed you will find our summary of the health and drug services covered by Bright Health Medicare Advantage plans from January 1, 2019 to December 31, 2019 for Kings, New York, and Queens counties.

Keep in mind, this is a *summary* of what's covered and what you would pay for those benefits and services. For a complete coverage list, including limitations and exclusions, please refer to our Evidence of Coverage ("EOC"). You can find an EOC online at www.brighthealthplan.com/medicare, or you can request a printed copy to be mailed to you by calling us at 844-667-5502, 8 am - 8 pm local time, 7 days a week Oct. 1-Mar. 31, Monday-Friday Apr. 1-Sept. 30, TTY: 711.

We designed our plans a little differently.

We believe that health insurance and healthcare work better together. So, that's why we built our health plans from the ground up, with carefully selected Care Partners like Mount Sinai. Our partnership with Mount Sinai means you benefit from a connected care system that puts your healthcare needs at the center. With a network of hand-picked doctors, working together on your behalf, you get to focus on living your best life.

This is healthcare that revolves around you.

When your health plan and your healthcare providers are working together, you're always at the center – but never caught in the middle.

We're proud of our Medicare Advantage plans, and we think you'll love them, too. But we also believe it's important that you enroll in the health plan that's right for you. So, take a look, and give us a call if you have any questions.

We look forward to helping you live your best life.

Some Frequently Asked Questions:

May I choose my providers?

Bright Health has carefully selected a network of doctors, hospitals, pharmacies, and other providers. **To keep your costs down, it's important that you receive care from an in-network provider.** In most cases, if you choose to get care outside of the plan's network, you will pay for the full cost of the service. However, if you need out-of-network emergency services, urgently needed services or dialysis services, then we've got you covered.

To find an in-network provider near you, visit our website at www.brighthealthplan.com/medicare or call Bright Health at 844-667-5502.

What is a prescription drug formulary?

A formulary is a list of drugs covered by a health plan. To make sure your drugs are included in the Bright Advantage (HMO), Bright Advantage Plus (HMO) and Bright Advantage Assist (HMO) formulary, you can search and download our formulary online at www.brighthealthplan.com/medicare. Or you can call Bright Health at 844-667-5502 to discuss your drugs. Please note that the formulary is subject to change, and you can always find the most up-to-date list of drugs on our website.

For more information, or if you have any questions, just give us a call.

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844-667-5502, 8 am - 8 pm local time
7 days a week Oct. 1-Mar. 31
Monday-Friday Apr. 1-Sept. 30
TTY: 711
www.brighthealthplan.com/medicare

If you'd like to know more about the coverage and costs of Original Medicare, please look in your current *Medicare & You* handbook. You can 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.

Bright Health Premiums & Benefits

	Bright Advantage (HMO)	Bright Advantage Plus (HMO)	Bright Advantage Assist (HMO)
Monthly Plan Premium	$0	$55	$39
Annual Medical Deductible	$0	$0	$0
Maximum Out-Of-Pocket Amount*	$6,200	$4,900	$6,500

Bright Health Benefits

	Bright Advantage (HMO)	Bright Advantage Plus (HMO)	Bright Advantage Assist (HMO)
Inpatient Hospital Coverage	$295 per day for days 1-5 $0 per day for days 6+	$250 per day for days 1-5 $0 per day for days 6+	$300 per day for days 1-5 $0 per day for days 6+
Outpatient Hospital Services and Observation	$300 copay	$250 copay	$350 copay
Doctor Visits			
Primary Care Providers (PCP)	$0 copay	$0 copay	$0 copay
Specialists	$25 copay	$20 copay	$30 copay
Annual Routine Physical Exam	$0 copay	$0 copay	$0 copay
Preventive Care Any additional preventive services approved by Medicare during the contract year will be covered.	$0 copay	$0 copay	$0 copay
	Our plan covers many preventive services at no cost when you see an in-network provider, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Annual Wellness Visit • Bone mass measurement		

	Bright Advantage (HMO)	Bright Advantage Plus (HMO)	Bright Advantage Assist (HMO)
	• Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screening (cholesterol, lipids, triglycerides) • Cervical and vaginal cancer screening • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) • Depression screening • Diabetes screening • Diabetes self-management training • Glaucoma test • Hepatitis C screening • HIV screening • Lung cancer screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infection screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including flu shots, hepatitis B shots, pneumococcal shots • "Welcome to Medicare" preventive visit (one-time)		
Emergency Care	$90 copay Copay is waived if you are admitted to a hospital within 24 hours.	$90 copay Copay is waived if you are admitted to a hospital within 24 hours.	$90 copay Copay is waived if you are admitted to a hospital within 24 hours.
Urgently Needed Services	$25 copay	$25 copay	$30 copay
Diagnostic Services/Labs/Imaging			
Diagnostic Tests and Procedures	20% coinsurance	20% coinsurance	20% coinsurance
Lab Services	$0 copay	$0 copay	$0 copay
Diagnostic Radiology Services (e.g. MRI, CAT Scan)	$50 copay for ultrasound 20% coinsurance for all other diagnostic services	$50 copay for ultrasound 20% coinsurance for all other diagnostic services	$50 copay for ultrasound 20% coinsurance for all other diagnostic services
Outpatient X-rays	$10 copay	$10 copay	$15 copay

	Bright Advantage (HMO)	Bright Advantage Plus (HMO)	Bright Advantage Assist (HMO)
Hearing Services			
Exam to Diagnose and Treat Hearing and Balance Issues	$0 copay	$0 copay	$0 copay
Routine Hearing Exam	$0 copay Limited to 1 visit every year	$0 copay Limited to 1 visit every year	$0 copay Limited to 1 visit every year
Fitting-Evaluation(s) for Hearing Aids	$0 copay Limited to 1 visit every year	$0 copay Limited to 1 visit every year	$0 copay Limited to 1 visit every year
Hearing Aids	Up to a $3,000 allowance for both ears combined every three years for hearing aids.	Up to a $3,000 allowance for both ears combined every three years for hearing aids.	Up to a $3,000 allowance for both ears combined every three years for hearing aids.
Dental Services			
Medicare-covered Dental Services	$0 copay	$0 copay	$0 copay
Annual Dental Benefit Maximum	No benefit maximum for preventive dental services.	Up to a $1,000 benefit maximum for all plan covered dental services not covered by Medicare every year.	Up to a $1,000 benefit maximum for all plan covered dental services not covered by Medicare every year.
Oral Exams	$0 copay Limited to 2 oral exams every year	$0 copay Limited to 2 oral exams every year	$0 copay Limited to 2 oral exams every year
Prophylaxis (Cleaning)	$0 copay Limited to 2 cleanings every year	$0 copay Limited to 2 cleanings every year	$0 copay Limited to 2 cleanings every year
Dental X-rays	$0 copay Limited to 2 x-rays every 3 years	$0 copay Limited to 2 x-rays every 3 years	$0 copay Limited to 2 x-rays every 3 years

	Bright Advantage (HMO)	Bright Advantage Plus (HMO)	Bright Advantage Assist (HMO)
Fluoride Treatment	$0 copay Limited to 1 fluoride treatment every year	$0 copay Limited to 1 fluoride treatment every year	$0 copay Limited to 1 fluoride treatment every year
Non-Routine Services	Available for an additional $13 monthly premium. Up to a $1,000 benefit maximum for all plan covered dental services not covered by Medicare every year. Please see Evidence of Coverage for details.	50% coinsurance	50% coinsurance
Diagnostic Services		$0 copay	$0 copay
Restorative Services		30% - 50% coinsurance	30% - 50% coinsurance
Endodontics		50% coinsurance	50% coinsurance
Periodontics		50% coinsurance	50% coinsurance
Extractions		50% coinsurance	50% coinsurance
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services		50% coinsurance	50% coinsurance
Vision Services			
Exam to Diagnose and Treat Diseases and Conditions of the Eye	$0 copay	$0 copay	$0 copay
Eyewear After Cataract Surgery	$0 copay	$0 copay	$0 copay
Routine Eye Exam	$0 copay Limited to 1 visit every year	$0 copay Limited to 1 visit every year	$0 copay Limited to 1 visit every year
Contact Lenses	$0 - $60 copay Up to a $130 allowance every two years for contact lenses or eyeglasses.	$0 - $60 copay Up to a $130 allowance every two years for contact lenses or eyeglasses.	$0 - $60 copay Up to a $130 allowance every two years for contact lenses or eyeglasses.

	Bright Advantage (HMO)	Bright Advantage Plus (HMO)	Bright Advantage Assist (HMO)
Eyeglasses (Lenses and Frames)	$25 copay Up to a $130 allowance every two years for contact lenses or eyeglasses.	$25 copay Up to a $130 allowance every two years for contact lenses or eyeglasses.	$25 copay Up to a $130 allowance every two years for contact lenses or eyeglasses.
Mental Health Services			
Inpatient Visit	$295 copay per day for days 1-5 $0 copay per day for days 6-90	$250 copay per day for days 1-5 $0 copay per day for days 6-90	$300 copay per day for days 1-5 $0 copay per day for days 6-90
Outpatient Group Therapy Visit	$20 copay	$20 copay	$20 copay
Outpatient Individual Therapy Visit	$40 copay	$40 copay	$40 copay
Skilled Nursing Facility (SNF) Care	$0 copay per day for days 1-20 $172 copay per day for days 21-100	$0 copay per day for days 1-20 $172 copay per day for days 21-100	$0 copay per day for days 1-20 $172 copay per day for days 21-100
Physical Therapy, Occupational Therapy, or Speech Therapy Visit	$25 copay	$25 copay	$30 copay
Ambulance Services			
Ground Ambulance	$175 copay	$175 copay	$200 copay
Air Ambulance	$225 copay	$225 copay	$225 copay
Transportation	Not Covered	Not Covered	Not Covered
Medicare Part B Prescription Drugs			
Chemotherapy Drugs	20% coinsurance	20% coinsurance	20% coinsurance

	Bright Advantage (HMO)	Bright Advantage Plus (HMO)	Bright Advantage Assist (HMO)
Other Part B Drugs	20% coinsurance	20% coinsurance	20% coinsurance
Foot Care (Podiatry Services)			
Medicare-covered Foot Exams & Treatment	$25 copay	$25 copay	$25 copay
Medical Equipment / Supplies			
Durable Medical Equipment (e.g., wheelchairs, oxygen)	20% coinsurance	20% coinsurance	20% coinsurance
Prosthetics (e.g., braces, artificial limbs)	20% coinsurance	20% coinsurance	20% coinsurance
Diabetic Monitoring Supplies	$0 copay	$0 copay	$0 copay
Therapeutic Shoes or Inserts	$0 copay	$0 copay	$0 copay
Outpatient Surgery			
Ambulatory Surgical Center	$200 copay	$150 copay	$300 copay
Outpatient Hospital Facility	$300 copay	$250 copay	$350 copay
Acupuncture Services	$20 copay Limited to 12 visits every year within network of participating acupuncturists	$20 copay Limited to 12 visits every year within network of participating acupuncturists	$20 copay Limited to 12 visits every year within network of participating acupuncturists
Fitness Program	$0 copay at participating locations	$0 copay at participating locations	$0 copay at participating locations

	Bright Advantage (HMO)	Bright Advantage Plus (HMO)	Bright Advantage Assist (HMO)
Over-the-Counter (OTC) Debit Card	Not Covered	$0 copay $30 allowance every three months to be used toward the purchase of OTC health and wellness products	Not Covered

*The annual out-of-pocket maximum does not apply to Part D prescription drugs or Bright Health Extra Benefits.

Some services may require prior authorization. Refer to your Evidence of Coverage for details.

Bright Health plans are HMOs and PPOs with a Medicare contract. Our SNPs also have contracts with State Medicaid programs. Our plans are issued through Bright Health Insurance Company or one of its affiliates. Enrollment in our plans depends on contract renewal.

To enroll in a Bright Health Medicare Advantage Plan, you must be entitled to Medicare Part A, enrolled in Medicare Part B, and live in the plan's service area.

Bright Health Extra Benefits Information

To find network providers for the following services, call Bright Health Member Services at 844-202-4974, 8 am - 8 pm local time, 7 days a week Oct. 1-Mar. 31, Monday-Friday Apr. 1-Sept. 30, TTY: 711.

- Hearing
- Vision
- Dental
- Acupuncture

Fitness Membership: Offered through Silver&Fit® Fitness program. To find a participating facility near you, call Bright Member Services at 844-202-4974, 8 am - 8 pm local time, 7 days a week Oct. 1-Mar. 31, Monday-Friday Apr. 1-Sept. 30, TTY: 711.

Over-the-Counter (OTC): Offered through InComm. For more information, call Bright Member Services at 844-202-4974, 8 am - 8 pm local time, 7 days a week Oct. 1-Mar. 31, Monday-Friday Apr. 1-Sept. 30, TTY: 711.

Prescription Drug Benefits

The chart below outlines your costs. The tier your drugs are in will determine how much you will pay. Generally, the higher the tier, the higher the cost.

Prescription Drug Coverage	Bright Advantage (HMO)	Bright Advantage Plus (HMO)	Bright Advantage Assist (HMO)
Stage 1: Annual Prescription Deductible			
Deductible	$200 for Tiers 3-5. For all other drugs, you will not have to pay any deductible and will start receiving coverage immediately.	$0 This plan has no deductible for Part D drugs, this payment stage doesn't apply.	Your deductible amount is either $0, $85, or $415, depending on the level of "Extra Help" you receive.
Stage 2: Initial Coverage (after you pay your deductible, if applicable)			
Standard retail cost-sharing (30-day / 90-day supply)			
Tier 1 (Preferred Generic)	$0/$0 copay	$0/$0 copay	$0, $1.25, $3.40 copay, 15%, or up to 25% of the total cost, depending on the level of "Extra Help" you receive.
Tier 2 (Generic)	$10/$30 copay	$8/$24 copay	
Tier 3 (Preferred Brand)	$45/$135 copay	$45/$135 copay	$0, $3.80, $8.50 copay, 15%, or up to 25% of the total cost, depending on the level of "Extra Help" you receive.
Tier 4 (Non-Preferred Drug)	$95/$285 copay	$95/$285 copay	
Tier 5 (Specialty Tier)	29% coinsurance	33% coinsurance	
Standard mail-order cost-sharing (up to a 90-day supply)			
Tier 1 (Preferred Generic)	$0 copay	$0 copay	$0, $1.25, $3.40 copay, 15%, or up to 25% of the total cost, depending on the level of "Extra Help" you receive.
Tier 2 (Generic)	$30 copay	$0 copay	
Tier 3 (Preferred Brand)	$135 copay	$135 copay	$0, $3.80, $8.50 copay, 15%, or up to 25% of the total cost, depending on the level of "Extra Help" you receive.
Tier 4 (Non-Preferred Drug)	$285 copay	$285 copay	
Tier 5 (Specialty Tier)	29% coinsurance	33% coinsurance	

Prescription Drug Coverage	Bright Advantage (HMO)	Bright Advantage Plus (HMO)	Bright Advantage Assist (HMO)
Stage 3: Coverage Gap			
After your yearly total drug costs (including what our plan has paid and what you have paid) reach $3,820, you will enter the coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. Not everyone will enter the coverage gap. If you enter the coverage gap, you will pay no more than 37% coinsurance for covered generic drugs or 25% coinsurance for covered brand name drugs until your costs total $5,100, which is the end of the coverage gap. If you receive "Extra Help" to pay for your prescription drugs, you may have lower cost-sharing for covered drugs.			
Stage 4: Catastrophic Coverage			

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,100, you qualify for the Catastrophic Coverage Stage. If you receive "Extra Help" to pay for your prescription drugs, your costs for covered drugs will depend on the level of "Extra Help" you receive. During this stage, your share of the cost for a covered drug will be either:
• $0; or
• The greater of:
  ○ 5% coinsurance, or
  ○ $3.40 copay for generic (including brand drugs treated as generic) and a $8.50 copay for all other drugs.			

Long-term care facilities

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

Out-of-network pharmacies

If you choose to get drugs from an out-of-network pharmacy, you will pay the full cost of the prescription. The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Extra Help

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify 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 http://www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

ATENCIÓN: Si usted habla español, tiene a su disposición servicios de asistencia de idioma gratuitos. Llame al 844-667-5502 (TTY: 711).

注意: 如果您说普通话, 您可以使用免费的语言帮助服务。请致电 844-667-5502（听障专线: 711）.

Our plans are issued through Bright Health Insurance Company or one of its affiliates. Other providers and pharmacies are available in our network. Most network providers participate through our Care Partner.

Out-of-network/noncontracted providers are under no obligation to treat Bright Health members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

This information is not a complete description of benefits. Call 844-667-5502 (TTY: 711) for more information.

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 844-667-5502.

Understand the Benefits

- Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit www.brighthealthplan.com/medicare or call 844-667-5502 to view a copy of the EOC.
- Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understand Important Rules

- In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- Benefits, premiums and/or copays/co-insurance may change on January 1 of each year.
- Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory

bright[SM] HEALTH

Nondiscrimination Notice and Assistance with Communication

Bright Health does not exclude, deny benefits to, or otherwise discriminate against any individual on the basis of sex, age, race, color, national origin, or disability. “Bright Health” means Bright Health plans and their affiliates, which are listed below.

Language assistance and alternate formats:
Assistance is available *at no cost* to help you communicate with us. The services include, but are not limited to:

- Interpreters for languages other than English;
- Written information in alternative formats such as large print; and
- Assistance with reading Bright Health websites.

To ask for help with these services, please call (844) 606-4633.

If you think that we failed to provide language assistance or alternate formats, or you were discriminated against because of your sex, age, race, color, national origin, or disability, you can send a complaint to:

Bright Health Civil Rights Coordinator
PO Box 853943, Richardson, TX 75085-3943
Phone: (844) 202-2154
Fax: (800) 894-7742

You can also file a complaint with the U.S Dept. of Health and Human Services, the Office of Civil Rights:

- **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

If you need help with your complaint, please call (844) 202-2154.

"Bright Health” means Bright Health Insurance Company of Alabama, Inc; Bright Health Company of Arizona; Bright Health Insurance Company; Bright Health Insurance Company of Tennessee; Bright Health Insurance Company of Ohio, Inc.; Bright Health Insurance Company of New York.

Updated 06/29/2018

Section 1557 / Multi Language Insert

This information is available in other formats like large print. To ask for another format, please call (844) 606-4633.

