www.ulstercountyny.gov/personnel/

Benefit Open Enrollment
October 14—October 31, 2022

Benefit Plan Year
January 1—December 31, 2023

2023 Non-Medicare Eligible Retiree Benefits Guide

Medical and Prescription Drugs, Dental, and Vision

Benefits provided in association with

ALERAGROUP
RELPH BENEFIT ADVISORS

Questions | Help
1-800-836-0026, x7400
support@aleracare.zendesk.com

ULSTER COUNTY PERSONNEL DEPARTMENT
244 Fair St., P.O. Box 1800, Kingston, New York 12402-1800
Telephone: 845-340-3550
Fax: 845-340-3592

JOHANNA CONTRERAS
Interim County Executive

DAWN SPADER
Personnel Director

JAMES FARINA
Director of Employee Relations

APRIL RODMAN
Administrator, Civil Service & Personnel

TO: Ulster County Retiree Health Insurance Participant

FROM: Dawn Spader, Personnel Director

DATE: October 28, 2022

RE: 2023 Health Insurance Rates and Important Changes
For **Non-Medicare Eligible Retirees**

In 2023, the County will continue to offer Empire Blue Cross / Blue Shield PPO20, PPO25, and Direct POS20 medical programs as provided in 2022. **There are no changes to any of our coverages or premiums**. You are encouraged to review the PPO25, especially if you live outside of the Hudson Valley and are currently paying for the more expensive PPO plan. A comparison chart can be found on page 5.

IF YOU DO NOT PAY A PREMIUM FOR YOUR COVERAGES OR IF YOU WISH TO MAKE A COVERAGE PLAN CHANGE, YOU MUST RESPOND TO THIS LETTER BY COMPLETING THE FORM ON PAGE 5 AND RETURNING IT DIRECTLY TO THE BENEFITS OFFICE BY NOVEMBER 30, 2022

The premium amount for 2023 will begin with your December 15, 2022 premium payment withdrawal. Failure to provide funding for your premium will result in cancellation.

Medical Benefits - Coverage descriptions, and benefit comparisons, and prescription formularies are available on the Personnel Department website at:

http://ulstercountyny.gov/personnel/new-current-employees/benefits-management

(click on *'2023 Non-Medicare Eligible Retiree Health Insurance Benefit Information),* or from the Benefits Office. If needed, the rate chart may be found in the 2022 guide book.

We strongly encourage you to review the information provided and to visit the ***empireblue.com*** website to see what programs your doctors may participate in, so you may make the best plan choice for you and your family. If you desire to make coverage changes, you must inform the Benefits Office in writing of your new plan choice by returning the form on page 5.

Pharmacy Benefits: MagellanRx will continue to be the administrator for the Pharmacy program. Please be sure to check for changes in the Formulary. Each year, a select group of products are removed from Formularies (also called Preferred Prescriptions) and will no longer be covered in these plans. Members who attempt to obtain medications no longer covered will experience a claim reject at the point of sale and will be required to pay 100% of the full, non- discounted cost of the medication.

Some products also will move from preferred (tier 2) to non-preferred (tier 3) status. MagellanRx allows exceptions when medically necessary.
In addition, there will be other changes to the Preferred Formulary (addition of new drugs, changes from formulary to non-formulary.

Cards for 2023: There will not be any new ID Cards for any of our coverages. Continue to use your 2022 cards.

Dental Coverage - Our dental coverage is still provided by Met Life Dental. The coverages are identical to the 2022 coverages.

Vision Coverage - Our vision coverages remain with Davis Vision. There are no changes.

Please be reminded that the County offers a Medicare supplement health plan or a Medicare buyout to retirees when they become Medicare eligible. It is mandatory for retirees and dependents to switch to a Medicare plan immediately when said plan is available to them. Please notify the Employee Benefits Office three months prior to Medicare eligibility so that a smooth transition can be accomplished. Failure to notify the Benefits Department of Medicare eligibility will result in repayment of any claims payments made due to this error. Please call Kevin Roach, Employee Benefits Administrator; (845) 340-3545 to discuss your plan choices.

Urgent Care Out of Network Reminder – Our Urgent Care Copay, both in and out of network, is the same as your office copay. If you or a covered family member cannot locate an in-network urgent care center, you may go to an out of network center and pay the office visit copay. This is advantageous since the cost of going to the emergency room includes a copay of $100 on the POS20 and PPO20, and $200 for PPO25. This can be especially useful when you are traveling away from home.