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call (844) 606-4633.
Spanish (US)	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de ayuda con el idioma. Llame al (844) 606-4633.
Chinese (S)	注意：如果您讲中文，您可以获得免费的语言协助服务。请致电 (844) 606-4633。
Russian	ВНИМАНИЕ! Если Вы говорите по-русски, то услуги бесплатной языковой поддержки доступны Вам. Позвоните по телефону (844) 606-4633.
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (844) 606-4633 로 전화하십시오.
Haitian Creole	ATANSYON: Si w pale kreyòl ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele (844) 606-4633.
Italian	ATTENZIONE: se parla italiano, sono disponibili per Lei servizi di assistenza linguistica gratuiti. Chiami il numero (844) 606-4633.
Yiddish	אויפמערקאזמקייט: אויב איר רעדט יידיש, שפראך הילף סערוויסעס, פריי פון אָפּצאָל, זענען פאראן פאר אייך. רופט (844) 606-4633
Bengali	মনোযোগ দিন: আপনি যদি বাংলায় কথা বলেন, তাহলে ভাষা সহায়তা পরিষেবাগুলি, বিনামূল্যে, আপনার জন্য উপলব্ধ আছে। (844) 606-4633 নম্বরে ফোন করুন।
Arabic	تنبيه: إذا كنت تتكلم العربية، فإن خدمات المساعدة اللغوية متاحة لك من دون مقابل. اتصل على الرقم 606-4633 (844).
Polish	UWAGA: Jeżeli posługuje się Pan/ Pani językiem polskim, może Pan/ Pani skorzystać z bezpłatnej pomocy językowej. Prosimy zadzwonić pod numer (844) 606-4633.
French (FR)	REMARQUE : si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Appelez le (844) 606-4633.
Tagalog	PANSININ: Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyong pangwika. Tawagan ang (844) 606-4633.
Vietnamese	LƯU Ý: Nếu quý vị nói tiếng Việt, sẽ có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Hãy gọi số (844) 606-4633.
Navajo	DÍÍ BAA AKÓ NÍNÍZIN: Díí bee yáníłti'go Diné bizaad, saad bee áká'ánida'áwo'dęę', t'áá jiik'eh, ná hóló. Kojį' hódíílnih (844) 606-4633.
Urdu	توجہ دیں: اگر آپ اردو بولتے/بولتی ہیں، تو آپ کے لیے زبان سے متعلق اعانت کی خدمات، بلامعاوضہ دستیاب ہیں۔ 606-4633 (844) پر کال کریں۔
Japanese	ご注意：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。(844) 606-4633 までお電話ください。
Portuguese (BR)	ATENÇÃO: caso você fale português, há serviços gratuitos de assistência de idioma à sua disposição. Ligue para (844) 606-4633.
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie unter (844) 606-4633 an.
Persian Farsi	توجه: اگر زبان شما فارسی است، خدمات پشتیبانی زبانی به صورت رایگان در اختیار شماست. با 4633 -606 (844) تماس بگیرید.

For more information, call Bright Health: 844-667-5502

8 am - 8 pm local time

7 days a week Oct. 1-Mar. 31

Monday-Friday Apr. 1-Sept. 30

TTY: 711

or

Go online: www.brighthealthplan.com/medicare

Find Bright Health’s provider directory, pharmacy directory, and formulary (drug list) at www.brighthealthplan.com/medicare

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2019

Bright Health Summary of Benefits

Bright Advantage Flex (PPO)
H9516-001

Bright Advantage Flex Plus (PPO)
H9516-002

H9516_MA-DIR-2442_M Accepted 9/9/2018

Welcome to Bright Health.

Enclosed you will find our summary of the health and drug services covered by Bright Health Medicare Advantage plans from January 1, 2019 to December 31, 2019 for Kings, New York and Queens counties.

Keep in mind, this is a *summary* of what's covered and what you would pay for those benefits and services. For a complete coverage list, including limitations and exclusions, please refer to our Evidence of Coverage ("EOC"). You can find an EOC online at www.brighthealthplan.com/medicare, or you can request a printed copy to be mailed to you by calling us at 844-667-5502, 8 am - 8 pm local time, 7 days a week Oct. 1-Mar. 31, Monday-Friday Apr. 1-Sept. 30, TTY: 711.

We designed our plans a little differently.

We believe that health insurance and healthcare work better together. So, that's why we built our health plans from the ground up, with carefully selected Care Partners like Mount Sinai. Our partnership with Mount Sinai means you benefit from a connected care system that puts your healthcare needs at the center. With a network of hand-picked doctors, working together on your behalf, you get to focus on living your best life.

This is healthcare that revolves around you.

When your health plan and your healthcare providers are working together, you're always at the center – but never caught in the middle.

We're proud of our Medicare Advantage plans, and we think you'll love them, too. But we also believe it's important that you enroll in the health plan that's right for you. So, take a look, and give us a call if you have any questions.

We look forward to helping you live your best life.

Some Frequently Asked Questions:

May I choose my providers?

Bright Health has carefully selected a network of doctors, hospitals, pharmacies, and other providers. **To keep your costs down, it's important that you receive care from an in-network provider.** In most cases, if you choose to get care outside of the plan's network, you will likely pay more for the service. However, if you need out-of-network emergency services, urgently needed services or dialysis services, then we've got you covered.

To find an in-network provider near you, visit our website at www.brighthealthplan.com/medicare or call Bright Health at 844-667-5502.

What is a prescription drug formulary?

A formulary is a list of drugs covered by a health plan. To make sure your drugs are included in the Bright Advantage Flex (PPO) and Bright Advantage Flex Plus (PPO) formulary, you can search and download our formulary online at www.brighthealthplan.com/medicare. Or you can call Bright Health at 844-667-5502 to discuss your drugs. Please note that the formulary is subject to change, and you can always find the most up-to-date list of drugs on our website.

For more information, or if you have any questions, just give us a call.

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844-667-5502, 8 am - 8 pm local time
7 days a week Oct. 1-Mar. 31
Monday-Friday Apr. 1-Sept. 30
TTY: 711
www.brighthealthplan.com/medicare

If you'd like to know more about the coverage and costs of Original Medicare, please look in your current *Medicare & You* handbook. You can 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.

Bright Health Premiums & Benefits

	Bright Advantage Flex (PPO)	Bright Advantage Flex Plus (PPO)
Monthly Plan Premium	$0	$110
Annual Medical Deductible	$250	$0
Maximum Out-Of-Pocket Amount*	**For In-Network Services:** $6,500 **For In-Network and Out-of-Network Services Combined:** $10,000	**For In-Network Services:** $4,900 **For In-Network and Out-of-Network Services Combined:** $10,000

Bright Health Benefits

	Bright Advantage Flex (PPO)	Bright Advantage Flex Plus (PPO)
Inpatient Hospital Coverage	**In-Network** $295 per day for days 1-5 $0 per day for days 6+ **Out-of-Network** 40% coinsurance	**In-Network** $250 per day for days 1-5 $0 per day for days 6+ **Out-of-Network** 35% coinsurance
Outpatient Hospital Services and Observation	**In-Network** $300 copay **Out-of-Network** 40% coinsurance	**In-Network** $250 copay **Out-of-Network** 35% coinsurance
Doctor Visits		
Primary Care Providers (PCP)	**In-Network** $0 copay **Out-of-Network** 40% coinsurance	**In-Network** $0 copay **Out-of-Network** 35% coinsurance
Specialists	**In-Network** $25 copay **Out-of-Network** 40% coinsurance	**In-Network** $20 copay **Out-of-Network** 35% coinsurance
Annual Routine Physical Exam	**In-Network** $0 copay **Out-of-Network** 40% coinsurance	**In-Network** $0 copay **Out-of-Network** 35% coinsurance

	Bright Advantage Flex (PPO)	Bright Advantage Flex Plus (PPO)
Preventive Care Any additional preventive services approved by Medicare during the contract year will be covered.	**In-Network** $0 copay **Out-of-Network** 40% coinsurance	**In-Network** $0 copay **Out-of-Network** 35% coinsurance
	Our plan covers many preventive services at no cost when you see an in-network provider, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Annual Wellness Visit • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screening (cholesterol, lipids, triglycerides) • Cervical and vaginal cancer screening • Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) • Depression screening • Diabetes screening • Diabetes self-management training • Glaucoma test • Hepatitis C screening • HIV screening • Lung cancer screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infection screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including flu shots, hepatitis B shots, pneumococcal shots • "Welcome to Medicare" preventive visit (one-time)	
Emergency Care	$90 copay Copay is waived if you are admitted to a hospital within 24 hours.	$90 copay Copay is waived if you are admitted to a hospital within 24 hours.
Urgently Needed Services	$25 copay	$25 copay
Diagnostic Services/Labs/Imaging		
Diagnostic Tests and Procedures	**In-Network** 20% coinsurance **Out-of-Network** 40% coinsurance	**In-Network** 20% coinsurance **Out-of-Network** 35% coinsurance

	Bright Advantage Flex (PPO)	Bright Advantage Flex Plus (PPO)
Lab Services	**In-Network** $0 copay **Out-of-Network** 40% coinsurance	**In-Network** $0 copay **Out-of-Network** 35% coinsurance
Diagnostic Radiology Services (e.g. MRI, CAT Scan)	**In-Network** $50 copay for ultrasound 20% coinsurance for all other diagnostic services **Out-of-Network** 40% coinsurance	**In-Network** $50 copay for ultrasound 20% coinsurance for all other diagnostic services **Out-of-Network** 35% coinsurance
Outpatient X-rays	**In-Network** $10 copay **Out-of-Network** 40% coinsurance	**In-Network** $10 copay **Out-of-Network** 35% coinsurance
Hearing Services		
Exam to Diagnose and Treat Hearing and Balance Issues	**In-Network** $0 copay **Out-of-Network** 40% coinsurance	**In-Network** $0 copay **Out-of-Network** 35% coinsurance
Routine Hearing Exam	**In-Network** $0 copay **Out-of-Network** 40% coinsurance *Limited to 1 visit every year*	**In-Network** $0 copay **Out-of-Network** 35% coinsurance *Limited to 1 visit every year*
Fitting-Evaluation(s) for Hearing Aids	**In-Network** $0 copay **Out-of-Network** 40% coinsurance *Limited to 1 visit every year*	**In-Network** $0 copay **Out-of-Network** 35% coinsurance *Limited to 1 visit every year*
Hearing Aids	Up to a $3,000 allowance for both ears combined every three years for hearing aids.	Up to a $3,000 allowance for both ears combined every three years for hearing aids.

	Bright Advantage Flex (PPO)	Bright Advantage Flex Plus (PPO)
Dental Services		
Medicare-covered Dental Services	**In-Network** $0 copay **Out-of-Network** 40% coinsurance	**In-Network** $0 copay **Out-of-Network** 35% coinsurance
Annual Dental Benefit Maximum	No benefit maximum for preventive dental services.	Up to a $1,000 benefit maximum for all in-network and out-of-network non-Medicare covered dental services every year.
Oral Exams	**In-Network** $0 copay **Out-of-Network** 30% coinsurance *Limited to 2 oral exams every year*	**In-Network** $0 copay **Out-of-Network** 30% coinsurance *Limited to 2 oral exams every year*
Prophylaxis (Cleaning)	**In-Network** $0 copay **Out-of-Network** 30% coinsurance *Limited to 2 cleanings every year*	**In-Network** $0 copay **Out-of-Network** 30% coinsurance *Limited to 2 cleanings every year*
Dental X-rays	**In-Network** $0 copay **Out-of-Network** 30% coinsurance *Limited to 2 x-rays every 3 years*	**In-Network** $0 copay **Out-of-Network** 30% coinsurance *Limited to 2 x-rays every 3 years*
Fluoride Treatment	**In-Network** $0 copay **Out-of-Network** 30% coinsurance *Limited to 1 fluoride treatment every year*	**In-Network** $0 copay **Out-of-Network** 30% coinsurance *Limited to 1 fluoride treatment every year*

	Bright Advantage Flex (PPO)	Bright Advantage Flex Plus (PPO)
Non-Routine Services	Available for an additional $18 monthly premium. Up to a $1,000 benefit maximum for all in-network and out-of-network non-Medicare covered dental services every year. Please see Evidence of Coverage for details.	**In-Network** 50% coinsurance **Out-of-Network** 75% coinsurance
Diagnostic Services		**In-Network** $0 copay **Out-of-Network** 30% coinsurance
Restorative Services		**In-Network** 30% - 50% coinsurance **Out-of-Network** 60% - 75% coinsurance
Endodontics		**In-Network** 50% coinsurance **Out-of-Network** 75% coinsurance
Periodontics		**In-Network** 50% coinsurance **Out-of-Network** 75% coinsurance
Extractions		**In-Network** 50% coinsurance **Out-of-Network** 75% coinsurance
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services		**In-Network** 50% coinsurance **Out-of-Network** 75% coinsurance
Vision Services		
Exam to Diagnose and Treat Diseases and Conditions of the Eye	**In-Network** $0 copay **Out-of-Network** 40% coinsurance	**In-Network** $0 copay **Out-of-Network** 35% coinsurance
Eyewear After Cataract Surgery	**In-Network** $0 copay **Out-of-Network** 40% coinsurance	**In-Network** $0 copay **Out-of-Network** 35% coinsurance

	Bright Advantage Flex (PPO)	Bright Advantage Flex Plus (PPO)
Routine Eye Exam	**In-Network** $0 copay **Out-of-Network** $0 copay (up to $45 benefit maximum) *Limited to 1 visit every year*	**In-Network** $0 copay **Out-of-Network** $0 copay (up to $45 benefit maximum) *Limited to 1 visit every year*
Contact Lenses	**In-Network** $0-$60 copay **Out-of-Network** $0-$60 copay (Benefit maximum applies. See Evidence of Coverage for details.)	**In-Network** $0-$60 copay **Out-of-Network** $0-$60 copay (Benefit maximum applies. See Evidence of Coverage for details.)
Eyeglasses (Lenses and Frames)	**In-Network** $25 copay **Out-of-Network** $25 copay (Benefit maximum applies. See Evidence of Coverage for details.)	**In-Network** $25 copay **Out-of-Network** $25 copay (Benefit maximum applies. See Evidence of Coverage for details.)
Eyewear Allowance	**In-Network** Up to a $130 allowance every two years for contact lenses or eyeglasses. **Out-of-Network** Benefit maximum depends on type of eyeglasses or contacts. See Evidence of Coverage for details.	**In-Network** Up to a $130 allowance every two years for contact lenses or eyeglasses. **Out-of-Network** Benefit maximum depends on type of eyeglasses or contacts. See Evidence of Coverage for details.
Mental Health Services		
Inpatient Visit	**In-Network** $295 copay per day for days 1-5 $0 copay per day for days 6-90 **Out-of-Network** 40% coinsurance	**In-Network** $250 copay per day for days 1-5 $0 copay per day for days 6-90 **Out-of-Network** 35% coinsurance
Outpatient Group Therapy Visit	**In-Network** $20 copay **Out-of-Network** 40% coinsurance	**In-Network** $20 copay **Out-of-Network** 35% coinsurance
Outpatient Individual Therapy Visit	**In-Network** $40 copay **Out-of-Network** 40% coinsurance	**In-Network** $40 copay **Out-of-Network** 35% coinsurance

	Bright Advantage Flex (PPO)	Bright Advantage Flex Plus (PPO)
Skilled Nursing Facility (SNF) Care	**In-Network** $0 copay per day for days 1-20 $172 copay per day for days 21-100 **Out-of-Network** 40% coinsurance	**In-Network** $0 copay per day for days 1-20 $172 copay per day for days 21-100 **Out-of-Network** 35% coinsurance
Physical Therapy, Occupational Therapy, or Speech Therapy Visit	**In-Network** $25 copay **Out-of-Network** 40% coinsurance	**In-Network** $25 copay **Out-of-Network** 35% coinsurance
Ambulance Services		
Ground Ambulance	**In-Network** $175 copay **Out-of-Network** $175 copay	**In-Network** $175 copay **Out-of-Network** $175 copay
Air Ambulance	**In-Network** $225 copay **Out-of-Network** $225 copay	**In-Network** $225 copay **Out-of-Network** $225 copay
Transportation	Not Covered	Not Covered
Medicare Part B Prescription Drugs		
Chemotherapy Drugs	**In-Network** 20% coinsurance **Out-of-Network** 40% coinsurance	**In-Network** 20% coinsurance **Out-of-Network** 35% coinsurance
Other Part B Drugs	**In-Network** 20% coinsurance **Out-of-Network** 40% coinsurance	**In-Network** 20% coinsurance **Out-of-Network** 35% coinsurance
Foot Care (Podiatry Services)		
Medicare-covered Foot Exams & Treatment	**In-Network** $25 copay **Out-of-Network** 40% coinsurance	**In-Network** $25 copay **Out-of-Network** 35% coinsurance

	Bright Advantage Flex (PPO)	Bright Advantage Flex Plus (PPO)
Medical Equipment / Supplies		
Durable Medical Equipment (e.g., wheelchairs, oxygen)	**In-Network** 20% coinsurance **Out-of-Network** 40% coinsurance	**In-Network** 20% coinsurance **Out-of-Network** 35% coinsurance
Prosthetics (e.g., braces, artificial limbs)	**In-Network** 20% coinsurance **Out-of-Network** 40% coinsurance	**In-Network** 20% coinsurance **Out-of-Network** 35% coinsurance
Diabetic Monitoring Supplies	**In-Network** $0 copay **Out-of-Network** 40% coinsurance	**In-Network** $0 copay **Out-of-Network** 35% coinsurance
Therapeutic Shoes or Inserts	**In-Network** $0 copay **Out-of-Network** 40% coinsurance	**In-Network** $0 copay **Out-of-Network** 35% coinsurance
Outpatient Surgery		
Ambulatory Surgical Center	**In-Network** $200 copay **Out-of-Network** 40% coinsurance	**In-Network** $150 copay **Out-of-Network** 35% coinsurance
Outpatient Hospital Facility	**In-Network** $300 copay **Out-of-Network** 40% coinsurance	**In-Network** $250 copay **Out-of-Network** 35% coinsurance
Acupuncture Services	$20 copay Limited to 12 visits every year within network of participating acupuncturists	$20 copay Limited to 12 visits every year within network of participating acupuncturists
Fitness Program	$0 copay at participating locations	$0 copay at participating locations

*The annual out-of-pocket maximum does not apply to Part D prescription drugs or Bright Health Extra Benefits.

Some services may require prior authorization. Refer to your Evidence of Coverage for details.

Bright Health plans are HMOs and PPOs with a Medicare contract. Our SNPs also have contracts with State Medicaid programs. Our plans are issued through Bright Health Insurance Company or one of its affiliates. Enrollment in our plans depends on contract renewal.

To enroll in a Bright Health Medicare Advantage Plan, you must be entitled to Medicare Part A, enrolled in Medicare Part B, and live in the plan's service area.

Bright Health Extra Benefits Information

To find network providers for the following services, call Bright Health Member Services at 844-202-4974, 8 am - 8 pm local time, 7 days a week Oct. 1-Mar. 31, Monday-Friday Apr. 1-Sept. 30, TTY:711.