CanaRx Zero Co-pay Mail Order Brand Name Drug Program - For 2023, our non-Medicare eligible retirees may continue to purchase brand-name maintenance medications through a mail order program without paying any co-pay. This plan was formerly known as Ulster Scripts. The information and forms, including the list of available medications for the CanaRx program, are available on the Personnel Department website in the aforementioned Benefits Book or at the Benefits Office. The CanaRx (Certain Brand Name Drugs For Free) program is available to all retirees covered by the Empire Blue Cross Blue Shield plans. There have been changes to the classification of some drugs, so please check the formulary. **Medicare eligible retirees are not allowed to use the CanaRx program.**

Live Health Online – Live Health Online continues as a covered benefit under our Health Plan. With a computer and webcam, or applicable smartphone app, you can talk to a medical professional 24/7, 365 days a year. You can be at home, at work, or out of town (though not all services may be available in all locations.) No appointment is necessary to speak with Live Health Online. This benefit saves time and costs the same as a primary care office visit. To activate your account, go to **livehealthonline.com** on your computer or download the appropriate application from your smartphone's app store.

Empire Blue Cross Blue Shield Premiums – There are no changes in premiums hence whatever you paid in 2022 will continue in 2023*). **For your reference, your Ulster County percentage is printed after your name on your envelope label.***

2023 Non-Medicare Eligible Retiree Rates

UC %	TIER	POS20	PPO20	PPO25	D&V Only
50%	Retiree Only	$453.55	$645.14	$409.74	$20.63
	Retiree & Spouse	$1,016.62	$1,447.69	$918.03	$42.55
	Retiree & 1 Child	$868.77	$1,232.78	$785.52	$46.22
	Retiree & Children	$955.35	$1,357.68	$863.34	$46.22
	Family	$1,404.54	$1,998.45	$1,268.71	$62.49
60%	Retiree Only	$362.84	$516.11	$327.79	$16.50
	Retiree & Spouse	$813.29	$1,158.15	$734.42	$34.04
	Retiree & 1 Child	$695.01	$986.22	$628.41	$36.97
	Retiree & Children	$764.28	$1,086.14	$690.67	$36.97
	Family	$1,123.63	$1,598.76	$1,014.97	$49.99
65%	Retiree Only	$317.48	$451.59	$286.81	$14.44
	Retiree & Spouse	$711.63	$1,013.38	$642.62	$29.78
	Retiree & 1 Child	$608.14	$862.94	$549.86	$32.35
	Retiree & Children	$668.75	$950.38	$604.33	$32.35
	Family	$983.18	$1,398.92	$888.10	$43.74
70%	Retiree Only	$272.13	$387.08	$245.84	$12.38
	Retiree & Spouse	$609.97	$868.61	$550.82	$25.53
	Retiree & 1 Child	$521.26	$739.67	$471.31	$27.73
	Retiree & Children	$573.21	$814.61	$518.00	$27.73
	Family	$842.75	$1,199.07	$761.23	$37.49
75%	Retiree Only	$226.77	$322.57	$204.87	$10.31
	Retiree & Spouse	$508.31	$723.84	$459.02	$21.27
	Retiree & 1 Child	$434.38	$616.39	$392.76	$23.11
	Retiree & Children	$477.67	$678.84	$431.67	$23.11
	Family	$702.27	$999.22	$634.35	$31.24
80%	Retiree Only	$181.42	$258.05	$163.89	$8.25
	Retiree & Spouse	$406.65	$579.07	$367.21	$17.02
	Retiree & 1 Child	$347.51	$493.11	$314.21	$18.49
	Retiree & Children	$382.14	$543.07	$345.33	$18.49
	Family	$561.82	$799.38	$507.48	$24.99
85%	Retiree Only	$136.06	$193.54	$122.92	$6.19
	Retiree & Spouse	$304.98	$434.31	$275.41	$12.76
	Retiree & 1 Child	$260.63	$369.83	$235.65	$13.86
	Retiree & Children	$286.60	$407.30	$259.00	$13.86
	Family	$421.36	$599.53	$380.61	$18.75
90%	Retiree Only	$90.71	$129.03	$81.95	$4.12
	Retiree & Spouse	$203.32	$289.54	$183.61	$8.51
	Retiree & 1 Child	$173.75	$246.55	$157.10	$9.24
	Retiree & Children	$191.07	$271.54	$172.67	$9.24
	Family	$280.91	$399.69	$253.74	$12.50
95%	Retiree Only	$45.35	$64.51	$40.97	$2.06
	Retiree & Spouse	$101.66	$144.77	$91.80	$4.25
	Retiree & 1 Child	$86.88	$123.28	$78.55	$4.62
	Retiree & Children	$95.54	$135.77	$86.33	$4.62
	Family	$140.45	$199.85	$126.87	$6.25
100%	Retiree Only	$0.00	$0.00	$0.00	$0.00
	Retiree & Spouse	$0.00	$0.00	$0.00	$0.00
	Retiree & 1 Child	$0.00	$0.00	$0.00	$0.00
	Retiree & Children	$0.00	$0.00	$0.00	$0.00
	Family	$0.00	$0.00	$0.00	$0.00

Benefit Feature	POS 20	PPO 20	PPO 25
Deductible	In Network: N/A OutNetwork: $2,000/$5,000	In Network: N/A OutNetwork: $500/$1,250	In Network: N/A OutNetwork: $500/$1,250
Out of Pocket Maximum	InNetwork: $3,880/$9,700 OutNetwork: $8,000/$20,000	InNetwork: $3,880/$9,700 OutNetwork: $1,000/$2,500	InNetwork: $3,880/$9,700 OutNetwork: $1,000/$2,500
CoInsurance	InNetwork: N/A OutNetwork: 40%	InNetwork: N/A OutNetwork: 20%	InNetwork: N/A OutNetwork: 20%
In Network Copays | Out of Network: Deductible & Coinsurance Apply			
Office Visit	$20 Copay	$20 Copay	$25 Copay Primary Care $40 Copay Specialist Care $100 Outpatient Surgery $75 MRI/CAT/PET Scans
Urgent Care	$20 Copay	$20 Copay	$25 Copay
Emergency Room	$100 copayment *(waived if admitted w/in 24-hrs)*	$100 copayment *(waived if admitted w/in 24-hrs)*	$200 copayment *(waived if admitted w/in 24-hrs)*
Hospital Admission	$0 Copay	$0 Copay	$200 Copay
Prescriptions (30-day Supply)	$5 / $20 / $40	$10 / $25 /$40	$10 / $25 /$40

Family Awareness – We request that all retirees with any level of coverage make your family members aware of your coverage situation. Recently a retiree passed away and their coverages continued for months as no family member informed us. In another case, a retiree's family told their bank not to allow payments for their health insurance as they did not recognize the charges. Supplying your family with a copy of this letter annually would provide them the information they need to best help you when needed.

If you have any questions, please call Kevin Roach, Employee Benefits Administrator at (845) 340-3545 or Mary Connolly, Employee Benefits Specialist, at (845) 340-3546.

IF YOU DO NOT PAY A PREMIUM OR IF YOU WISH TO MAKE A PLAN CHANGE, YOU MUST COMPLETE THE FORM BELOW AND RETURN IT BY NOVEMBER 30, 2022 DIRECTLY TO: Kevin Roach, Ulster County Employee Benefits Office, P.O. Box 1800, Kingston, N.Y. 12402

_____

I DO NOT PAY A PREMIUM, AND WOULD LIKE TO CONTINUE MY COVERAGE: _____
I WOULD LIKE TO SWITCH MY PLAN TO (CHECK ONE BELOW):

_____ Empire BCBS POS20 Plan Signature _____

_____ Empire BCBS PPO20 Plan Printed Name _____

_____ Empire BCBS PPO25 Plan Date _____

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The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan documents, the actual plan documents will prevail.

All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996.

If you have any questions about your Guide, contact Employee Benefits.

ACH Form for Ulster County Retirees

ACH Form for Relph Benefit Advisors Inc

AUTOMATIC PAYMENT (ACH) REQUEST FORM

PLEASE READ:

1. **For Retiree billing, you must be paid through the current coverage month. Please note, ACH is only available for monthly billing periods.**
2. Complete **Section 1** -- Participant Information.
3. Attach a voided check (or photocopy). We are not able to accept deposit slips; they do not always show the required information.
4. If you do not supply a voided check, complete **Section 2**.
5. Complete **Section 3** and mail the form along with your voided check to the address below.
6. When adding your ACH, please note we need to receive notification at least 10 days prior to the 1st of the month.
7. When canceling or changing your ACH, please note we need to receive notification at least 15 days prior to the 1st of the month of your request. If your request is **received after** this timeframe, we will continue to process your ACH as normal.
8. We are not able to process incomplete forms.