- Hearing
- Vision
- Dental
- Acupuncture

Fitness Membership: Offered through Silver&Fit® Fitness program. To find a participating facility near you, call Bright Member Services at 844-202-4974, 8 am - 8 pm local time, 7 days a week Oct. 1-Mar. 31, Monday-Friday Apr. 1-Sept. 30, TTY:711.

Over-the-Counter (OTC): Offered through InComm. For more information, call Bright Member Services at 844-202-4974, 8 am - 8 pm local time, 7 days a week Oct. 1-Mar. 31, Monday-Friday Apr. 1-Sept. 30, TTY:711.

Prescription Drug Benefits

The chart below outlines your costs. The tier your drugs are in will determine how much you will pay. Generally, the higher the tier, the higher the cost.

Prescription Drug Coverage	Bright Advantage Flex (PPO)		Bright Advantage Flex Plus (PPO)	
Stage 1: Annual Prescription Deductible				
Deductible	$200 for Tiers 3-5. For all other drugs, you will not have to pay any deductible and will start receiving coverage immediately.		$0 This plan has no deductible for Part D drugs, this payment stage doesn't apply.	
Stage 2: Initial Coverage (after you pay your deductible, if applicable)				
	Standard retail cost-sharing (30-day / 90-day supply)	**Standard mail-order cost-sharing** (up to a 90-day supply)	**Standard retail cost-sharing** (30-day / 90-day supply)	**Standard mail-order cost-sharing** (up to a 90-day supply)
Tier 1 (Preferred Generic)	$0/$0 copay	$0 copay	$0/$0 copay	$0 copay
Tier 2 (Generic)	$10/$30 copay	$30 copay	$8/$24 copay	$0 copay
Tier 3 (Preferred Brand)	$45/$135 copay	$135 copay	$45/$135 copay	$135 copay
Tier 4 (Non-Preferred Drug)	$95/$285 copay	$285 copay	$95/$285 copay	$285 copay
Tier 5 (Specialty Tier)	29% coinsurance	29% coinsurance	33% coinsurance	33% coinsurance
Stage 3: Coverage Gap				
After your yearly total drug costs (including what our plan has paid and what you have paid) reach $3,820, you will enter the coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. Not everyone will enter the coverage gap. If you enter the coverage gap, you will pay no more than 37% coinsurance for covered generic drugs or 25% coinsurance for covered brand name drugs until your costs total $5,100, which is the end of the coverage gap.				
Stage 4: Catastrophic Coverage				
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $5,100, you pay the greater of: • 5% coinsurance, or • $3.40 copay for generic (including brand drugs treated as generic) and a $8.50 copay for all other drugs.				

Long-term care facilities

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

Out-of-network pharmacies

If you choose to get drugs from an out-of-network pharmacy, you will pay the full cost of the prescription. The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Extra Help

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify 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 http://www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

ATENCIÓN: Si usted habla español, tiene a su disposición servicios de asistencia de idioma gratuitos. Llame al 844-667-5502 (TTY: 711).

注意: 如果您说普通话, 您可以使用免费的语言帮助服务。请致电 844-667-5502（听障专线: 711）.

Our plans are issued through Bright Health Insurance Company or one of its affiliates. Other providers and pharmacies are available in our network. Most network providers participate through our Care Partner.

Out-of-network/noncontracted providers are under no obligation to treat Bright Health members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

This information is not a complete description of benefits. Call 844-667-5502 (TTY: 711) for more information.

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 844-667-5502.

Understand the Benefits

- Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit www.brighthealthplan.com/medicare or call 844-667-5502 to view a copy of the EOC.
- Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understand Important Rules

- In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- Benefits, premiums and/or copays/co-insurance may change on January 1 of each year.
- Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.

bright[SM] HEALTH

Nondiscrimination Notice and Assistance with Communication

Bright Health does not exclude, deny benefits to, or otherwise discriminate against any individual on the basis of sex, age, race, color, national origin, or disability. “Bright Health” means Bright Health plans and their affiliates, which are listed below.

Language assistance and alternate formats:
Assistance is available *at no cost* to help you communicate with us. The services include, but are not limited to:

- Interpreters for languages other than English;
- Written information in alternative formats such as large print; and
- Assistance with reading Bright Health websites.

To ask for help with these services, please call (844) 606-4633.

If you think that we failed to provide language assistance or alternate formats, or you were discriminated against because of your sex, age, race, color, national origin, or disability, you can send a complaint to:

Bright Health Civil Rights Coordinator
PO Box 853943, Richardson, TX 75085-3943
Phone: (844) 202-2154
Fax: (800) 894-7742

You can also file a complaint with the U.S Dept. of Health and Human Services, the Office of Civil Rights:

- **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

If you need help with your complaint, please call (844) 202-2154.

"Bright Health” means Bright Health Insurance Company of Alabama, Inc; Bright Health Company of Arizona; Bright Health Insurance Company; Bright Health Insurance Company of Tennessee; Bright Health Insurance Company of Ohio, Inc.; Bright Health Insurance Company of New York.

Updated 06/29/2018

Section 1557 / Multi Language Insert

This information is available in other formats like large print. To ask for another format, please call (844) 606-4633.

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call (844) 606-4633.
Spanish (US)	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de ayuda con el idioma. Llame al (844) 606-4633.
Chinese (S)	注意：如果您讲中文，您可以获得免费的语言协助服务。请致电 (844) 606-4633。
Russian	ВНИМАНИЕ! Если Вы говорите по-русски, то услуги бесплатной языковой поддержки доступны Вам. Позвоните по телефону (844) 606-4633.
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (844) 606-4633 로 전화하십시오.
Haitian Creole	ATANSYON: Si w pale kreyòl ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele (844) 606-4633.
Italian	ATTENZIONE: se parla italiano, sono disponibili per Lei servizi di assistenza linguistica gratuiti. Chiami il numero (844) 606-4633.
Yiddish	אויפמערקאזמקייט: אויב איר רעדט יידיש, שפראך הילף סערוויסעס, פריי פון אָפּצאָל, זענען פאראן פאר אייך. רופט (844) 606-4633
Bengali	মনোযোগ দিন: আপনি যদি বাংলায় কথা বলেন, তাহলে ভাষা সহায়তা পরিষেবাগুলি, বিনামূল্যে, আপনার জন্য উপলব্ধ আছে। (844) 606-4633 নম্বরে ফোন করুন।
Arabic	تنبيه: إذا كنت تتكلم العربية، فإن خدمات المساعدة اللغوية متاحة لك من دون مقابل. اتصل على الرقم (844) 606-4633.
Polish	UWAGA: Jeżeli posługuje się Pan/ Pani językiem polskim, może Pan/ Pani skorzystać z bezpłatnej pomocy językowej. Prosimy zadzwonić pod numer (844) 606-4633.
French (FR)	REMARQUE : si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Appelez le (844) 606-4633.
Tagalog	PANSININ: Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyong pangwika. Tawagan ang (844) 606-4633.
Vietnamese	LƯU Ý: Nếu quý vị nói tiếng Việt, sẽ có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Hãy gọi số (844) 606-4633.
Navajo	DÍÍ BAA AKÓ NÍNÍZIN: Díí bee yáníłti'go Diné bizaad, saad bee áká'ánida'áwo'dęę', t'áá jiik'eh, ná hóló. Kojį' hódíílnih (844) 606-4633.
Urdu	توجہ دیں: اگر آپ اردو بولتے/بولتی ہیں، تو آپ کے لیے زبان سے متعلق اعانت کی خدمات، بلامعاوضہ دستیاب ہیں۔ 606-4633 (844) پر کال کریں۔
Japanese	ご注意：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。(844) 606-4633 までお電話ください。
Portuguese (BR)	ATENÇÃO: caso você fale português, há serviços gratuitos de assistência de idioma à sua disposição. Ligue para (844) 606-4633.
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie unter (844) 606-4633 an.
Persian Farsi	توجه: اگر زبان شما فارسی است، خدمات پشتیبانی زبانی به صورت رایگان در اختیار شماست. با 4633 -606 (844) تماس بگیرید.

For more information, call Bright Health: 844-667-5502

8 am - 8 pm local time

7 days a week Oct. 1-Mar. 31

Monday-Friday Apr. 1-Sept. 30

TTY: 711

or

Go online: www.brighthealthplan.com/medicare

Find Bright Health’s provider directory, pharmacy directory, and formulary (drug list) at www.brighthealthplan.com/medicare

2019 Abridged Formulary

(Partial List of Covered Drugs)

Bright Advantage (HMO)

Bright Advantage Plus (HMO)

Bright Advantage Choice (HMO-POS)

Bright Advantage Choice Plus (HMO-POS)

Bright Advantage Assist (HMO)

Bright Advantage Flex (PPO)

Bright Advantage Flex Plus (PPO)

Throughout this document all plans are referred to as "Bright Health."

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

HPMS Approved Formulary File 00019258, Version Number 6
This abridged formulary was updated on 08/27/2018.
This is not a complete list of drugs covered by our plan. For a complete listing or other questions, please contact us, Bright Health, using the Member Services number on your member ID card, 8am-8pm, local time, 7 days a week Oct 1 – March 31, Monday-Friday April 1- Sep 30 or, for TTY users 711, or visit www.BrightHealthPlan.com/Medicare.

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 877-878-1676 (TTY: 711).

ATENCIÓN: Si usted habla español, tiene a su disposición servicios de asistencia de idioma gratuitos. Llame 877-878-1676 (TTY: 711).

ATTENTION: if you speak Mandarin, language assistance services, free of charge, are available to you. Call 877-878-1676 (TTY: 711).

注意: 如果您说普通话, 您可以使用免费的语言帮助服务。请致电 877-878-1676（听障专线: 711）。

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 Bright Health. When it refers to "plan" or "our plan," it means Bright Health.

This document includes a a partial list of the drugs (formulary) for our plan which is current as of 08/27/2018. For a complete 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, 2020, and from time to time during the year.

What is the Bright Health Formulary?

A formulary is a list of covered drugs selected by Bright Health 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. Bright Health will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Bright Health network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

This document is a partial formulary and includes only some of the drugs covered by Bright Health. For a complete listing of all prescription drugs covered by Bright Health, please visit our website or call us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

Can the Formulary (drug list) change?

The Formulary may change at any time. You will receive notice when necessary. Generally, if you are taking a drug on our 2019 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2019 coverage year except when a new, less expensive generic drug becomes available, when new information about the safety or effectiveness of a drug is released, or the drug is removed from the market. (See bullets below for more information on changes that affect members

currently taking the drug.) Other types of formulary changes, such as removing a drug from our formulary, will not affect members who are currently taking the drug. It will remain available at the same cost-sharing for those members taking it for the remainder of the coverage year. Below are changes to the drug list that will also affect members currently taking a drug:

- **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 the steps you may take to request an exception, and you can also find information in the section below entitled "How do I request an exception to the Bright Health 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 we may make changes based on new clinical guidelines. If we remove drugs from our formulary, or 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 08/27/2018. To get updated information about the drugs covered by Bright Health, please contact us. Our contact information appears on the front and back cover pages. In the event of any CMS-approved, mid-year non-maintenance formulary changes, the formulary will be updated and posted to our website.

How do I use the Formulary?

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

Medical Condition

The formulary begins on page 8. 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 below. 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 on page 48. The Index provides an alphabetical list of all 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?

Bright Health 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:** Bright Health requires you [or your physician] to get prior authorization for certain drugs. This means that you will need to get approval from Bright Health before you fill your prescriptions. If you don't get approval, Bright Health may not cover the drug.

- **Quantity Limits:** For certain drugs, Bright Health limits the amount of the drug that Bright Health will cover. For example, Bright Health provides 60 capsules per prescription for Lyrica 300mg. This may be in addition to a standard one-month or three-month supply.

- **Step Therapy:** In some cases, Bright Health 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, Bright Health may not cover Drug B unless you try Drug A first. If Drug A does not work for you, Bright Health 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 8. You can also get more information about the restrictions applied to specific covered drugs by visiting our Web site. We have posted on line a document 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 Bright Health 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 Bright Health formulary?" on page 5 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 Member Services and ask if your drug is covered. This document includes only a partial list of covered drugs, so Bright Health may cover your drug. For more information, 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 learn that Bright Health does not cover your drug, you have two options:

- You can ask Member Services for a list of similar drugs that are covered by Bright Health. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by Bright Health.
- You can ask Bright Health to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the Bright Health Formulary?

You can ask Bright Health 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, Bright Health 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, Bright Health will only approve your request for an exception if the alternative drugs 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, or utilization restriction exception. **When you request a formulary 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. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum 30-day supply of medication. 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.

For members who are experiencing a level of care change (being admitted to or discharged from a LTC facility), early refill edits will not be used to limit appropriate and necessary access to their Part D benefit, and such enrollees will be allowed to access a refill upon admission or discharge.

For more information

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

If you have questions about Bright Health, 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 users should call 1-877-486-2048. Or, visit http://www.medicare.gov.

Bright Health's Formulary

The formulary below provides coverage information about the drugs covered by Bright Health. If you have trouble finding your drug in the list, turn to the Index that begins on page 48.

Remember: This is only a partial list of drugs covered by Bright Health. If your prescription is not in this partial formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages. The first column of the chart lists the drug name. Brand name drugs are capitalized (e.g., COLCRYS) and generic drugs are listed in lower-case italics (e.g., *celecoxib*).

The information in the Requirements/Limits column tells you if Bright Health has any special requirements for coverage of your drug.

Bright Health plans are HMOs and PPOs with a Medicare contract. Our SNPs also have contracts with State Medicaid programs. Our plans are issued through Bright Health Insurance Company or one of its affiliates. Enrollment in our plans depends on contract renewal.

Drug Name	Drug Tier	Requirements/Limits
ANALGESICS		
GOUT		
allopurinol tab	2	
colchicine w/ probenecid	3	
COLCRYS	3	QL (120 tabs / 30 days)
MITIGARE	3	QL (60 caps / 30 days)
probenecid	3	
ULORIC	3	ST
NSAIDS		
celecoxib CAPS 50mg	3	QL (240 caps / 30 days)
celecoxib CAPS 100mg	3	QL (120 caps / 30 days)
celecoxib CAPS 200mg	3	QL (60 caps / 30 days)
celecoxib CAPS 400mg	3	QL (30 caps / 30 days)
diclofenac potassium	3	QL (120 tabs / 30 days)
diclofenac sodium TB24; TBEC	2	
diflunisal	3	
etodolac CAPS; TABS	3	
etodolac TB24	4	
flurbiprofen TABS	3	
ibu tab 600mg	1	
ibu tab 800mg	1	
ibuprofen SUSP	3	
ibuprofen TABS 400mg, 600mg, 800mg	1	
ketoprofen cap 75mg	3	
meloxicam TABS	1	
naproxen TABS	1	
naproxen dr	2	
naproxen sodium TABS 275mg, 550mg	4	
piroxicam CAPS	3	
sulindac TABS	2	
OPIOID ANALGESICS		
acetaminophen w/ codeine 300-15mg	2	QL (400 tabs / 30 days)
acetaminophen w/ codeine 300-30mg	2	QL (360 tabs / 30 days)
acetaminophen w/ codeine 300-60mg	2	QL (180 tabs / 30 days)
acetaminophen w/ codeine soln	2	QL (2700 mL / 30 days)
tramadol hcl tab 50 mg	2	QL (240 tabs / 30 days)
tramadol-acetaminophen	3	QL (240 tabs / 30 days)
OPIOID ANALGESICS, CII		

Drug Name	Drug Tier	Requirements/Limits
endocet 5-325mg	3	QL (360 tabs / 30 days)
endocet 7.5-325mg	3	QL (240 tabs / 30 days)
endocet 10-325mg	3	QL (180 tabs / 30 days)
fentanyl citrate LPOP	5	QL (120 lozenges / 30 days), PA
fentanyl patch 12 mcg/hr	4	QL (10 patches / 30 days), PA
fentanyl patch 25 mcg/hr	4	QL (10 patches / 30 days), PA
fentanyl patch 50 mcg/hr	4	QL (10 patches / 30 days), PA
fentanyl patch 75 mcg/hr	4	QL (10 patches / 30 days), PA
fentanyl patch 100 mcg/hr	4	QL (10 patches / 30 days), PA
FENTORA	5	QL (120 tabs / 30 days), PA
hydroco/apap tab 5-325mg	2	QL (240 tabs / 30 days)
hydroco/apap tab 7.5-325	2	QL (180 tabs / 30 days)
hydroco/apap tab 10-325mg	2	QL (180 tabs / 30 days)
hydrocodone-acetaminophen 7.5-325 mg/15ml	4	QL (2700 mL / 30 days)
hydrocodone-ibuprofen tab 7.5-200 mg	3	QL (150 tabs / 30 days)
hydromorphone hcl LIQD	4	QL (600 mL / 30 days)
hydromorphone hcl TABS	3	QL (180 tabs / 30 days)
HYSINGLA ER	3	QL (30 tabs / 30 days), PA
lorcet hd tab 10-325mg	2	QL (180 tabs / 30 days)
lorcet plus tab 7.5-325	2	QL (180 tabs / 30 days)
lorcet tab 5-325mg	2	QL (240 tabs / 30 days)
methadone hcl SOLN 5mg/5ml, 10mg/5ml	3	QL (450 mL / 30 days), PA
methadone hcl 5mg	3	QL (90 tabs / 30 days), PA

Drug Name	Drug Tier	Requirements/Limits
methadone hcl 10mg	3	QL (90 tabs / 30 days), PA
morphine ext-rel tab 15mg, 30mg, 60mg, 100mg	3	QL (90 tabs / 30 days), PA
morphine ext-rel tab 200mg	3	QL (60 tabs / 30 days), PA
morphine sulfate TABS 15mg	3	QL (180 tabs / 30 days)
morphine sulfate TABS 30mg	3	QL (90 tabs / 30 days)
morphine sulfate oral soln 10mg/5ml	3	QL (900 mL / 30 days)
morphine sulfate oral soln 20mg/5ml	3	QL (750 mL / 30 days)
morphine sulfate oral soln 100mg/5ml	3	QL (180 mL / 30 days)
NUCYNTA ER 50mg, 100mg, 200mg, 250mg	3	QL (60 tabs / 30 days), PA
NUCYNTA ER 150mg	3	QL (90 tabs / 30 days), PA
oxycodone hcl CAPS	4	QL (180 caps / 30 days)
oxycodone hcl CONC	4	QL (180 mL / 30 days)
oxycodone hcl SOLN	4	QL (900 mL / 30 days)
oxycodone hcl TABS	3	QL (180 tabs / 30 days)
oxycodone w/ acetaminophen 2.5-325mg	3	QL (360 tabs / 30 days)
oxycodone w/ acetaminophen 5-325mg	3	QL (360 tabs / 30 days)
oxycodone w/ acetaminophen 7.5-325mg	3	QL (240 tabs / 30 days)
oxycodone w/ acetaminophen 10-325mg	3	QL (180 tabs / 30 days)