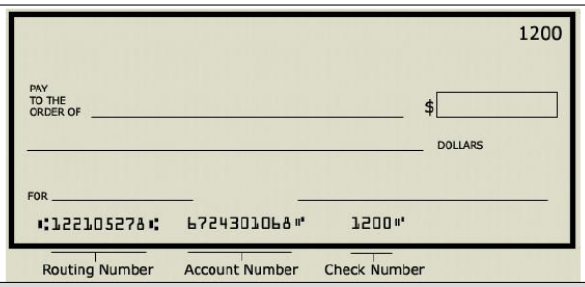
SECTION 1 - PARTICIPANT INFORMATION

☐ **ADD** AUTHORIZATION	☐ **CANCEL** AUTHORIZATION Effective:	☐ **CHANGE** AUTHORIZATION Effective:

Your Full Name (please print clearly)	**Your Social Security Number** ☐☐☐ - ☐☐ - ☐☐☐☐
Phone Number:	**Member ID Number:**

SECTION 2 - BANK ACCOUNT INFORMATION

Bank Name:	**Account Type** (check one) ☐ CHECKING ☐ SAVINGS
Routing Number:	
Account Number:	



SECTION 3 - AUTHORIZATION SIGNATURE

Authorized Account Holder Signature	**Date**

SECTION 3 - AUTHORIZATION SIGNATURE

Authorized Account Holder Signature	**Date**

I authorize Relph Benefit Advisors Inc ("Company") to initiate a debit from my checking or savings account for my recurring scheduled payment via ACH. If the required payment changes for any reason, this authorization will be automatically amended to authorize the debit of the amount equal to the new required premium payment plus any additional service fees, if any.
This authorization is to remain in full force and effective until Company has received written notification from me of its termination in such time and manner as to afford Company a reasonable opportunity to act on it. I understand that automatic debits will automatically cease if my coverage ends, is terminated or my automatic debit rejects for insufficient funds. I understand and agree to the terms outlined and authorize Company to make appropriate changes to my required premium deduction as necessary.

Return This Form & Check To:	**All Other Questions & Support Issues:**
Mary Connolly Benefits Department	Mary Connolly 845-340-3546 mcon@co.ulster.ny.us
Date Rec'd **Date Processed**	**Processor** **V&V**

Ulster County Retiree Health Insurance Enrollment Form

ULSTER COUNTY NON MEDICARE ELIGIBLE RETIREE INFORMATION FORM

LAST NAME	FIRST NAME & MIDDLE INITIAL	DATE OF BIRTH

HOME PHONE #	CELL PHONE #	PERSONAL EMAIL ADDRESS

LEGAL ADDRESS: *(Your Social Security / Medicare mailing address)*

STREET NAME OR PO BOX	TOWN	STATE	ZIP

BILLING ADDRESS IF DIFFERENT FROM LEGAL ADDRESS:

STREET NAME OR PO BOX	TOWN	STATE	ZIP

EMERGENCY CONTACT: (WE SUGGEST LISTING SOMEONE OTHER THAN A SPOUSE)

LAST NAME	FIRST NAME	RELATIONSHIP	HOME TELEPHONE #

STREET ADDRESS OR PO BOX	TOWN	STATE	ZIP

PLAN CHOICE:

INCLUDES DENTAL & VISION COVERAGE IN ALL OPTIONS

	EMPIRE PPO25		***EMPIRE POS20***		***EMPIRE PPO20***		***DENTAL & VISION ONLY***
	RETIREE ONLY		*RETIREE ONLY*		*RETIREE ONLY*		*RETIREE ONLY*
	RETIREE & SPOUSE		RETIREE & SPOUSE		RETIREE & SPOUSE		RETIREE & SPOUSE
	RETIREE & CHILD		*RETIREE & CHILD*		*RETIREE & CHILD*		*RETIREE & CHILD*
	RETIREE & CHILDREN		*RETIREE & CHILDREN*		*RETIREE & CHILDREN*		*RETIREE & CHILDREN*
	FAMILY		*FAMILY*		*FAMILY*		*FAMILY*

DEPENDENT LAST NAME	***RELATIONSHIP***	***DATE OF BIRTH***

By signing below I am requesting Ulster County Personnel to enroll me in the selected Health Care Program or continue my coverage and I am agreeing to pay my share of the premium, and I attest the dependents as listed above meet the Ulster County eligibility criteria.

RETIREE SIGNATURE: **DATE:**

FOR PERSONNEL DEPARTMENT USE ONLY:

Retirement Date:

Effective Date of Retiree Coverage:

Comments:

Date Employed:

Department:

Bargaining Unit:

% of Contribution:

RETIREE HI FORM Revised 09/09/2020 KROA

Benefit Enrollment Change Form

1 Employee Information *(please print)*

Group Name	Billing Code	Employee Billing Code	Effective Date of Change
Ulster County			

Last Name	First Name	M.I.	❑Single ❑Married ❑Separated ❑Divorced ❑Widowed	Date of Marriage / Date of Divorce

Mailing Address ❑ If, NEW	Social Security Number	Medicare Number (if any) /A&B Effective Dates

City	State	Zip	Phone ❑ Cell ❑ Home	Date Employed

Employment Status: ❑Full-time ❑Part-time ❑Active ❑Retired ❑COBRA	Date of Retirement	Retire Benefit %

2 Benefit Election

	Type	Plan	Individual	Individual +Spouse	Individual +Child	Individual +Children	Family
❑ New Enrollment /Reinstatement (*Complete Section 3*)							
❑ Change Coverage to: *(check new coverage)*	Medical with Metlife Dental & Davis Vision	❑ Empire POS 20 ❑ Empire PPO 20 ❑ Empire PPO 25	❑	❑	❑	❑	❑
❑ Cancel Coverage: *(check those that apply)*							
❑ Add or Delete Dependent: *(Complete Section 4)*							
❑ Active to Retiree Date:	Buy-Out/ Standalone Dental & Vision	No Medical MetLife Dental & Davis Vision	❑	❑	❑	❑	❑
❑ Change Enrollee's Information: *(complete Section 1 with new information)* Reason:	Waive All	❑					

3 Dependent Coverage Information

(Circle elections and print information)

A=Add Coverage

T=Terminate Coverage

List Applicant and All Eligible Dependents

Medical	Dental	Vision	Relationship	Name (Last, First, MI	Date of Birth	Social Security #	Medicare Number (if any) A&B Effective Dates
A T	A T	A T	Self ❑M ❑F				
A T	A T	A T	Spouse ❑M ❑F				
A T	A T	A T	❑Son ❑ Daughter				
A T	A T	A T	❑Son ❑ Daughter				
A T	A T	A T	❑Son ❑ Daughter				
A T	A T	A T	❑Son ❑ Daughter				

4 Dependent Status *(please print)*

Do your dependents reside in your home? ❑Yes ❑No, if no, give address	Do you have a disabled dependent beyond age 26? ❑No ❑Yes, list name/s

Applicant's Signature	Date Signed	Employer's Signature

Ways to $ave Money on Your Health Care Expenses

For those who pay 10% 15% or 20% and are currently enrolled in the PPO20 you may want to consider choosing the PPO25. This plan offers less money out of your paycheck. Pay for what you need at time of service.

The PPO25 plan provides same benefits as the PPO20 except that there are copays for some services and the provider office visit copayments are $25/$40. The PPO25 plan gives you access to the same local and national network of providers and provides lower co-pays on prescription coverage.

Benefit Feature	POS20	PPO20	PPO25
Deductible	In Network: N/A OutNetwork: $2,000/$5,000	In Network: N/A OutNetwork: $500/$1,250	In Network: N/A OutNetwork: $500/$1,250
Out of Pocket Maximum	InNetwork: $3,880/$9,700 OutNetwork: $8,000/$20,000	InNetwork: $3,880/$9,700 OutNetwork: $1,000/$2,500	InNetwork: $3,880/$9,700 OutNetwork: $1,000/$2,500
CoInsurance	InNetwork: N/A OutNetwork: 40%	InNetwork: N/A OutNetwork: 20%	InNetwork: N/A OutNetwork: 20%
In Network Copays | Out of Network: Deductible & Coinsurance Apply			
Office Visit	$20 Copay	$20 Copay	$25 Copay Primary Care $40 Copay Specialist Care
OutPatient Surgery	$0 Copay	$0 Copay	$100 Copay
MRI/CAT/PET Scans	$0 Copay	$0 Copay	$75 Copay
Urgent Care	$20 Copay	$20 Copay	$25 Copay
Emergency Room	$100 copayment *(waived if admitted w/in 24-hrs)*	$100 copayment *(waived if admitted w/in 24-hrs)*	$200 copayment *(waived if admitted w/in 24-hrs)*
Hospital Admission	$0 Copay	$0 Copay	$200 Copay
Prescriptions (30-day Supply)	$5 / $20 / $40	$10 / $25 /$40	$10 / $25 /$40