ANTI-INFECTIVES

ANTI-BACTERIALS - MISCELLANEOUS

amikacin sulfate SOLN	4	
gentamicin sulfate SOLN	3	
neomycin sulfate TABS	3	
tobramycin NEBU	5	NM, PA
tobramycin inj 10mg/ml	3	
tobramycin inj 80mg/2ml	3	

ANTI-INFECTIVES - MISCELLANEOUS

BILTRICIDE	3	
CAYSTON	5	NM, LA, PA
clindamycin cap 75mg	2	
clindamycin cap 300 mg	2	
clindamycin hcl cap 150 mg	2	
clindamycin phosphate inj	3	
clindamycin soln 75mg/5ml	4	
dapsone TABS	3	
imipenem-cilastatin	3	
ivermectin TABS	3	
linezolid inj	4	
linezolid susp	5	
linezolid tab 600mg	5	
methenamine hippurate	3	

Drug Name	Drug Tier	Requirements/Limits
metronidazole TABS	2	
metronidazole in nacl	2	
nitrofurantoin macrocrystal 50mg, 100mg	3	PA; PA applies if 70 years and older after a 90 day supply in a calendar year
nitrofurantoin monohyd macro	3	PA; PA applies if 70 years and older after a 90 day supply in a calendar year
SIVEXTRO	5	
sulfamethoxazole-trimethop ds	1	
sulfamethoxazole-trimethoprim susp	4	
sulfamethoxazole-trimethoprim tab 400-80mg	1	
trimethoprim TABS	2	
vancomycin hcl CAPS 125mg	4	
vancomycin hcl CAPS 250mg	5	
ANTIFUNGALS		
amphotericin b SOLR	3	B/D
fluconazole SUSR	3	
fluconazole TABS	2	
fluconazole inj nacl 200	3	
fluconazole inj nacl 400	3	
griseofulvin microsize SUSP	3	
griseofulvin microsize TABS	4	
griseofulvin ultramicrosize	4	
itraconazole CAPS	4	PA
ketoconazole TABS	3	PA
NOXAFIL SUSP	5	QL (630 mL / 30 days)
NOXAFIL TBEC	5	QL (93 tabs / 30 days)
nystatin TABS	3	
terbinafine hcl TABS	2	QL (90 tabs / year)
ANTIMALARIALS		
atovaquone-proguanil hcl	4	
chloroquine phosphate TABS	4	
mefloquine hcl	3	
PRIMAQUINE PHOSPHATE	3	
quinine sulfate CAPS	4	PA
ANTIRETROVIRAL AGENTS		
abacavir sulfate SOLN	4	
abacavir sulfate TABS	3	
atazanavir sulfate	5	
efavirenz CAPS 50mg	4	
efavirenz CAPS 200mg	5	
efavirenz TABS	5	

Drug Name	Drug Tier	Requirements/Limits
EMTRIVA	3	
fosamprenavir tab 700 mg	5	
ISENTRESS CHEW 25mg	3	
ISENTRESS CHEW 100mg	5	
ISENTRESS PACK	3	
ISENTRESS TABS	5	
lamivudine	3	
nevirapine tab 200mg	3	
nevirapine tb24	4	
NORVIR CAPS	3	
NORVIR SOLN	4	
PREZISTA SUSP	5	QL (400 mL / 30 days)
PREZISTA TABS 75mg	3	QL (480 tabs / 30 days)
PREZISTA TABS 150mg	5	QL (240 tabs / 30 days)
PREZISTA TABS 600mg	5	QL (60 tabs / 30 days)
PREZISTA TABS 800mg	5	QL (30 tabs / 30 days)
REYATAZ PACK	5	
ritonavir	3	
stavudine	3	
tenofovir disoproxil fumarate	5	
TIVICAY 10mg	3	
TIVICAY 25mg, 50mg	5	
TYBOST	4	
VIREAD POWD	5	
VIREAD TABS 150mg, 200mg, 250mg	5	
zidovudine cap 100mg	4	
zidovudine syp 50mg/5ml	4	
zidovudine tab 300mg	3	
ANTIRETROVIRAL COMBINATION AGENTS		
abacavir sulfate-lamivudine	3	
ATRIPLA	5	
EVOTAZ	5	
lamivudine-zidovudine	4	
TRUVADA TAB 100-150	5	QL (60 tabs / 30 days)
TRUVADA TAB 133-200	5	QL (30 tabs / 30 days)
TRUVADA TAB 167-250	5	QL (30 tabs / 30 days)
TRUVADA TAB 200-300	5	QL (30 tabs / 30 days)
ANTITUBERCULAR AGENTS		
ethambutol hcl TABS	3	
isoniazid TABS	1	
isoniazid syp 50mg/5ml	4	
rifampin CAPS	3	
SIRTURO	5	LA, PA
ANTIVIRALS		
acyclovir CAPS; TABS	2	

Drug Name	Drug Tier	Requirements/Limits
acyclovir SUSP	4	
entecavir	5	
EPCLUSA	5	NM, PA
famciclovir TABS	3	
HARVONI	5	NM, PA
lamivudine (hbv)	4	
MAVYRET	5	NM, PA
oseltamivir phosphate CAPS 30mg	3	QL (168 caps / year)
oseltamivir phosphate CAPS 45mg, 75mg	3	QL (84 caps / year)
oseltamivir phosphate SUSR	3	QL (1080 mL / year)
PEGASYS	5	NM, PA
PEGASYS PROCLICK 180mcg/0.5ml	5	NM, PA
REBETOL SOLN	5	NM
RELENZA DISKHALER	3	QL (6 inhalers / year)
ribasphere CAPS	3	NM
ribasphere TABS 200mg	4	NM
ribasphere TABS 400mg, 600mg	5	NM
ribavirin cap 200mg	3	NM
ribavirin tab 200mg	4	NM
rimantadine hydrochloride	3	
valacyclovir hcl TABS	3	
VOSEVI	5	NM, PA
ZEPATIER	5	NM, PA
CEPHALOSPORINS		
cefaclor CAPS	3	
cefaclor SUSR	4	
CEFACLOR ER TAB 500MG	4	
cefadroxil CAPS	2	
cefadroxil SUSR	3	
cefadroxil TABS	4	
cefazolin inj	3	
cefdinir CAPS	3	
cefdinir SUSR	4	
cefixime	4	
cefpodoxime proxetil SUSR	4	
cefpodoxime proxetil TABS	3	
cefprozil	3	
ceftazidime SOLR	3	
ceftriaxone sodium SOLR 1gm, 2gm, 10gm, 250mg, 500mg	3	
cefuroxime axetil	3	
cephalexin CAPS 250mg, 500mg	1	
cephalexin SUSR	3	
SUPRAX CAPS	3	
SUPRAX CHEW	4	

Drug Name	Drug Tier	Requirements/Limits
SUPRAX SUSR 500mg/5ml	3	
tazicef SOLR	3	
ERYTHROMYCINS/MACROLIDES		
azithromycin PACK; SOLR; SUSR	3	
azithromycin TABS	1	
clarithromycin TABS	3	
clarithromycin er	3	
clarithromycin for susp	4	
DIFICID	5	
ery-tab	4	
erythromycin base	4	
FLUOROQUINOLONES		
ciprofloxacin SUSR	4	
ciprofloxacin hcl tab 100mg	4	
ciprofloxacin hcl tab 250mg, 500mg, 750mg	1	
ciprofloxacin in d5w	3	
levofloxacin TABS	1	
levofloxacin in d5w	3	
levofloxacin inj 25mg/ml	4	
levofloxacin oral soln 25 mg/ml	4	
PENICILLINS		
amoxicillin CAPS; SUSR; TABS	1	
amoxicillin CHEW	2	
amoxicillin & pot clavulanate CHEW; TB12	4	
amoxicillin & pot clavulanate SUSR	3	
amoxicillin & pot clavulanate TABS	2	
ampicillin cap 500mg	2	
dicloxacillin sodium	3	
penicillin v potassium SOLR	2	
penicillin v potassium TABS	1	
TETRACYCLINES		
doxycycline (monohydrate) CAPS 50mg, 100mg	2	
doxycycline (monohydrate) TABS	3	
doxycycline hyclate CAPS	3	
doxycycline hyclate 20 mg	3	
doxycycline hyclate 100 mg	3	
minocycline hcl CAPS	3	
morgidox cap 1x50mg	3	
ANTINEOPLASTIC AGENTS		
ALKYLATING AGENTS		
cyclophosphamide CAPS	4	B/D
LEUKERAN	5	
ANTIMETABOLITES		

Drug Name	Drug Tier	Requirements/Limits
mercaptopurine TABS	4	
methotrexate sodium inj	2	B/D
BIOLOGIC RESPONSE MODIFIERS		
ERIVEDGE	5	NM, LA, PA
FARYDAK	5	NM, LA, PA
IBRANCE	5	NM, LA, PA
IDHIFA	5	NM, LA, PA
KISQALI	5	NM, PA
KISQALI FEMARA 200 DOSE	5	NM, PA
KISQALI FEMARA 400 DOSE	5	NM, PA
KISQALI FEMARA 600 DOSE	5	NM, PA
LYNPARZA	5	NM, LA, PA
NINLARO	5	NM, PA
ODOMZO	5	NM, LA, PA
RUBRACA	5	NM, LA, PA
VENCLEXTA 10mg, 50mg	4	NM, LA, PA
VENCLEXTA 100mg	5	NM, LA, PA
VENCLEXTA STARTING PACK	5	NM, LA, PA
VERZENIO	5	NM, LA, PA
ZEJULA	5	NM, LA, PA
ZOLINZA	5	NM, PA
HORMONAL ANTINEOPLASTIC AGENTS		
anastrozole TABS	2	
bicalutamide	3	
ERLEADA	5	NM, LA, PA
exemestane	4	
flutamide	3	
letrozole TABS	2	
leuprolide inj 1mg/0.2	3	NM, PA
LUPRON DEPOT (1-MONTH) 3.75mg	5	NM, PA
LUPRON DEPOT INJ 11.25MG (3-MONTH)	5	NM, PA
LYSODREN	3	
megestrol ac sus 40mg/ml	4	
megestrol ac tab 20mg	3	
megestrol ac tab 40mg	3	
megestrol sus 625mg/5ml	4	PA
tamoxifen citrate TABS	1	
TRELSTAR DEP INJ 3.75MG	5	NM, PA
TRELSTAR LA INJ 11.25MG	5	NM, PA
XTANDI	5	NM, LA, PA
ZYTIGA	5	NM, LA, PA
IMMUNOMODULATORS		
POMALYST	5	NM, LA, PA
REVLIMID	5	QL (28 caps / 28 days), NM, LA, PA

Drug Name	Drug Tier	Requirements/Limits
THALOMID 50mg, 100mg	5	QL (30 caps / 30 days), NM, PA
THALOMID 150mg, 200mg	5	QL (60 caps / 30 days), NM, PA
KINASE INHIBITORS		
AFINITOR	5	QL (30 tabs / 30 days), NM, PA
AFINITOR DISPERZ 2mg	5	QL (150 tabs / 30 days), NM, PA
AFINITOR DISPERZ 3mg	5	QL (90 tabs / 30 days), NM, PA
AFINITOR DISPERZ 5mg	5	QL (60 tabs / 30 days), NM, PA
ALECENSA	5	NM, LA, PA
ALUNBRIG	5	NM, LA, PA
BOSULIF	5	NM, PA
CABOMETYX	5	QL (30 tabs / 30 days), NM, LA, PA
CALQUENCE	5	NM, LA, PA
CAPRELSA	5	NM, LA, PA
COMETRIQ	5	NM, LA, PA
COTELLIC	5	NM, LA, PA
GILOTRIF TAB 20MG	5	NM, LA, PA
GILOTRIF TAB 30MG	5	NM, LA, PA
GILOTRIF TAB 40MG	5	NM, LA, PA
ICLUSIG	5	NM, LA, PA
imatinib mesylate 100mg	5	QL (90 tabs / 30 days), NM, PA
imatinib mesylate 400mg	5	QL (60 tabs / 30 days), NM, PA
IMBRUVICA	5	NM, LA, PA
INLYTA 1mg	5	QL (180 tabs / 30 days), NM, LA, PA
INLYTA 5mg	5	QL (120 tabs / 30 days), NM, LA, PA
IRESSA	5	NM, LA, PA
JAKAFI	5	QL (60 tabs / 30 days), NM, LA, PA
LENVIMA 8 MG DAILY DOSE	5	NM, LA, PA
LENVIMA 10 MG DAILY DOSE	5	NM, LA, PA
LENVIMA 14 MG DAILY DOSE	5	NM, LA, PA
LENVIMA 18 MG DAILY DOSE	5	NM, LA, PA
LENVIMA 20 MG DAILY DOSE	5	NM, LA, PA
LENVIMA 24 MG DAILY DOSE	5	NM, LA, PA
MEKINIST	5	NM, LA, PA
NERLYNX	5	NM, LA, PA
NEXAVAR	5	NM, LA, PA

Drug Name	Drug Tier	Requirements/Limits
RYDAPT	5	NM, PA
SPRYCEL	5	NM, PA
STIVARGA	5	NM, LA, PA
SUTENT	5	NM, PA
TAFINLAR	5	NM, LA, PA
TAGRISSO	5	NM, LA, PA
TARCEVA 25mg	5	QL (90 tabs / 30 days), NM, LA, PA
TARCEVA 100mg, 150mg	5	QL (30 tabs / 30 days), NM, LA, PA
TASIGNA	5	NM, PA
TYKERB	5	NM, LA, PA
VOTRIENT	5	NM, LA, PA
XALKORI	5	NM, LA, PA
ZELBORAF	5	NM, LA, PA
ZYDELIG	5	NM, LA, PA
ZYKADIA	5	NM, LA, PA
MISCELLANEOUS		
bexarotene	5	NM, PA
hydroxyurea CAPS	2	
LONSURF	5	NM, PA
SYLATRON KIT 200MCG	5	NM, PA
SYLATRON KIT 300MCG	5	NM, PA
SYLATRON KIT 600MCG	5	NM, PA
SYNRIBO	5	NM, PA
PROTECTIVE AGENTS		
leucovorin calcium TABS	3	
MESNEX TABS	5	
CARDIOVASCULAR		
ACE INHIBITOR COMBINATIONS		
amlodipine besylate-benazepril hcl cap 2.5-10 mg	1	
amlodipine besylate-benazepril hcl cap 5-10 mg	1	
amlodipine besylate-benazepril hcl cap 5-20 mg	1	
amlodipine besylate-benazepril hcl cap 5-40 mg	1	
amlodipine besylate-benazepril hcl cap 10-20 mg	1	
amlodipine besylate-benazepril hcl cap 10-40 mg	1	
benazepril & hydrochlorothiazide	1	
captopril & hydrochlorothiazide	1	
enalapril maleate & hydrochlorothiazide	1	
fosinopril sodium & hydrochlorothiazide	1	

Drug Name	Drug Tier	Requirements/Limits
lisinopril & hydrochlorothiazide	1	
moexipril-hydrochlorothiazide	1	
quinapril-hydrochlorothiazide	1	
ACE INHIBITORS		
benazepril hcl TABS	1	
captopril TABS	1	
enalapril maleate TABS	1	
fosinopril sodium	1	
lisinopril TABS	1	
moexipril hcl	1	
perindopril erbumine	1	
quinapril hcl	1	
ramipril	1	
trandolapril	1	
ALDOSTERONE RECEPTOR ANTAGONISTS		
eplerenone	3	
spironolactone TABS	1	
ALPHA BLOCKERS		
doxazosin mesylate TABS	2	
prazosin hcl	3	
terazosin hcl	1	
ANGIOTENSIN II RECEPTOR ANTAGONIST COMBINATIONS		
amlodipine besylate-olmesartan medoxomil	1	
amlodipine besylate-valsartan tab	1	
amlodipine-valsartan-hydrochlorothiazide tab	1	
ENTRESTO	3	
irbesartan-hydrochlorothiazide	1	
losartan-hydrochlorothiazide	1	
olmesartan medoxomil-amlodipine-hydrochlorothiazide	1	
olmesartan medoxomil-hydrochlorothiazide	1	
valsartan-hydrochlorothiazide	1	
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
irbesartan	1	
losartan potassium	1	
olmesartan medoxomil TABS	1	
telmisartan	1	
valsartan	1	
ANTIARRHYTHMICS		
amiodarone tab 100mg	4	
amiodarone tab 200mg	1	
amiodarone tab 400mg	4	
dofetilide	4	NM
flecainide acetate	3	

Drug Name	Drug Tier	Requirements/Limits
MULTAQ	4	
pacerone 100mg, 400mg	4	
pacerone 200mg	1	
propafenone hcl	3	
propafenone hcl 12hr	4	
sotalol hcl	2	
sotalol hcl (afib/afl)	2	
ANTILIPEMICS, HMG-CoA REDUCTASE INHIBITORS		
atorvastatin calcium TABS	1	
lovastatin	1	
pravastatin sodium	1	
rosuvastatin calcium	1	QL (30 tabs / 30 days)
simvastatin TABS 5mg, 10mg, 20mg, 40mg	1	
simvastatin TABS 80mg	1	QL (30 tabs / 30 days)
ANTILIPEMICS, MISCELLANEOUS		
colesevelam hcl	3	
colestipol hcl tabs	3	
ezetimibe	4	
fenofibrate TABS 48mg, 54mg, 145mg, 160mg	3	
fenofibrate micronized 67mg, 134mg, 200mg	3	
gemfibrozil TABS	2	
JUXTAPID	5	NM, LA, PA
KYNAMRO	5	NM, PA
niacin er (antihyperlipidemic) 500mg	4	QL (90 tabs / 30 days)
niacin er (antihyperlipidemic) 750mg, 1000mg	4	
niacor	3	
PRALUENT	5	NM, PA
VASCEPA	4	
WELCHOL PAK	3	
BETA-BLOCKER/DIURETIC COMBINATIONS		
atenolol & chlorthalidone	2	
bisoprolol & hydrochlorothiazide	1	
metoprolol & hydrochlorothiazide	3	
propranolol & hydrochlorothiazide	3	
BETA-BLOCKERS		
acebutolol hcl CAPS	2	
atenolol TABS	1	
BYSTOLIC 2.5mg, 5mg, 10mg	4	QL (30 tabs / 30 days)
BYSTOLIC 20mg	4	QL (60 tabs / 30 days)
carvedilol	1	
labetalol hcl TABS	3	