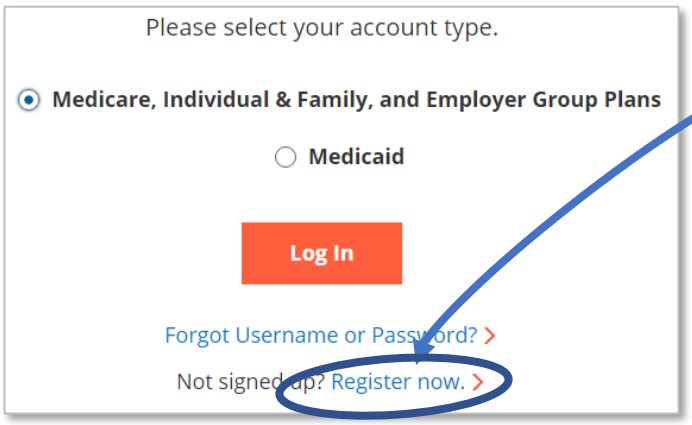
As a reminder - the next time you or a covered family member needs immediate care, consider using the services of one of the many local Urgent Care facilities. You will only have to pay the regular office visit co-pay instead of the emergency room co-pay. A list of Urgent Care providers follows. Plan ahead, become familiar with the location of the one most convenient for you and your family.

For your medications, ask your physician to prescribe a generic instead of a brand name medication, or one on our formulary (list of included drugs) instead of a non-formulary choice. Your co-pay will be less in either of these situations.

- **Using mail order methods for medications** will save you one co-pay every three months. Many retail stores also have lists of certain medications they offer for even less than our co-pay. Always use your coverage card too, as that can make your payment even lower than their 3-mont h supply price. The co-pay is a maximum you can be charged so if the price is lower, you will only have to pay that amount.
  You can also use Walgreens for your maintenance medication and receive a 3-month supply for 2-copayments. Walgreens is the only retail store that provides this service at this time.
- **For brand name maintenance medications** (ones that you take every month without changing anything) that do not have a generic option, consider using our mail order program, CANARx. Information and enrollment forms for employees covered by our prescription plan and your dependents can be found in this book and if your medication is on their available medications, you can receive a 3-month supply for NO co-pay.

Our coverage with Empire Blue Cross Blue Shield includes a free nurse helpline service. PH: 1-877-Talk2RN (1-877-825-5276). Consider making a phone call before your next trip to the doctor or emergency room. You might find your situation can be resolved without a needless inconvenient visit or possibly be delayed until your normal physician office is open the next morning.

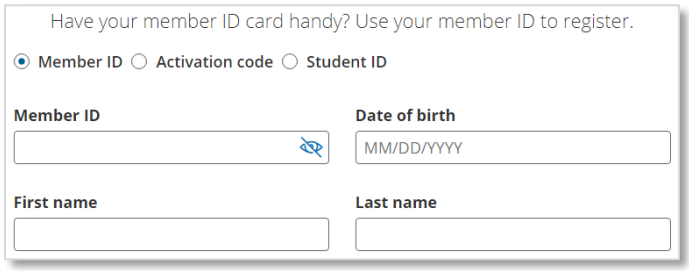
Empire BCBS Website & TeleMedicine

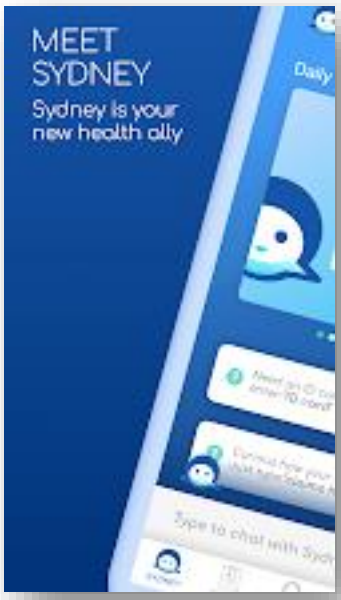


At www.empireblue.com, Select Login

First time users-select Register now

Then have your Member ID card to complete your Registration, following the website prompts.





Get the App—Sydney Health

Save time with Live Chat. Find the information you need about your health care benefits by chatting with an Empire Rep in real time.

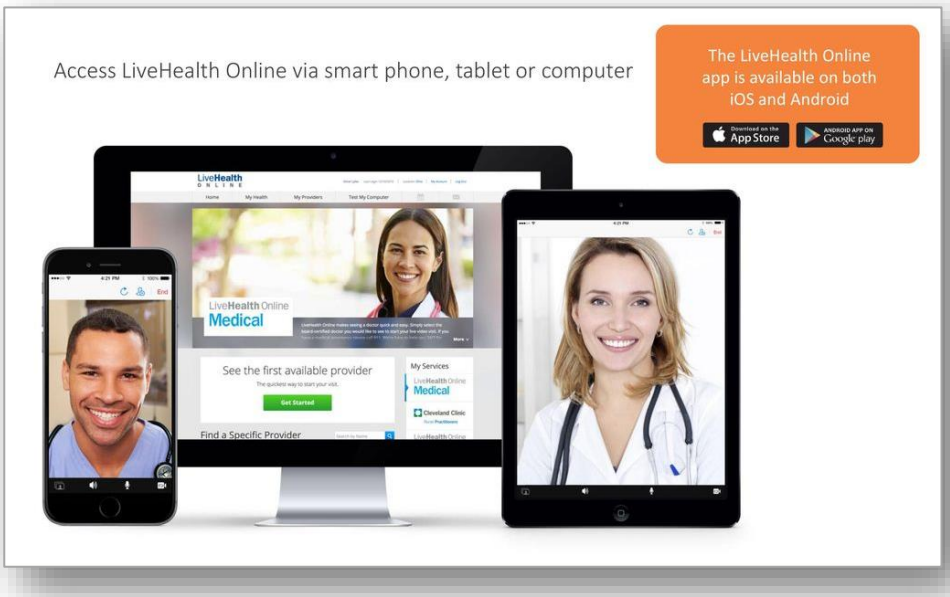
Telemedicine Services

Online or Phone App

LiveHealth ONLINE

See a doctor, 24/7/ 365

Sign-up now, so you're ready when you need it.



Empire BCBS Summary of Benefits— POS20 Plan

Your Summary of Benefits

Empire BlueCross BlueShield
An Anthem Company

Benefit	In-Network [2]	Out-of-Network [3]
Deductible	N/A	$2,000/$5,000
Coinsurance	N/A	40%
Out-of-Pocket Maximum	$3,880 / $9,700 (All In-Network Medical Cost Shares)	$20,000/$50,000 Coinsurance Stop Loss ($8,000/$20,000 out-of-pocket) coinsurance max
Lifetime Maximum	Unlimited	Unlimited
Dependent Children (covered through the end of the month)	Dependents to Age 26	Dependents to Age 26
Covered Preventive Care[1]	**Member Pays**	**Member Pays**
Covered Adult Preventive Care	$0	Deductible and coinsurance
Annual Physical Exam	$0	Deductible and coinsurance
Well-Child Care (Up to age 19; including covered immunizations)	$0	Deductible and coinsurance
Preventive Well-Woman Care	$0	Deductible and coinsurance
Home/Office/Outpatient Care	**Member Pays**	**Member Pays**
Home/Office/Outpatient Visits Copayment	$20 copayment	Deductible and coinsurance
Urgent Care Center	$20 copayment	$20 copayment
Online Visits	$0 copayment	Deductible and coinsurance
Emergency Room/Facility (initial visit per occurrence)	$100 copayment (Waived if admitted within 24 hours)	$100 copayment (Waived if admitted within 24 hou
Ambulatory/Outpatient Surgery [4,5]	$0	Deductible and coinsurance
Presurgical Testing, Anesthesia	$0	Deductible and coinsurance
Chemotherapy, Radiation Therapy	$0	Deductible and coinsurance
Routine Maternity Care	$0	Deductible and coinsurance
Laboratory Tests, X-rays, MRI[4]/MRA[4], CAT Scan[6], PET[6] and Nuclear Cardiology[6]	$0	Deductible and coinsurance
Allergy Care: Routine Testing and Treatment (Allergy Injections/Immunotherapy)	$20 copayment (Waived for treatment)	Deductible and coinsurance
Acupuncture (Up to 30 visits per calendar year)	$20 copayment	Deductible and coinsurance
Chiropractic Care (Up to 30 visits per calendar year) [7]	$20 copayment	Deductible and coinsurance
Home Healthcare (Up to 200 visits per calendar year)	$0	Coinsurance (no deductible)
Home Infusion Therapy	$0	Deductible and coinsurance
Hospice Care (Unlimited Days)	$0	Deductible and coinsurance
Physical Therapy[4] (Up to 90 visits per calendar year combined in home, office or outpatient facility)	$20 copayment	Deductible and coinsurance
Speech/Language[4], Occupational[4], Vision Therapies (Up to 60 visits per calendar year combined in home, office or outpatient facility)	$20 copayment	Deductible and coinsurance
Outpatient Cardiac Rehabilitation	$20 copayment	Deductible and coinsurance
Second Surgical Opinion	$20 copayment	Deductible and coinsurance
Kidney Dialysis	$0	Deductible and coinsurance