Drug Name	Drug Tier	Requirements/Limits
metoprolol succinate	2	
metoprolol tartrate TABS 25mg, 50mg, 100mg	1	
pindolol	3	
propranolol cap er	3	
propranolol hcl TABS	3	
propranolol oral sol	3	
timolol maleate TABS	3	
CALCIUM CHANNEL BLOCKERS		
afeditab cr	3	
amlodipine besylate TABS	1	
cartia xt	3	
dilt-xr cap	3	
diltiazem cap 240mg cd	3	
diltiazem cap er/12hr	4	
diltiazem hcl TABS	2	
diltiazem hcl coated beads cap sr 24hr	3	
diltiazem hcl extended release beads cap sr	3	
felodipine	2	
nifedipine TB24	3	
nifedipine er	3	
taztia xt	3	
verapamil cap er 100mg, 120mg, 180mg, 200mg, 240mg, 300mg	3	
verapamil cap er 360mg	4	
verapamil hcl TABS	1	
verapamil hcl TBCR	2	
verapamil tab er	2	
DIGITALIS GLYCOSIDES		
digitek .25mg	3	PA; PA if 70 years and older
digitek .125mg	3	QL (30 tabs / 30 days)
digox 125mcg	3	QL (30 tabs / 30 days)
digox 250mcg	3	PA; PA if 70 years and older
digoxin TABS 125mcg	3	QL (30 tabs / 30 days)
digoxin TABS 250mcg	3	PA; PA if 70 years and older
digoxin sol 50mcg/ml	4	PA; PA if 70 years and older
DIRECT RENIN INHIBITORS/COMBINATIONS		
TEKTURNA	4	
TEKTURNA HCT	4	
DIURETICS		
acetazolamide CP12	4	

Drug Name	Drug Tier	Requirements/Limits
acetazolamide TABS	3	
amiloride hcl TABS	3	
bumetanide inj 0.25/ml	3	
bumetanide tab	3	
chlorothiazide tabs	3	
chlorthalidone	3	
furosemide SOLN	2	
furosemide TABS	1	
furosemide inj	2	
hydrochlorothiazide CAPS; TABS	1	
methyclothiazide	3	
metolazone	3	
spironolactone & hydrochlorothiazide	3	
torsemide tabs	2	
triamterene & hydrochlorothiazide cap 37.5-25 mg	1	
triamterene & hydrochlorothiazide tabs	1	
MISCELLANEOUS		
clonidine hcl PTWK	4	
clonidine hcl TABS	1	
CORLANOR	4	
DEMSER	5	PA
hydralazine hcl TABS	2	
midodrine hcl	3	
NORTHERA	5	NM, LA, PA
RANEXA	3	
NITRATES		
isosorb mononitrate tab	2	
isosorbide dinitrate	3	
isosorbide dinitrate er	4	
isosorbide mononitrate er	2	
minitran	3	
NITRO-BID	3	
NITRO-DUR DIS 0.8MG/HR	4	
nitroglycerin SUBL	3	
nitroglycerin td patch	3	
PULMONARY ARTERIAL HYPERTENSION		
ADEMPAS	5	QL (90 tabs / 30 days), NM, LA, PA
LETAIRIS	5	QL (30 tabs / 30 days), NM, LA, PA
OPSUMIT	5	QL (30 tabs / 30 days), NM, LA, PA
sildenafil citrate tab 20 mg (pulmonary hypertension)	3	QL (90 tabs / 30 days), NM, PA

Drug Name	Drug Tier	Requirements/Limits
TRACLEER TABS 62.5mg	5	QL (120 tabs / 30 days), NM, LA, PA
TRACLEER TABS 125mg	5	QL (60 tabs / 30 days), NM, LA, PA
VENTAVIS	5	NM, PA
CENTRAL NERVOUS SYSTEM		
ANTIANXIETY		
alprazolam tab 0.5mg	2	QL (150 tabs / 30 days)
alprazolam tab 0.25mg	2	QL (150 tabs / 30 days)
alprazolam tab 1mg	2	QL (150 tabs / 30 days)
alprazolam tab 2 mg	2	QL (150 tabs / 30 days)
buspirone hcl TABS 5mg, 7.5mg, 10mg, 15mg	2	
buspirone hcl TABS 30mg	4	
fluvoxamine maleate TABS	2	
lorazepam TABS	2	QL (150 tabs / 30 days)
lorazepam intensol	3	QL (150 mL / 30 days)
ANTICONVULSANTS		
APTIOM 200mg	5	QL (180 tabs / 30 days)
APTIOM 400mg	5	QL (90 tabs / 30 days)
APTIOM 600mg, 800mg	5	QL (60 tabs / 30 days)
BANZEL SUS 40MG/ML	5	PA
BANZEL TAB 200MG	5	PA
BANZEL TAB 400MG	5	PA
BRIVIACT SOL 10MG/ML	5	PA
BRIVIACT TAB 10MG	5	PA
BRIVIACT TAB 25MG	5	PA
BRIVIACT TAB 50MG	5	PA
BRIVIACT TAB 75MG	5	PA
BRIVIACT TAB 100MG	5	PA
carbamazepine CHEW; TABS	3	
carbamazepine CP12; SUSP; TB12	4	
clonazepam TABS 2mg	2	QL (300 tabs / 30 days)
clonazepam TABS .5mg, 1mg	2	QL (90 tabs / 30 days)
clonazepam TBDP 2mg	3	QL (300 tabs / 30 days)
clonazepam TBDP .125mg, .25mg, .5mg, 1mg	3	QL (90 tabs / 30 days)
clorazepate dipotassium	4	QL (180 tabs / 30 days), PA; PA if 65 years and older
diazepam TABS	2	QL (120 tabs / 30 days), PA; PA if 65 years and older
diazepam intensol	3	QL (240 mL / 30 days), PA; PA if 65 years and older

Drug Name	Drug Tier	Requirements/Limits
diazepam oral soln 1 mg/ml	3	QL (1200 mL / 30 days), PA; PA if 65 years and older
DILANTIN CAP 30MG	3	
DILANTIN CAP 100MG	3	
DILANTIN CHEW TAB 50MG	3	
DILANTIN-125 SUSP	4	
divalproex sodium CSDR; TB24	4	
divalproex sodium TBEC	3	
epitol	3	
FYCOMPA SUSP	5	QL (720 mL / 30 days), PA
FYCOMPA TABS 2mg	4	QL (60 tabs / 30 days), PA
FYCOMPA TABS 4mg, 6mg	5	QL (60 tabs / 30 days), PA
FYCOMPA TABS 8mg, 10mg, 12mg	5	QL (30 tabs / 30 days), PA
gabapentin CAPS 100mg	2	QL (1080 caps / 30 days)
gabapentin CAPS 300mg	2	QL (360 caps / 30 days)
gabapentin CAPS 400mg	2	QL (270 caps / 30 days)
gabapentin SOLN	3	QL (2160 mL / 30 days)
gabapentin TABS 600mg	3	QL (180 tabs / 30 days)
gabapentin TABS 800mg	3	QL (120 tabs / 30 days)
lamotrigine CHEW	3	
lamotrigine TABS	2	
lamotrigine TB24	4	
levetiracetam TABS; TB24	3	
levetiracetam oral soln 100 mg/ml	3	
LYRICA CAPS 25mg, 50mg, 75mg, 100mg, 150mg	3	QL (120 caps / 30 days)
LYRICA CAPS 200mg	3	QL (90 caps / 30 days)
LYRICA CAPS 225mg, 300mg	3	QL (60 caps / 30 days)
LYRICA SOLN	3	QL (946 mL / 30 days)
ONFI	5	PA
oxcarbazepine SUSP	4	
oxcarbazepine TABS	3	
phenobarbital ELIX	4	PA; PA if 70 years and older
phenobarbital TABS	3	PA; PA if 70 years and older
PHENYTEK	3	
phenytoin CHEW; SUSP	3	
phenytoin sodium extended	3	
primidone TABS	2	
roweepra	3	

Drug Name	Drug Tier	Requirements/Limits
roweepra xr	3	
SABRIL TABS	5	QL (180 tabs / 30 days), NM, LA, PA
tiagabine hcl	4	
topiramate CPSP	3	
topiramate TABS	2	
valproate sodium oral soln	3	
valproic acid	3	
vigabatrin powd pack 500mg	5	QL (180 packets / 30 days), NM, LA, PA
VIMPAT 50mg	4	QL (120 tabs / 30 days)
VIMPAT 100mg, 150mg, 200mg	5	QL (60 tabs / 30 days)
VIMPAT SOL 10MG/ML	5	QL (1200 mL / 30 days)
zonisamide CAPS	3	
ANTIDEMENTIA		
donepezil hydrochloride TABS 5mg	2	QL (30 tabs / 30 days)
donepezil hydrochloride TABS 10mg	2	
donepezil hydrochloride TBDP 5mg	2	QL (30 tabs / 30 days)
donepezil hydrochloride TBDP 10mg	2	
galantamine hydrobromide SOLN	4	
galantamine hydrobromide TABS	4	QL (60 tabs / 30 days)
galantamine hydrobromide er	4	QL (30 caps / 30 days)
memantine hcl cp24	4	PA; PA if < 30 yrs
memantine soln	4	PA; PA if < 30 yrs
memantine tabs	3	PA; PA if < 30 yrs
NAMZARIC	4	
rivastigmine tartrate 1.5mg, 3mg	4	QL (90 caps / 30 days)
rivastigmine tartrate 4.5mg, 6mg	4	QL (60 caps / 30 days)
rivastigmine td patch 24hr 4.6 mg/24hr	4	QL (30 patches / 30 days)
rivastigmine td patch 24hr 9.5 mg/24hr	4	QL (30 patches / 30 days)
rivastigmine td patch 24hr 13.3 mg/24hr	4	QL (30 patches / 30 days)
ANTIDEPRESSANTS		
amitriptyline hcl TABS	3	
amoxapine	3	
bupropion hcl TABS; TB24	3	
bupropion hcl TB12	2	
citalopram hydrobromide SOLN	3	
citalopram hydrobromide TABS	1	
clomipramine hcl CAPS	4	PA
desvenlafaxine succinate	4	QL (30 tabs / 30 days), PA
doxepin hcl CAPS; CONC	3	
duloxetine hcl CPEP 20mg	3	QL (180 caps / 30 days)

Drug Name	Drug Tier	Requirements/Limits
duloxetine hcl CPEP 30mg	3	QL (120 caps / 30 days)
duloxetine hcl CPEP 60mg	3	QL (60 caps / 30 days)
EMSAM	5	QL (30 patches / 30 days), PA
escitalopram oxalate SOLN	4	
escitalopram oxalate TABS	1	
FETZIMA 20mg	4	QL (180 caps / 30 days), PA
FETZIMA 40mg	4	QL (90 caps / 30 days), PA
FETZIMA 80mg, 120mg	4	QL (30 caps / 30 days), PA
FETZIMA TITRATION PACK	4	PA
fluoxetine cap 10mg	1	
fluoxetine cap 20mg	1	
fluoxetine cap 40mg	1	
fluoxetine hcl SOLN	2	
imipramine hcl TABS	3	
MARPLAN TAB 10MG	4	QL (180 tabs / 30 days)
mirtazapine TABS	2	
mirtazapine TBDP	3	
paroxetine hcl tabs	2	
PAXIL SUSP	4	QL (900 mL / 30 days)
phenelzine sulfate TABS	3	
sertraline hcl CONC	4	
sertraline hcl TABS	1	
trazodone hcl TABS 50mg, 100mg, 150mg	1	
trimipramine maleate CAPS 25mg	4	QL (240 caps / 30 days)
trimipramine maleate CAPS 50mg	4	QL (120 caps / 30 days)
trimipramine maleate CAPS 100mg	4	QL (60 caps / 30 days)
TRINTELLIX 5mg	4	QL (120 tabs / 30 days)
TRINTELLIX 10mg	4	QL (60 tabs / 30 days)
TRINTELLIX 20mg	4	QL (30 tabs / 30 days)
venlafaxine hcl CP24	2	
venlafaxine hcl TABS	3	
VIIBRYD STARTER PACK	4	
VIIBRYD TAB	4	QL (30 tabs / 30 days)
ANTIPARKINSONIAN AGENTS		
amantadine hcl CAPS	3	QL (120 caps / 30 days)
amantadine hcl SYRP	2	
amantadine hcl TABS	3	
APOKYN	5	QL (20 cartridges / 30 days), NM, LA, PA
benztropine mesylate tab 0.5mg	3	PA; PA if 70 years and older

Drug Name	Drug Tier	Requirements/Limits
benztropine mesylate tab 1mg	3	PA; PA if 70 years and older
benztropine mesylate tab 2mg	3	PA; PA if 70 years and older
carbidopa-levodopa TABS	2	
carbidopa-levodopa TBCR	3	
carbidopa-levodopa TBDP	4	
NEUPRO	4	
pramipexole tab 0.5mg	2	
pramipexole tab 0.25mg	2	
pramipexole tab 0.75mg	2	
pramipexole tab 0.125mg	2	
pramipexole tab 1.5mg	2	
pramipexole tab 1mg	2	
ropinirole tab 0.5mg	2	
ropinirole tab 0.25mg	2	
ropinirole tab 1mg	2	
ropinirole tab 2mg	2	
ropinirole tab 3mg	2	
ropinirole tab 4mg	2	
ropinirole tab 5mg	2	
selegiline hcl CAPS; TABS	3	
trihexyphenidyl hcl	3	PA; PA if 70 years and older
ANTIPSYCHOTICS		
ABILIFY MAINTENA	5	QL (1 injection / 28 days)
aripiprazole odt	5	QL (60 tabs / 30 days)
aripiprazole oral solution 1 mg/ml	5	QL (900 mL / 30 days)
aripiprazole tab	4	QL (30 tabs / 30 days)
ARISTADA 441mg/1.6ml, 662mg/2.4ml, 882mg/3.2ml	5	QL (1 injection / 28 days)
ARISTADA 1064mg/3.9ml	5	QL (1 injection / 56 days)
clozapine odt 12.5mg, 25mg	4	PA
clozapine odt 100mg	4	QL (270 tabs / 30 days), PA
clozapine odt 150mg	4	QL (180 tabs / 30 days), PA
clozapine odt 200mg	5	QL (135 tabs / 30 days), PA
clozapine tab 25mg	3	
clozapine tab 50mg	3	
clozapine tab 100mg	4	QL (270 tabs / 30 days)
clozapine tab 200mg	4	QL (135 tabs / 30 days)
FANAPT	4	QL (60 tabs / 30 days)

Drug Name	Drug Tier	Requirements/Limits
FANAPT TITRATION PACK	4	
GEODON SOLR	4	QL (6 mL / 3 days)
haloperidol TABS	3	
haloperidol lactate inj 5mg/ml	3	
INVEGA SUST INJ 39 MG/0.25 ML	4	QL (1 injection / 28 days)
INVEGA SUST INJ 78 MG/0.5 ML	5	QL (1 injection / 28 days)
INVEGA SUST INJ 117 MG/0.75 ML	5	QL (1 injection / 28 days)
INVEGA SUST INJ 156MG/ML	5	QL (1 injection / 28 days)
INVEGA SUST INJ 234 MG/1.5 ML	5	QL (1 injection / 28 days)
INVEGA TRINZA	5	QL (1 injection / 90 days)
LATUDA 20mg, 60mg, 80mg	4	QL (60 tabs / 30 days)
LATUDA 40mg, 120mg	4	QL (30 tabs / 30 days)
loxapine succinate	3	
NUPLAZID TABS 17mg	5	QL (60 tabs / 30 days), NM, LA, PA
olanzapine SOLR	4	QL (3 vials / 1 day)
olanzapine TABS 2.5mg	3	QL (240 tabs / 30 days)
olanzapine TABS 5mg	3	QL (120 tabs / 30 days)
olanzapine TABS 7.5mg, 15mg, 20mg	3	QL (30 tabs / 30 days)
olanzapine TABS 10mg	3	QL (60 tabs / 30 days)
olanzapine TBDP 5mg, 15mg, 20mg	4	QL (30 tabs / 30 days)
olanzapine TBDP 10mg	4	QL (60 tabs / 30 days)
paliperidone 1.5mg, 3mg, 9mg	5	QL (30 tabs / 30 days)
paliperidone 6mg	5	QL (60 tabs / 30 days)
quetiapine fumarate TABS	2	
quetiapine fumarate TB24 50mg, 300mg, 400mg	4	QL (60 tabs / 30 days)
quetiapine fumarate TB24 150mg, 200mg	4	QL (30 tabs / 30 days)
REXULTI 1mg	5	QL (90 tabs / 30 days)
REXULTI 2mg	5	QL (60 tabs / 30 days)
REXULTI 3mg, 4mg	5	QL (30 tabs / 30 days)
REXULTI .5mg	5	QL (180 tabs / 30 days)
REXULTI .25mg	5	QL (360 tabs / 30 days)
RISPERDAL INJ 12.5MG	4	QL (2 injections / 28 days)
RISPERDAL INJ 25MG	4	QL (2 injections / 28 days)
RISPERDAL INJ 37.5MG	5	QL (2 injections / 28 days)
RISPERDAL INJ 50MG	5	QL (2 injections / 28 days)

Drug Name	Drug Tier	Requirements/Limits
risperidone SOLN	3	QL (240 mL / 30 days)
risperidone TABS	2	
risperidone TBDP .5mg	4	QL (90 tabs / 30 days)
risperidone TBDP .25mg, 1mg, 2mg, 3mg, 4mg	4	QL (60 tabs / 30 days)
SAPHRIS 2.5mg	4	QL (240 tabs / 30 days)
SAPHRIS 5mg	4	QL (120 tabs / 30 days)
SAPHRIS 10mg	4	QL (60 tabs / 30 days)
thioridazine hcl TABS	3	
trifluoperazine hcl	3	
VERSACLOZ	5	QL (600 mL / 30 days), PA
VRAYLAR 1.5mg	5	QL (60 caps / 30 days), PA
VRAYLAR 3mg, 4.5mg, 6mg	5	QL (30 caps / 30 days), PA
VRAYLAR THERAPY PACK	4	PA
ziprasidone hcl	4	QL (60 caps / 30 days)
ZYPREXA RELPREVV INJ 210MG	4	QL (2 vials / 28 days), PA
ATTENTION DEFICIT HYPERACTIVITY DISORDER		
amphetamine-dextroamphetamine cap sr 24hr 5 mg	4	QL (90 caps / 30 days)
amphetamine-dextroamphetamine cap sr 24hr 10 mg	4	QL (90 caps / 30 days)
amphetamine-dextroamphetamine cap sr 24hr 15 mg	4	QL (30 caps / 30 days)
amphetamine-dextroamphetamine cap sr 24hr 20 mg	4	QL (30 caps / 30 days)
amphetamine-dextroamphetamine cap sr 24hr 25 mg	4	QL (30 caps / 30 days)
amphetamine-dextroamphetamine cap sr 24hr 30 mg	4	QL (30 caps / 30 days)
amphetamine-dextroamphetamine tab 5 mg	3	QL (360 tabs / 30 days)
amphetamine-dextroamphetamine tab 7.5 mg	3	QL (240 tabs / 30 days)
amphetamine-dextroamphetamine tab 10 mg	3	QL (180 tabs / 30 days)
amphetamine-dextroamphetamine tab 12.5 mg	3	QL (90 tabs / 30 days)
amphetamine-dextroamphetamine tab 15 mg	3	QL (120 tabs / 30 days)
amphetamine-dextroamphetamine tab 20 mg	3	QL (90 tabs / 30 days)
amphetamine-dextroamphetamine tab 30 mg	3	QL (60 tabs / 30 days)

Drug Name	Drug Tier	Requirements/Limits
atomoxetine hcl 10mg, 18mg, 25mg	4	QL (120 caps / 30 days)
atomoxetine hcl 40mg	4	QL (60 caps / 30 days)
atomoxetine hcl 60mg, 80mg, 100mg	4	QL (30 caps / 30 days)
dexmethylphenidate hcl TABS 2.5mg, 5mg	3	QL (120 tabs / 30 days)
dexmethylphenidate hcl TABS 10mg	3	QL (60 tabs / 30 days)
guanfacine er (adhd)	3	PA; PA if 70 years and older
metadate er tab 20mg	4	QL (90 tabs / 30 days)
methylphenidate hcl TABS 5mg, 10mg	3	QL (180 tabs / 30 days)
methylphenidate hcl TABS 20mg	3	QL (90 tabs / 30 days)
methylphenidate hcl oral soln 5mg/5ml	4	QL (1800 mL / 30 days)
methylphenidate hcl oral soln 10mg/5ml	4	QL (900 mL / 30 days)
methylphenidate tab 10mg er	4	QL (90 tabs / 30 days)
methylphenidate tab 20mg er	4	QL (90 tabs / 30 days)
HYPNOTICS		
HETLIOZ	5	NM, LA, PA
SILENOR 3mg	3	QL (60 tabs / 30 days)
SILENOR 6mg	3	QL (30 tabs / 30 days)
temazepam 7.5mg	2	QL (30 caps / 30 days), PA; PA applies if 65 years and older after a 90 day supply in a calendar year
temazepam 15mg	2	QL (60 caps / 30 days), PA; PA applies if 65 years and older after a 90 day supply in a calendar year
zolpidem tartrate TABS	2	QL (30 tabs / 30 days), PA; PA applies if 70 years and older after a 90 day supply in a calendar year
MIGRAINE		
dihydroergotamine mesylate nasal	5	QL (8 mL / 30 days)
eletriptan hydrobromide	4	QL (12 tabs / 30 days)
naratriptan hcl	3	QL (12 tabs / 30 days)
rizatriptan benzoate	3	QL (18 tabs / 30 days)
rizatriptan benzoate odt	3	QL (18 tabs / 30 days)
sumatriptan SOLN 5mg/act	4	QL (24 inhalers / 30 days)
sumatriptan SOLN 20mg/act	4	QL (12 inhalers / 30 days)
sumatriptan inj 4mg/0.5ml	4	QL (18 injections / 30 days)

Drug Name	Drug Tier	Requirements/Limits
sumatriptan inj 6mg/0.5ml	4	QL (12 injections / 30 days)
sumatriptan succinate TABS	2	QL (12 tabs / 30 days)
zolmitriptan TABS	4	QL (12 tabs / 30 days)
zolmitriptan odt	4	QL (12 tabs / 30 days)
MISCELLANEOUS		
AUSTEDO 6mg	5	QL (60 tabs / 30 days), NM, LA, PA
AUSTEDO 9mg, 12mg	5	QL (120 tabs / 30 days), NM, LA, PA
lithium carbonate CAPS	1	
lithium carbonate TABS	2	
lithium carbonate er	2	
LITHIUM SOLN 8MEQ/5ML	4	
NUEDEXTA	4	QL (60 caps / 30 days), PA
pyridostigmine tab 60mg	3	
riluzole	3	
tetrabenazine 12.5mg	5	QL (240 tabs / 30 days), NM, PA
tetrabenazine 25mg	5	QL (120 tabs / 30 days), NM, PA
MULTIPLE SCLEROSIS AGENTS		
AMPYRA	5	NM, LA, PA
BETASERON	5	QL (14 syringes / 28 days), NM, PA
GILENYA	5	QL (28 caps / 28 days), NM, PA
glatiramer acetate 20mg/ml	5	QL (30 syringes / 30 days), NM, PA
glatiramer acetate 40mg/ml	5	QL (12 syringes / 28 days), NM, PA
glatopa 20mg/ml	5	QL (30 syringes / 30 days), NM, PA
glatopa 40mg/ml	5	QL (12 syringes / 28 days), NM, PA
MUSCULOSKELETAL THERAPY AGENTS		
baclofen TABS 10mg, 20mg	2	
cyclobenzaprine hcl TABS 5mg, 10mg	3	PA; PA if 70 years and older
tizanidine hcl TABS	2	
NARCOLEPSY/CATAPLEXY		
armodafinil 50mg	4	QL (90 tabs / 30 days), PA
armodafinil 150mg, 200mg, 250mg	4	QL (30 tabs / 30 days), PA

Drug Name	Drug Tier	Requirements/Limits
XYREM	5	QL (540 mL / 30 days), NM, LA, PA
PSYCHOTHERAPEUTIC-MISC		
buprenorphine hcl SUBL	3	QL (90 tabs / 30 days), PA
buprenorphine hcl-naloxone hcl sl	2	QL (90 tabs / 30 days)
bupropion hcl (smoking deterrent)	3	
CHANTIX	4	PA
CHANTIX CONTINUING MONTH	4	PA
CHANTIX STARTER PACK	4	PA
disulfiram TABS	3	
naloxone inj 0.4mg/ml	3	
naloxone inj 1mg/ml	3	
naltrexone hcl TABS	3	
NARCAN	3	
NICOTROL INHALER	4	
NICOTROL NS	4	
SUBOXONE MIS 2-0.5MG	4	QL (90 films / 30 days)
SUBOXONE MIS 4-1MG	4	QL (90 films / 30 days)
SUBOXONE MIS 8-2MG	4	QL (90 films / 30 days)
SUBOXONE MIS 12-3MG	4	QL (60 films / 30 days)
ENDOCRINE AND METABOLIC		
ANDROGENS		
ANADROL-50	5	PA
ANDRODERM	4	QL (30 patches / 30 days), PA
oxandrolone tab 2.5mg	3	PA
oxandrolone tab 10mg	4	PA
testosterone GEL 1%, 25mg/2.5gm, 50mg/5gm	4	QL (300 grams / 30 days), PA
testosterone cypionate SOLN	3	PA
testosterone enanthate SOLN	3	PA
ANTIDIABETICS, INJECTABLE		
ALCOHOL SWABS	3	
BASAGLAR KWIKPEN	3	
BD ULTRAFINE INSULIN SYRINGE	3	
BD ULTRAFINE/NANO PEN NEEDLES	3	
BYDUREON BCISE	3	QL (4 pens / 28 days)
BYDUREON INJ	3	QL (4 vials / 28 days)
BYDUREON PEN	3	QL (4 pens / 28 days)
BYETTA	4	QL (1 pen / 30 days)
FIASP	3	
FIASP FLEXTOUCH	3	
GAUZE PADS 2" X 2"	3	
HUMULIN R INJ U-500	5	B/D

Drug Name	Drug Tier	Requirements/Limits
HUMULIN R U-500 KWIKPEN	5	
INSULIN PEN NEEDLE	3	
INSULIN SAFETY NEEDLES	3	
INSULIN SYRINGE	3	
LEVEMIR	3	
LEVEMIR FLEXTOUCH	3	
NOVOLIN 70/30	3	(brand RELION not covered)
NOVOLIN N	3	(brand RELION not covered)
NOVOLIN R	3	(brand RELION not covered)
NOVOLOG	3	
NOVOLOG 70/30 FLEXPEN	3	
NOVOLOG FLEXPEN	3	
NOVOLOG MIX 70/30	3	
NOVOLOG PENFILL	3	
OZEMPIC INJ 0.25 OR 0.5MG/DOSE	3	QL (1 pen / 28 days)
OZEMPIC INJ 1MG/DOSE	3	QL (2 pens / 28 days)
SOLIQUA 100/33	3	QL (10 pens / 30 days)
TRESIBA FLEXTOUCH	3	
TRULICITY	3	QL (4 pens / 28 days)
VICTOZA	3	QL (3 pens / 30 days)
XULTOPHY 100/3.6	3	QL (5 pens / 30 days)
ANTIDIABETICS, ORAL		
acarbose	3	
FARXIGA 5mg	3	QL (60 tabs / 30 days)
FARXIGA 10mg	3	QL (30 tabs / 30 days)
glimepiride 1mg	1	QL (240 tabs / 30 days)
glimepiride 2mg	1	QL (120 tabs / 30 days)
glimepiride 4mg	1	QL (60 tabs / 30 days)
glip/metform tab 2.5-250mg	1	QL (240 tabs / 30 days)
glip/metform tab 2.5-500mg	1	QL (120 tabs / 30 days)
glip/metform tab 5-500mg	1	QL (120 tabs / 30 days)
glipizide TABS 5mg	1	QL (240 tabs / 30 days)
glipizide TABS 10mg	1	QL (120 tabs / 30 days)
glipizide TB24 2.5mg	1	QL (240 tabs / 30 days)
glipizide TB24 5mg	1	QL (120 tabs / 30 days)
glipizide TB24 10mg	1	QL (60 tabs / 30 days)
JANUMET	3	QL (60 tabs / 30 days)
JANUMET XR TAB 50-500MG	3	QL (60 tabs / 30 days)
JANUMET XR TAB 50-1000	3	QL (60 tabs / 30 days)
JANUMET XR TAB 100-1000	3	QL (30 tabs / 30 days)
JANUVIA	3	QL (30 tabs / 30 days)
JARDIANCE 10mg	3	QL (60 tabs / 30 days)
JARDIANCE 25mg	3	QL (30 tabs / 30 days)

Drug Name	Drug Tier	Requirements/Limits
JENTADUETO	3	QL (60 tabs / 30 days)
JENTADUETO TAB XR 2.5-1000 MG	3	QL (60 tabs / 30 days)
JENTADUETO TAB XR 5-1000 MG	3	QL (30 tabs / 30 days)
metformin er 500mg	1	QL (120 tabs / 30 days); (generic of GLUCOPHAGE XR)
metformin er 750mg	1	QL (60 tabs / 30 days); (generic of GLUCOPHAGE XR)
metformin hcl TABS 500mg	1	QL (150 tabs / 30 days)
metformin hcl TABS 850mg	1	QL (90 tabs / 30 days)
metformin hcl TABS 1000mg	1	QL (75 tabs / 30 days)
nateglinide	1	QL (90 tabs / 30 days)
pioglitazone hcl	1	QL (30 tabs / 30 days)
repaglinide 2mg	1	QL (240 tabs / 30 days)
repaglinide .5mg, 1mg	1	QL (120 tabs / 30 days)
SYNJARDY TAB 5-500MG	3	QL (120 tabs / 30 days)
SYNJARDY TAB 5-1000MG	3	QL (60 tabs / 30 days)
SYNJARDY TAB 12.5-500MG	3	QL (60 tabs / 30 days)
SYNJARDY TAB 12.5-1000MG	3	QL (60 tabs / 30 days)
SYNJARDY XR TAB 5-1000MG	3	QL (60 tabs / 30 days)
SYNJARDY XR TAB 10-1000MG	3	QL (60 tabs / 30 days)
SYNJARDY XR TAB 12.5-1000MG	3	QL (60 tabs / 30 days)
SYNJARDY XR TAB 25-1000MG	3	QL (30 tabs / 30 days)
TRADJENTA	3	QL (30 tabs / 30 days)
XIGDUO XR TAB 2.5-1000MG	3	QL (60 tabs / 30 days)
XIGDUO XR TAB 5-500MG	3	QL (60 tabs / 30 days)
XIGDUO XR TAB 5-1000MG	3	QL (60 tabs / 30 days)
XIGDUO XR TAB 10-500MG	3	QL (30 tabs / 30 days)
XIGDUO XR TAB 10-1000MG	3	QL (30 tabs / 30 days)
BISPHOSPHONATES		
alendronate sodium TABS	1	
ibandronate sodium TABS	3	B/D
CALCIUM RECEPTOR AGONISTS		
SENSIPAR 30mg, 90mg	5	B/D, QL (120 tabs / 30 days), NM
SENSIPAR 60mg	5	B/D, QL (60 tabs / 30 days), NM
CHELATING AGENTS		
JADENU	5	NM, LA, PA
JADENU SPRINKLE	5	NM, LA, PA
kionex sus 15gm/60ml	3	
sodium polystyrene sulfonate powder	3	
sps susp 15gm/60ml	3	
trientine hcl	5	PA
CONTRACEPTIVES		

Drug Name	Drug Tier	Requirements/Limits
cryselle-28	2	
medroxyprogesterone acetate (contraceptive)	2	
sprintec 28	2	
tri-sprintec	2	
ENDOMETRIOSIS		
danazol CAPS	4	
SYNAREL	5	
ENZYME REPLACEMENTS		
CARBAGLU	5	NM, LA, PA
CERDELGA	5	NM, PA
CYSTAGON	4	NM, LA, PA
KUVAN	5	NM, LA, PA
levocarnitine (metabolic modifiers)	4	B/D
miglustat	5	NM, PA
ORFADIN	5	NM, LA, PA
sodium phenylbutyrate	5	NM, PA
ESTROGENS		
estradiol PTWK	3	
estradiol vaginal cream	4	
estradiol vaginal tab	3	
estradiol valerate inj	3	
fyavolv	3	
jinteli	3	
norethindrone acetate-ethinyl estradiol	3	
yuvafem vaginal tablet 10mcg	3	
GLUCOCORTICOIDS		
DEXAMETHASONE CONC	4	
dexamethasone ELIX	3	
dexamethasone TABS	2	
fludrocortisone acetate TABS	2	
hydrocortisone TABS	3	
methylpred pak 4mg	2	
methylpred tab 4mg	3	B/D
methylpred tab 8mg	3	B/D
methylpred tab 16mg	3	B/D
methylpred tab 32mg	3	B/D
pred sod pho sol 5mg/5ml	4	B/D
prednisolone sol 15mg/5ml	2	B/D
prednisolone sol 25mg/5ml	4	B/D
PREDNISONE CON 5MG/ML	4	B/D
prednisone pak 5mg	2	
prednisone pak 10mg	2	
prednisone sol 5mg/5ml	4	B/D
prednisone tab 1mg	1	B/D

Drug Name	Drug Tier	Requirements/Limits
prednisone tab 2.5mg	1	B/D
prednisone tab 5mg	1	B/D
prednisone tab 10mg	1	B/D
prednisone tab 20mg	1	B/D
prednisone tab 50mg	1	B/D
GLUCOSE ELEVATING AGENTS		
GLUCAGEN HYPOKIT	3	
GLUCAGON EMERGENCY KIT	3	
PROGLYCEM SUS 50MG/ML	4	
MISCELLANEOUS		
calcitonin (salmon)	3	B/D
FORTEO	5	NM, PA
GENOTROPIN	5	NM, PA
GENOTROPIN MINIQUICK .2mg	4	NM, PA
GENOTROPIN MINIQUICK .4mg, .6mg, .8mg, 1mg, 1.2mg, 1.4mg, 1.6mg, 1.8mg, 2mg	5	NM, PA
INCRELEX	5	NM, LA, PA
KORLYM	5	NM, LA, PA
NATPARA	5	NM, PA
octreotide acetate 50mcg/ml, 100mcg/ml, 200mcg/ml	4	NM, PA
octreotide acetate 500mcg/ml, 1000mcg/ml	5	NM, PA
PROLIA	4	QL (1 injection / 180 days), NM
raloxifene tab 60mg	3	
SIGNIFOR	5	NM, LA, PA
SOMATULINE DEPOT	5	NM, PA
SOMAVERT	5	NM, LA, PA
TYMLOS	5	NM, PA
XGEVA	5	NM, PA
PHOSPHATE BINDER AGENTS		
AURYXIA	5	QL (360 tabs / 30 days)
calcium acetate (phosphate binder) CAPS	4	QL (360 caps / 30 days)
calcium acetate (phosphate binder) TABS	3	QL (360 tabs / 30 days)
sevelamer carbonate PACK 2.4gm	5	QL (180 packets / 30 days)
sevelamer carbonate PACK .8gm	5	QL (540 packets / 30 days)
sevelamer carbonate TABS	4	QL (540 tabs / 30 days)
PROGESTINS		
medroxyprogesterone acetate tab	1	
norethindrone acetate TABS	3	
THYROID AGENTS		
levothyroxine sodium TABS	2	

Drug Name	Drug Tier	Requirements/Limits
liothyronine sodium TABS	3	
methimazole TABS	2	
propylthiouracil TABS	3	
VASOPRESSINS		
desmopressin acetate spray refrigerated	4	
desmopressin acetate tabs	3	
STIMATE	5	NM
GASTROINTESTINAL		
ANTIEMETICS		
dronabinol	4	B/D, QL (60 caps / 30 days)
meclizine hcl TABS	2	
metoclopramide hcl SOLN	2	
metoclopramide hcl TABS	1	
ondansetron hcl TABS	3	B/D
ondansetron hcl oral soln	4	B/D
ondansetron odt	2	B/D
prochlorperazine maleate TABS	2	
prochlorperazine supp	4	
promethazine hcl SYRP; TABS	2	PA; PA if 70 years and older
scopolamine patch	4	QL (10 patches / 30 days), PA; PA if 70 years and older
ANTISPASMODICS		
dicyclomine hcl cap 10mg	3	
dicyclomine hcl tab 20mg	3	
glycopyrrolate TABS	3	
H2-RECEPTOR ANTAGONISTS		
famotidine SUSR	4	
famotidine TABS 20mg, 40mg	1	
ranitidine hcl TABS	1	
ranitidine syrup	3	
INFLAMMATORY BOWEL DISEASE		
APRISO	3	QL (120 caps / 30 days)
budesonide ec	5	
CANASA	4	
DELZICOL	4	
sulfasalazine TABS	2	
sulfasalazine ec	3	
LAXATIVES		
constulose	2	
gavilyte-g	2	
GOLYTELY	3	
lactulose	2	

Drug Name	Drug Tier	Requirements/Limits
MOVIPREP	4	
NULYTELY/FLAVOR PACKS	3	
peg 3350-kcl-sod bicarb-sod chloride-sod sulfate	2	
polyethylene glycol 3350 POWD	2	
SUPREP BOWEL PREP KIT	4	
MISCELLANEOUS		
alosetron hcl	5	PA
AMITIZA CAP 8MCG	3	QL (180 caps / 30 days)
AMITIZA CAP 24MCG	3	QL (60 caps / 30 days)
GATTEX	5	NM, LA, PA
LINZESS	3	QL (30 caps / 30 days)
loperamide hcl CAPS	2	
misoprostol TABS	3	
MOVANTIK 12.5mg	3	QL (60 tabs / 30 days)
MOVANTIK 25mg	3	QL (30 tabs / 30 days)
RELISTOR SOLN	5	PA
sucralfate TABS	3	
SYMPROIC	3	
ursodiol CAPS	3	
XIFAXAN 550mg	5	PA
PANCREATIC ENZYMES		
CREON	3	
ZENPEP	4	
PROTON PUMP INHIBITORS		
DEXILANT	4	QL (30 caps / 30 days)
esomeprazole magnesium	4	QL (30 caps / 30 days)
lansoprazole CPDR	3	QL (30 caps / 30 days)
omeprazole cap 10mg	1	
omeprazole cap 20mg	1	
omeprazole cap 40mg	1	
pantoprazole sodium tbec	2	
GENITOURINARY		
BENIGN PROSTATIC HYPERPLASIA		
alfuzosin hcl	2	QL (30 tabs / 30 days)
dutasteride CAPS	3	QL (30 caps / 30 days)
dutasteride-tamsulosin hcl	4	QL (30 caps / 30 days)
finasteride TABS 5mg	2	
tamsulosin hcl	2	
MISCELLANEOUS		
bethanechol chloride TABS	3	
potassium citrate (alkalinizer) er tabs	4	
URINARY ANTISPASMODICS		
MYRBETRIQ 25mg	4	QL (60 tabs / 30 days)
MYRBETRIQ 50mg	4	QL (30 tabs / 30 days)

Drug Name	Drug Tier	Requirements/Limits
oxybutynin chloride SYRP	3	
oxybutynin chloride TABS	3	
oxybutynin chloride TB24 5mg	3	QL (30 tabs / 30 days)
oxybutynin chloride TB24 10mg, 15mg	3	QL (60 tabs / 30 days)
tolterodine tartrate CP24	4	QL (30 caps / 30 days), ST
tolterodine tartrate TABS	4	ST
TOVIAZ	3	QL (30 tabs / 30 days)
trospium chloride TABS	3	QL (60 tabs / 30 days)
VESICARE	4	QL (30 tabs / 30 days)
VAGINAL ANTI-INFECTIVES		
clindamycin phosphate vaginal	3	
metronidazole vaginal	4	
terconazole vaginal	3	
HEMATOLOGIC		
ANTICOAGULANTS		
COUMADIN	3	
ELIQUIS	3	
ELIQUIS STARTER PACK	3	
enoxaparin sodium	4	
heparin sod inj 1000/ml	3	B/D
heparin sod inj 5000/ml	3	B/D
heparin sod inj 10000/ml	3	B/D
heparin sod inj 20000/ml	3	B/D
jantoven	1	
PRADAXA	4	
warfarin sodium	1	
XARELTO	3	
XARELTO STARTER PACK	3	
HEMATOPOIETIC GROWTH FACTORS		
GRANIX	5	NM, PA
NEUPOGEN	5	NM, PA
PROCRIT 2000unit/ml, 3000unit/ml, 4000unit/ml, 10000unit/ml	3	NM, PA
PROCRIT 20000unit/ml, 40000unit/ml	5	NM, PA
MISCELLANEOUS		
BERINERT	5	QL (24 boxes / 30 days), NM, LA, PA
cilostazol	2	
DROXIA	3	
ENDARI	5	NM, LA, PA
FIRAZYR	5	QL (9 syringes / 30 days), NM, PA
HAEGARDA 2000unit	5	QL (30 vials / 30 days), NM, LA, PA

Drug Name	Drug Tier	Requirements/Limits
HAEGARDA 3000unit	5	QL (20 vials / 30 days), NM, LA, PA
pentoxifylline TBCR	2	
PROMACTA 12.5mg	5	QL (360 tabs / 30 days), NM, LA, PA
PROMACTA 25mg	5	QL (180 tabs / 30 days), NM, LA, PA
PROMACTA 50mg	5	QL (90 tabs / 30 days), NM, LA, PA
PROMACTA 75mg	5	QL (60 tabs / 30 days), NM, LA, PA
tranexamic acid TABS	3	
PLATELET AGGREGATION INHIBITORS		
aspirin-dipyridamole	4	
BRILINTA	3	
clopidogrel tab 75mg	1	
prasugrel hcl	4	
ZONTIVITY	4	
IMMUNOLOGIC AGENTS		
DISEASE-MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS)		
HUMIRA 10mg/0.1ml, 20mg/0.2ml	5	QL (2 injections / 28 days), NM, PA
HUMIRA 40mg/0.4ml	5	QL (6 injections / 28 days), NM, PA
HUMIRA INJ 10MG/0.2ML	5	QL (2 syringes / 28 days), NM, PA
HUMIRA KIT 20MG/0.4ML	5	QL (2 syringes / 28 days), NM, PA
HUMIRA KIT 40MG/0.8ML	5	QL (6 syringes / 28 days), NM, PA
HUMIRA PEDIATRIC CROHNS DISEASE	5	NM, PA
HUMIRA PEN	5	QL (6 pens / 28 days), NM, PA
HUMIRA PEN INJ CD/UC/HS STARTER	5	NM, PA
HUMIRA PEN INJ PS/UV STARTER	5	NM, PA
hydroxychloroquine sulfate	3	
leflunomide TABS	3	
methotrexate sodium tabs	3	
XELJANZ	5	QL (60 tabs / 30 days), NM, PA
XELJANZ XR	5	QL (30 tabs / 30 days), NM, PA
IMMUNOGLOBULINS		
BIVIGAM	5	NM, PA
CARIMUNE NANOFILTERED	5	NM, PA
FLEBOGAMMA DIF	5	NM, PA

Drug Name	Drug Tier	Requirements/Limits
GAMMAGARD LIQUID	5	NM, PA
GAMMAGARD S/D	5	NM, PA
GAMMAKED	5	NM, PA
GAMMAPLEX	5	NM, PA
GAMMAPLEX 10GM/100ML	5	NM, PA
GAMUNEX-C	5	NM, PA
OCTAGAM	5	NM, PA
PRIVIGEN	5	NM, PA
IMMUNOMODULATORS		
ACTIMMUNE	5	NM, LA, PA
ARCALYST	5	NM, PA
INTRON-A INJ 10MU	5	B/D, NM
INTRON-A INJ 18MU	5	B/D, NM
INTRON-A INJ 25MU	5	B/D, NM
INTRON-A INJ 50MU	5	B/D, NM
IMMUNOSUPPRESSANTS		
azathioprine TABS	3	B/D
BENLYSTA	5	NM, PA
cyclosporine modified (for microemulsion)	4	B/D
mycophenolate mofetil CAPS; TABS	3	B/D
mycophenolate mofetil SUSR	5	B/D
mycophenolate sodium tbec	4	B/D
SANDIMMUNE SOLN 100mg/ml	3	B/D
tacrolimus CAPS	4	B/D
VACCINES		
ADACEL	3	
BOOSTRIX	3	
HAVRIX	3	
SHINGRIX	3	QL (2 vials per lifetime)
ZOSTAVAX	3	QL (1 vial per lifetime)
NUTRITIONAL/SUPPLEMENTS		
ELECTROLYTES		
klor-con 8	2	
klor-con 10	2	
klor-con m10	2	
KLOR-CON M15	3	
klor-con pak 20meq	4	
klor-con spr cap 8meq	3	
klor-con spr cap 10meq	3	
magnesium sulfate SOLN	3	
magnesium sulfate inj 50%	3	
potassium chloride CPCR	3	
potassium chloride SOLN	4	
potassium chloride TBCR	2	

Drug Name	Drug Tier	Requirements/Limits
potassium chloride microencapsulated crystals er	2	
sodium fluoride chew; tab; 1.1 (0.5 f) mg/ml soln	2	
IV NUTRITION		
INTRALIPID 30%	4	B/D
intralipid inj 20%	4	B/D
premasol 6%	4	B/D
PREMASOL 10%	4	B/D
IV REPLACEMENT SOLUTIONS		
dextrose 5%	2	
dextrose 5%/nacl 0.9%	2	
DEXTROSE 10%/NACL 0.2%	3	
sodium chloride 0.45%	2	
sodium chloride inj 0.9%	2	
VITAMINS		
calcitriol CAPS	3	B/D
calcitriol oral soln 1 mcg/ml	4	B/D
paricalcitol CAPS	4	B/D
PNV PRENATAL TAB PLUS	3	
OPHTHALMIC		
ANTI-INFECTIVE/ANTI-INFLAMMATORY		
bacitracin-poly-neomycin-hc	3	
neomycin-polymy-dexameth	2	
TOBRADEX OINT	3	
TOBRADEX ST	3	
tobramycin-dexamethasone	4	
ZYLET	3	
ANTI-INFECTIVES		
bacitracin (ophthalmic)	3	
BESIVANCE	3	
CILOXAN OINT	3	
ciprofloxacin hcl (ophth)	2	
erythromycin (ophth)	2	
gentak	2	
gentamicin sulfate soln (ophth)	2	
MOXEZA	3	
moxifloxacin hcl (ophth)	3	
neomycin-bacitracin zn-polymyxin	3	
neomycin-polymyxin-gramicidin	3	
ofloxacin (ophth)	2	
polymyxin b-trimethoprim	2	
sulfacetamide sodium (ophth)	3	
tobramycin (ophth)	2	
trifluridine SOLN	3	

Drug Name	Drug Tier	Requirements/Limits
ZIRGAN	4	
ANTI-INFLAMMATORIES		
ALREX	3	
dexamethasone sodium phosphate (ophth)	3	
diclofenac sodium (ophth)	3	
DUREZOL	3	
fluorometholone	3	
ILEVRO	3	
ketorolac tromethamine (ophth)	3	
LOTEMAX	3	
prednisolone acetate (ophth)	3	
PREDNISOLONE SODIUM PHOSPHATE (OPHTH)	3	
PROLENSA	3	
ANTIALLERGICS		
azelastine drop 0.05%	3	
BEPREVE	3	
cromolyn sodium (ophth)	1	
LASTACAFT	4	
olopatadine hcl 0.2%	4	
PAZEO	3	
ANTIGLAUCOMA		
ALPHAGAN P SOL 0.1%	3	
AZOPT	3	
betaxolol hcl (ophth)	3	
BETOPTIC-S	3	
brimonidine sol 0.2%	2	
brimonidine sol 0.15%	4	
COMBIGAN	3	
dorzolamide hcl	3	
dorzolamide hcl-timolol maleate	3	
latanoprost SOLN	2	
LUMIGAN	3	
metipranolol	3	
pilocarpine hcl SOLN	3	
SIMBRINZA	3	
timolol maleate (ophth) soln	1	
timolol maleate gel	4	
timolol maleate ophth soln 0.5% (once-daily)	4	
TRAVATAN Z	3	
MISCELLANEOUS		
CYSTARAN	5	NM, LA, PA
proparacaine hcl SOLN	3	

Drug Name	Drug Tier	Requirements/Limits
RESTASIS	3	QL (60 single use vials / 30 days)
RESPIRATORY		
ANTICHOLINERGIC/BETA AGONIST COMBINATIONS		
ANORO ELLIPTA	3	QL (60 blisters / 30 days)
BEVESPI AEROSPHERE	3	QL (1 inhaler / 30 days)
COMBIVENT RESPIMAT	4	QL (2 inhalers / 30 days)
ipratropium-albuterol nebu	3	B/D
TRELEGY ELLIPTA	3	QL (60 blisters / 30 days)
ANTICHOLINERGICS		
ATROVENT HFA	4	QL (2 inhalers / 30 days)
INCRUSE ELLIPTA	3	QL (30 blisters / 30 days)
ipratropium bromide SOLN	2	B/D
ipratropium bromide (nasal)	3	
ANTIHISTAMINES		
azelastine spr 0.1%	3	
azelastine spr 0.15%	4	
cetirizine syrup	2	
cyproheptadine hcl SYRP; TABS	3	PA; PA if 70 years and older
hydroxyzine hcl SYRP	3	PA; PA if 70 years and older
hydroxyzine hcl TABS	2	PA; PA if 70 years and older
hydroxyzine pamoate CAPS 25mg, 50mg	2	PA; PA if 70 years and older
levocetirizine dihydrochloride SOLN	4	
levocetirizine dihydrochloride TABS	2	
BETA AGONISTS		
albuterol sulfate NEBU	2	B/D
albuterol sulfate SYRP	3	
albuterol sulfate TABS; TB12	4	
levalbuterol hcl soln nebu conc 1.25 mg/0.5ml	4	B/D
levalbuterol tartrate hfa	3	QL (2 inhalers / 30 days)
SEREVENT DISKUS	3	QL (60 inhalations / 30 days)
VENTOLIN HFA	3	QL (2 inhalers / 30 days)
LEUKOTRIENE MODULATORS		

Drug Name	Drug Tier	Requirements/Limits
montelukast sodium CHEW; TABS	2	
montelukast sodium PACK	4	
zafirlukast	3	
MAST CELL STABILIZERS		
cromolyn sod neb 20mg/2ml	3	B/D
MISCELLANEOUS		
acetylcysteine SOLN 10%, 20%	3	B/D
ARALAST NP	5	NM, LA, PA
DALIRESP	4	
epinephrine (anaphylaxis) .15mg/0.15ml, .3mg/0.3ml	3	(generic of Adrenaclick)
ESBRIET	5	NM, PA
KALYDECO	5	NM, PA
OFEV	5	NM, PA
ORKAMBI TABS	5	NM, PA
PROLASTIN-C	5	NM, LA, PA
PULMOZYME	5	NM, PA
SYMDEKO	5	NM, LA, PA
THEO-24	4	
theophylline SOLN	4	
theophylline TB12; TB24	3	
XOLAIR	5	NM, LA, PA
ZEMAIRA	5	NM, LA, PA
NASAL STEROIDS		
flunisolide (nasal)	3	QL (3 bottles / 30 days)
fluticasone propionate (nasal)	2	QL (1 bottle / 30 days)
STEROID INHALANTS		
ARNUITY ELLIPTA	3	QL (30 inhalations / 30 days)
budesonide (inhalation) .25mg/2ml, .5mg/2ml	4	B/D
FLOVENT DISKUS 50mcg/blist, 100mcg/blist	3	QL (120 inhalations / 30 days)
FLOVENT DISKUS 250mcg/blist	3	QL (240 inhalations / 30 days)
FLOVENT HFA	3	QL (2 inhalers / 30 days)
PULMICORT FLEXHALER	4	QL (2 inhalers / 30 days)
STEROID/BETA-AGONIST COMBINATIONS		
ADVAIR DISKUS	3	QL (60 inhalations / 30 days)
ADVAIR HFA	3	QL (1 inhaler / 30 days)
BREO ELLIPTA	3	QL (60 blisters / 30 days)
SYMBICORT	3	QL (1 inhaler / 30 days)

Drug Name	Drug Tier	Requirements/Limits
TOPICAL		
DERMATOLOGY, ACNE		
amnesteem	4	PA
avita	4	PA
claravis	4	PA
clindacin-p	3	
clindamycin phosphate (topical) GEL; LOTN	4	
clindamycin phosphate (topical) SOLN; SWAB	3	
ery pad 2%	3	
erythromycin (acne aid) GEL	4	
erythromycin (acne aid) SOLN	3	
isotretinoin CAPS	4	PA
myorisan	4	PA
tretinoin CREA	4	PA
tretinoin GEL .01%, .025%	4	PA
zenatane	4	PA
DERMATOLOGY, ANTIBIOTICS		
gentamicin sulfate (topical)	3	
mupirocin OINT	2	
silver sulfadiazine CREA	2	
SULFAMYLON CREA	4	
DERMATOLOGY, ANTIFUNGALS		
ciclopirox CREA; SUSP	3	
ciclopirox GEL	4	
ciclopirox shampoo 1%	4	
clotrimazole (topical)	3	
clotrimazole w/ betamethasone CREA	3	
ketoconazole cream	3	
nyamyc	3	
nystatin (topical)	3	
nystop	3	
DERMATOLOGY, ANTIPSORIATICS		
acitretin	5	PA
calcipotriene CREA; OINT	4	QL (120 gm / 30 days), PA
calcipotriene SOLN	4	QL (120 mL / 30 days), PA
tazarotene CREA	3	PA
TAZORAC CREA .05%	4	PA
DERMATOLOGY, ANTISEBORRHEICS		
ketoconazole shampoo	2	
selenium sulfide LOTN	2	
DERMATOLOGY, CORTICOSTEROIDS		

Drug Name	Drug Tier	Requirements/Limits
ala-cort 1%	1	
ala-cort 2.5%	2	
alclometasone dipropionate	3	
betamethasone dipropionate (topical) CREA; LOTN	3	
betamethasone dipropionate (topical) OINT	4	
betamethasone dipropionate augmented CREA	3	
betamethasone dipropionate augmented GEL; LOTN; OINT	4	
betamethasone valerate CREA; LOTN; OINT	3	
fluocinonide GEL	4	
fluocinonide SOLN	3	
fluticasone propionate CREA; OINT	3	
halobetasol propionate	4	
hydrocortisone (topical) CREA 1%	1	
hydrocortisone (topical) CREA 2.5%	2	
hydrocortisone (topical) LOTN	3	
hydrocortisone (topical) OINT 2.5%	2	
mometasone furoate CREA	2	
mometasone furoate OINT; SOLN	3	
triamcinolone acetonide (topical) CREA; OINT	2	
triamcinolone acetonide (topical) LOTN	3	
DERMATOLOGY, LOCAL ANESTHETICS		
lidocaine PTCH	4	QL (3 patches / 1 day), PA
lidocaine hcl GEL	3	QL (30 mL / 30 days), PA
lidocaine hcl SOLN 4%	2	QL (50 mL / 30 days), PA
lidocaine oint 5%	4	QL (50 grams / 30 days), PA
lidocaine-prilocaine	3	QL (30 grams / 30 days), PA
DERMATOLOGY, MISCELLANEOUS SKIN AND MUCOUS MEMBRANE		
ammonium lactate CREA; LOTN	3	
diclofenac sodium (topical) 1% gel	3	PA
fluorouracil (topical) CREA 5%	4	
fluorouracil (topical) SOLN	3	
PICATO .05%	3	QL (2 tubes / 30 days)
PICATO .015%	3	QL (3 tubes / 30 days)
podofilox SOLN	3	
procto-med hc	3	

Drug Name	Drug Tier	Requirements/Limits
procto-pak	3	
proctosol hc cre 2.5%	3	
proctozone-hc	3	
tacrolimus (topical)	4	
TARGRETIN GEL	5	NM, PA
VALCHLOR	5	NM, LA, PA
DERMATOLOGY, SCABICIDES AND PEDICULIDES		
malathion	4	
permethrin cre 5%	3	
DERMATOLOGY, WOUND CARE AGENTS		
REGRANEX	5	PA
SANTYL	4	
sodium chlor sol 0.9% irr	2	
MOUTH/THROAT/DENTAL AGENTS		
chlorhexidine gluconate (mouth-throat)	1	
lidocaine hcl (mouth-throat)	2	
nystatin (mouth-throat)	3	
periogard	1	
triamcinolone acetonide (mouth)	3	
OTIC		
acetic acid (otic)	3	
CIPRODEX	3	
fluocinolone acetonide (otic)	4	
neomycin-polymyxin-hc (otic)	3	
ofloxacin (otic)	4	

Index

HPMS Approved Formulary File 00019258, Version Number 6.

This abridged formulary was updated on 08/27/2018. This is not a complete list of drugs covered by our plan. For a complete listing or other questions, please contact us, Bright Health, using the Member Services number on your member ID card, 8am-8pm, local time, 7 days a week Oct 1 – March 31, Monday-Friday April 1- Sep 30 or, for TTY users 711, or visit www.BrightHealthPlan.com/Medicare.

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Notes:

Enrollment Materials

Y0127_TEMPL-MA-MARC-2310_C

Ready to Enroll?

Here's how. It's Easy.

OPTION 1

Work with your certified Bright Health agent and schedule an appointment

Go online or call Bright Health to get help with the any part of the process.

OPTION 2

Call Bright Health 844-667-5502 (TTY: 711)

8am – 8pm local time, Monday – Sunday (October 1 – March 31),
Monday – Friday (April 1 – September 30)

OPTION 3

Go online at MedicareMadeBright.com

Follow the directions online to enroll in the plan you chose.

OPTION 4

Mail us your completed application

Simply fill out the enclosed enrollment form.

We're always here to help.

Robots are great and all, but when you call Bright Health, you'll speak to a real person ready to get you the answers you're looking for. If you ever have questions, give us a call.

Call us today at 844-667-5502 (TTY: 711)

Monday – Sunday (October 1 – March 31)

Monday – Friday (April 1 – September 30)

Bright Health plans are HMO's and PPO's with a Medicare contract. Our SNP's also have contracts with state Medicaid programs. Our plans are issued through Bright Health Insurance Company or one of its affiliates. Enrollment in our plans depends on contract renewal. Other providers and pharmacies are available in our network.

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 844-667-5502 (TTY: 711).

ATENCIÓN: Si usted habla español, tiene a su disposición servicios de asistencia de idioma gratuitos. Llame al 844-667-5502 (TTY: 711).

ATTENTION: if you speak Mandarin, language assistance services, free of charge, are available to you. Call 844-667-5502 (TTY: 711).

注意: 如果您说普通话, 您可以使用免费的语言帮助服务 • 请致电 844-667-5502 (TTY: 711)

Y0127_TEMPL-MA-FLR-2311_M H2288, H9516 Accepted 09/09/2018

Scope of Appointment Confirmation Form

To make sure you understand what you (or your authorized representative) will be discussing with a licensed sales representative, Medicare requires this form to be completed before your meeting. All the information provided here is confidential. A separate form should be completed for each Medicare enrollee or authorized representative.

By signing this form, you are indicating that you understand your meeting will focus on a review of Bright Heath's Medicare Advantage plans and Optional Supplemental Benefits. The person who will discuss the products is either employer or enrolled in a plan. Signing this form does NOT obligate you to enroll in a plan, affect your current or future Medicare enrollment, or enroll you in a Medicare plan.

BENEFICIARY OR AUTHORIZED REPRESENTATIVE SIGNATURE & DATE	
PLEASE CHECK WHICH PLAN YOU WANT TO ENROLL IN	
Signature	Signature date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __
Printed name (first, last)	Relationship to beneficiary
BENEFICIARY OR AUTHORIZED REPRESENTATIVE SIGNATURE & DATE	
TO BE COMPLETED BY LICENSED SALES REPRESENTATIVE	
Licensed sales representative name (first, last)	Licensed sales representative phone (__ __ __) - __ __ __ - __ __ __ __
Licensed sales representative ID	Beneficiary name (first, last)
Appointment date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __	Beneficiary phone (optional) (__ __ __) - __ __ __ - __ __ __ __
Beneficiary address (optional)	
Initial method of contact	Plan(s) the licensed sales representative will represent during the meeting
Signature of licensed sales representative	Signature date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __
If applicable, explain why SOA was not documented and signed by beneficiary prior to meeting:	

Please fax completed Scope of Appointment Form to number below or included with completed enrollment form.

Fax: 1 (844) 667-5502, www.MedicareMadeBright.com

Bright Health plans are HMO's and PPO's with a Medicare contract. Our SNP's also have contracts with state Medicaid programs. Our plans are issued through Bright Health Insurance Company or one of its affiliates. Enrollment in our plans depends on contract renewal. Other providers are available in our network.

This information is not a complete description of benefits. Call Bright Health customer service for more information.

ATENCIÓN: Si usted habla español, tiene a su disposición servicios de asistencia de idioma gratuitos. Llame al (844) 667-5502 (TTY: 711).

注意: 如果您说普通话, 您可以使用免费的语言帮助服务。请致电 (844) 667-5502 (听障专线: 711) 。

Bright Health Medicare Advantage Plan Enrollment Summary

To make sure you fully understand the details and benefits of the Bright Health Medicare Advantage plan you enrolled in, we ask that you carefully review and confirm the information below, with your licensed sales representative.

2019 Benefit Materials:

Plan Information

I enrolled in:

- ☐ Bright Advantage (HMO)
  $ _____ monthly premium
- ☐ Bright Advantage Plus (HMO)
  $ _____ monthly premium
- ☐ Bright Advantage Assist (HMO)
  $ _____ monthly premium
- ☐ Bright Advantage Flex (PPO)
  $ _____ monthly premium
- ☐ Bright Advantage Flex Plus (PPO)
  $ _____ monthly premium

My optional benefits are:

- ☐ Vision
  $ _____ monthly premium
- ☐ Dental
  $ _____ monthly premium

My plan coverage begins: __ __ / __ __ / __ __ __ __

Network/Provider Information

My primary care provider is:

Name: _____

Address: _____

Phone: _____

My specialist(s) is/are:

_____

_____

_____

Prescription Information

My prescription medications are listed below:

Name	Dosage	Frequency

If I have questions about my plan or if my needs change, I can call my licensed sales representative, _____ at (_____) - _____ - _____ or Bright Health at (844) 667-5502, 8am – 8pm, local time, 7 days a week Oct. 1 – Mar. 31, Monday – Friday Apr. 1 – Sept. 30 (TTY: 711).

Bright Health plans are HMO's and PPO's with a Medicare contract. Our SNP's also have contracts with state Medicaid programs. Our plans are issued through Bright Health Insurance Company or one of its affiliates. Enrollment in our plans depends on contract renewal. Other providers are available in our network.

This information is not a complete description of benefits. Call (844) 667-5502 for more information.

Y0127_TEMPL-MA-BKRG-2452_M H2288, H9516 Accepted 09/09/2018

Bright Health Medicare Advantage Plan Enrollment Checklist

To make sure you fully understand the details and benefits of the Bright Health Medicare Advantage plan you enrolled in, we ask that you carefully review and confirm the information below, with your licensed sales representative.

Plan Information

By initialing below, I understand that:

_____ I must have Medicare Part A and Part B to enroll in this plan.

_____ My plan is available in _____ County only. If I move outside of _____ for more than six months in a row, I understand I will need to enroll in a new plan.

_____ My plan will now provide all of my Medicare health and prescription drug coverage.

_____ My plan is a ☐ Health Maintenance Organization (HMO), ☐ Preferred Provider Organization (PPO), or ☐ Dual Eligible Special Needs (DSNP) and I understand that services outside the network may not be covered by Bright Health.

_____ If I am not sure if a provider is in the network, I can call Bright Health at (844) 667-5502, 8am – 8pm, local time, 7 days a week Oct. 1 – Mar. 31, weekdays Apr. 1 – Sept. 30 (TTY: 711) or go online www.BrightHealthPlan.com/Medicare to confirm if they are in the network.

_____ I cannot be enrolled in both a Medicare Advantage plan and a Medicare Supplement Insurance (Medigap) policy, at the same time. If I have a Medicare Supplement Insurance policy right now, I will cancel the Medicare Supplement Insurance policy once I receive confirmation of my Bright Health Medicare Advantage plan enrollment.

_____ I cannot be enrolled in both a Bright Health Medicare Advantage plan and a stand-alone Medicare Part D prescription drug plan, at the same time. If I have a stand-alone Medicare Part D prescription drug plan, CMS will automatically cancel my Medicare Part D prescription drug plan once my Bright Health Medicare Advantage plan enrollment has been accepted.

_____ I can cancel enrollment in my Bright Health Medicare Advantage plan before my coverage starts by calling Bright Health at (844) 667-5502. If, after my coverage starts, I want to switch or leave my Bright Health Medicare Advantage plan, I understand I will need to wait until the Open Enrollment Period (January 1 – March 31 or Annual Enrollment Period October 15 – December 7, 2019 of each year) to switch Medicare Advantage plans unless I qualify for a Special Enrollment Period.

_____ I understand that this plan could change each year. My 2019 Bright Health Medicare Advantage plan is effective from _____ , 2019 to December 31, 2019.

_____ I need to continue to pay my Medicare Part B premium unless the state or another third party pays this premium for me. If there is a plan premium, I understand that I must pay that premium to receive plan coverage.

_____ If I owe a Late Enrollment Penalty (LEP), it will be in addition to the monthly premium (if any) that comes with my Bright Health Medicare Advantage plan.

_____ My Bright Health Medicare Advantage plan annual prescription drug deductible is $ _____ .

Agent/Client Signature

Client Signature

_____

Agent Signature

_____

Bright Health plans are HMOs and PPOs with a Medicare contract. Our SNPs also have contracts with State Medicaid programs. Our plans are issued through Bright Health Insurance Company or one of its affiliates. Enrollment in our plans depends on contract renewal.

Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor.

Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.

Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.

Benefits, premiums and/or copayments/co-insurance may change on January 1, 2019.

Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care.

ATENCIÓN: Si usted habla español, tiene a su disposición servicios de asistencia de idioma gratuitos. Llame al (844) 667-5502 (TTY: 711).
注意: 如果您说普通话, 您可以使用免费的语言帮助服务。请致电 (844) 667-5502 (听障专线: 711) 。

New York

2019 Medicare Advantage Enrollment Form

In Collaboration with bright HEALTH | Mount Sinai

Please contact Bright Health at 844-667-5502 (TTY: 711) if you need information in another language or format (Braille).

To Enroll in Bright Health Please Provide the Following Information:

Please check which plan you want to enroll in:

Contract	PBP	Plan Name	Plan Type	Premium
☐ H2288	001	Bright Advantage	HMO	$0
☐ H2288	002	Bright Advantage Plus	HMO	$55.00
☐ H2288	003	Bright Advantage Special Care	HMO - SNP	$0
☐ H2288	005	Bright Advantage Assist	HMO	$39.00
☐ H9516	001	Bright Advantage Flex	PPO	$0
☐ H9516	002	Bright Advantage Flex Plus	PPO	$110

Please check which Optional Supplemental Benefits (OSB) Plan you want to enroll in:

Dental

Contract	PBP	Plan Name	Plan Type	Premium
☐ H2288	001	Bright Advantage	Comprehensive Dental	$13.00
☐ H9516	002	Bright Advantage Flex Plus	Comprehensive Dental	$18.00

☐ Mr. ☐ Mrs. ☐ Ms.

LAST Name:	FIRST Name:	MI:

Birthdate (MM/DD/YYYY): __ __ / __ __ / __ __ __ __	Sex: ☐ M ☐ F
Home Phone Number: (__ __ __) __ __ __ - __ __ __ __	Alternate Phone Number: (__ __ __) __ __ __ - __ __ __ __

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

City:	County:	State:	ZIP Code:

Mailing Address (only if different form your Permanent Residence Address):			
City:	County:	State:	ZIP Code:
Emergency Contact:			
Emergency Contact Phone Number: (__ __ __) __ __ __ - __ __ __ __	Relationship to You:		
Email Address:			

Please Provide Your Medicare Insurance Information

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 form Social Security or the Railroad Retirement Board.	Name (as it appears on your Medicare card):	
	Medicare Number:	
	Is Entitled to:	Effective Date:
	HOSPITAL (Part A)	
	MEDICAL (Part B)	
	You must have Medicare Part A and Part B to join a Medicare Advantage plan.	

Paying Your Plan Premium

If we determine that you owe a late enrollment penalty (or if you currently have a late enrollment penalty), we need to know how you would prefer to pay it. You can pay by mail or Electronic Funds Transfer (EFT) each month.

You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month. If you are assessed a Part D-Income related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. DO NOT pay Bright Health the Part D-IRMAA.

You can pay your monthly plan premium (including any late enrollment penalty that you currently have or may owe) by mail or Electronic Funds Transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or RRB. DO NOT pay Bright Health the Part D-IRMAA.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify will not be subject to the 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 qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

☐ Monthly Invoice

☐ Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Account holder name: _____

Bank routing number: _ _ _ _ _ _ _ _ Bank account number: _ _ _ _ _ _ _ _ _ _ _ _

Account Type: ☐ Checking ☐ Saving

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. I get monthly benefits from: ☐ Social Security ☐ RRB

The Social Security/RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.

Please read and answer these important questions:

1. Do you have End-Stage Renal Disease (ESRD)? ☐ Yes ☐ No

If yes, and you have had a successful kidney transplant and/or you don't need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

2. Do you have additional coverage (e.g., TRICARE, Federal employee health benefits coverage, VA benefits , or State pharmaceutical assistance programs etc.)? ☐ Yes ☐ No

If yes, please tell us what it covers along with information on the other coverage:
☐ Medical ☐ Prescription Drugs

Name of Other Insurance:

Member ID Number: Group ID Number:

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

If "yes," please provide the following information:
Name of Institution: _____
Address & Phone Number of Institution (number and street): _____

4. Are you enrolled in your State Medicaid Program? ☐ Yes ☐ No	If yes, please provide your state Medicaid number or if your Medicaid Number is not available, provide your SSN#: _ _ _ - _ _ - _ _ _ _

5. Do you or your spouse work? ☐ Yes ☐ No

Primary Care Physician (PCP)

Please tell us the name of your Primary Care Provider (PCP):

First Name	Last Name

Are you already a patient of the provider you listed above? ☐ Yes ☐ No

Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format:

☐ Spanish ☐ Chinese

☐ Braille ☐ Audio Tape ☐ Large Print

Please contact Bright Health at 844-667-5502 if you need information in an accessible format or language other than what is listed above. Our office hours are 8am – 8pm local time, 7 days a week, Oct 1. – Mar. 31, Monday – Friday, Apr. 1 – Sept. 30, TTY users should call (TTY: 711).

STOP! Please Read this Important Information

If you currently have health coverage from an employer or union, joining Bright Health could affect your employer or union health benefits. You could lose your employer or union health coverage if you join Bright Health. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't any information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please Read and Sign Below

By completing this enrollment application, I agree to the following:

Bright Health is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage Plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future.

Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15 – December 7 of every year), or under certain special circumstances.

Bright Health serves a specific service area. If I move out of the area that Bright Health serves, I need to notify the plan, so I can disenroll and find a new plan in my new area. Once I am a member of Bright Health, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Bright Health when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

Services authorized by Bright Health and other services contained in my Bright Health Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR BRIGHT HEALTH WILL PAY FOR THE SERVICES**.

I understand that if I am getting assistance from sales agent, broker, or other individual employed by or contracted with Bright Health, he/she may be paid based on my enrollment in Bright Health.

If you are requesting enrollment in an HMO plan the following statement applies: I understand that beginning on the date Bright Health coverage begins, I must get all of my health care from Bright Health participating providers, except for emergency or urgently needed services or out-of-area dialysis services.

If you are requesting enrollment in an HMO-POS plan the following statement applies: I understand that beginning on the date Bright Health coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Bright Health may reimburse you for certain services when provided by an out of network provider.

If you are requesting enrollment in an PPO plan the following statement applies: I understand that beginning on the date Bright Health coverage begins, using services in-network can cost less than using services out-of-network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Bright Health provides reimbursement for all covered benefits, even if I get services out of network.

Release of Information: By joining this Medicare health plan, I acknowledge that Bright Health will release my information to Medicare and other plans as necessary other parties for treatment, payment and health care operations, including without limitation to Medicare, other plans, providers, and Bright Health's Care Partner. I also acknowledge that Bright Health will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.

The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled form the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Signature:	**Today's Date:**

If you are the authorized representative, you must sign above and provide the following information:
Name: _____
Address: _____ Phone Number: (__ __ __) __ __ __ - __ __ __ __
Relationship to Enrollee: _____

Office Use Only:	
Name of staff member/agent/broker (if assisted in the enrollment):	
Broker/Agent #:	
Plan ID#:	Effective Date of Coverage:
ICEP/IEP: _____ AEP: _____ SEP Type: _____ Not Eligible: _____	

Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside this period.

Read the following statements carefully and check the box if a statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am new to Medicare
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) _____.
- ☐ I recently was released from incarceration. I was released on (insert date) _____.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____.
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____.
- ☐ I have both Medicare and Medicaid (or my state helps pay for Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) _____.
- ☐ I recently left a PACE program on (insert date) _____.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.
- ☐ I am leaving employer or union coverage on (insert date) _____.
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____.
- ☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.

☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

If none of these statements applies to you or you're not sure, please contact Bright Health at (844) 667-5502 TTY users should call (TTY: 711) to see if you are eligible to enroll. We are open 8am – 8pm local time, 7 days a week (Oct. 1 – Mar. 31) or Monday-Friday (Apr. 1 – Sept. 30).

What's next?

After enrolling in a Bright Health plan, we'll keep you in the loop on your application process.

You'll get a confirmation letter that confirms your enrollment in a Bright Health Medicare Advantage plan.*

You'll get a Bright Health Medicare plan ID card as well as a New Member Welcome packet in the mail.

If more information is needed to complete your application, we'll call you or send you a letter.

If you have any questions along the way, call Bright Health. We're always here to help.

Breathe easy.
Bright Health has you covered.

*As a member you may be contacted for more information if a late enrollment penalty applies or if you have a health plan with your job.

Y0127_TEMPL-MA-FLR-2313_C