Empire BCBS Summary of Benefits— POS20 Plan

Benefit	In-Network[2]	Out-of-Network [3]
Inpatient Care[4]		
Inpatient Hospital (As many days as is medically necessary; semiprivate room and board)	$0	Deductible and coinsurance
Surgery, Surgical Assistant, Anesthesia	$0	Deductible and coinsurance
Physical Therapy, Physical Medicine, or Rehabilitation (Up to 90 inpatient days per calendar year)	$0	Deductible and coinsurance
Skilled Nursing Facility (Up to 60 days per calendar year)	$0	Deductible and coinsurance
Mental Health		
Outpatient Visits in Office	$20 copayment	Deductible and coinsurance
Outpatient Visits in Facility	$0	Deductible and coinsurance
Inpatient Care[8]As many days as is medically necessary; semiprivate room and board)	$0	Deductible and coinsurance
Alcohol/Substance Abuse		
Outpatient Visits in Office	$20 copayment	Deductible and coinsurance
Outpatient Visits in Facility	$0	Deductible and coinsurance
Inpatient Detoxification[8] (As many days as is medically Necessary; semiprivate room and board)	$0	Deductible and coinsurance
Inpatient Rehabilitation[8]	$0	Deductible and coinsurance
Other		
Medical Supplies	$0 when obtained through Empire's medical supplies vendor	Deductible and coinsurance
Durable Medical Equipment[4]	$0	Deductible and coinsurance
Prosthetics & Orthotics[4]	$0	Deductible and coinsurance
Ambulance (air ambulance)	$0	In-network benefits apply

Services provided by Empire HealthChoice HMO, Inc. and/or Empire HealthChoice Assurance, Inc., licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. In Connecticut, Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans, Inc., an independent licensee of the Blue Cross and Blue Shield Association.

1) Preventive Care benefits not subject to copayment, deductible and coinsurance; when provided In-Network include; mammography screenings, cervical cancer screenings, colorectal cancer screenings, prostate cancer screenings, hypercholesterolemia screenings, diabetes screenings for pregnant women, bone density testing, annual physical examinations and annual obstetric and gynecological examinations. May also include other services as required under State and Federal Law. May be subject to age and frequency limits.
(2) In-network provider delivers care. In-network providers are in Empire's POS network, and in our affiliate POS network in Connecticut, Anthem Blue Cross and Blue Shield.
(3) Out-of-network providers are providers who are not in Empire's POS network or our affiliate network in Connecticut, Anthem Blue Cross and Blue Shield. Out-of-network services rendered by providers who do not participate with Empire or with another Blue Cross Blue Shield plan through the BlueCard Program are subject to balance billing over the allowed amount. (This does not apply to emergency benefits.)
(4) Empire's or Anthem's, CT network provider must precertify INN services or services may be denied; Empire or Anthem, CT network providers cannot bill members beyond INN copayment (if applicable) for covered services. You are responsible for obtaining precertification for out-of-network services. Your provider may call for you, but you will be responsible for penalties applied to out-of-network claims if precertification is not obtained.
(5) For ambulatory surgery, please call the toll-free number on your member ID card to determine exactly which outpatient services require pre-certification.
(6) Empire's or Anthem's, CT network provider must precertify INN services or services may be denied; Empire or Anthem, CT network providers cannot bill members for covered services. Precertification is not necessary for out-of-network services.
(7) Empire's network provider must obtain authorization for clinical/medical necessity for in-network services after 5th visit.
(8) Precertification must be obtained from the Behavioral Healthcare Manager, or penalties apply.

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Included are preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.

Empire BCBS Summary of Benefits—PPO20 Plan

Your Summary of Benefits

Empire BlueCross BlueShield
An Anthem Company

Benefit	In-Network [1]	Out-of-Network [2,3]
Deductible	N/A	$500/$1,250
Coinsurance	N/A	20%
Out-of-Pocket Maximum	$3,880 / $9,700 (All In-Network Cost Shares)	$5,000/$12,500 Coinsurance Stop Loss / $1,500 / $3,750 Out-of-Pocket Max
Lifetime Maximum	Unlimited	Unlimited
Dependent Children (covered to the end of the month of the dependent's birthday)	Dependents to age 26	Dependents to age 26
Covered Preventive Care[4]	**Member Pays In-Network**	**Member Pays Out-of-Network**
Covered Adult Preventive Care	$0	Deductible and Coinsurance
Annual Physical Exam	$0	Covered in-network only
Well-Child Care (Up to age 19; including necessary covered immunizations)	$0	Deductible and Coinsurance
Preventive Well-Woman Care	$0	Deductible and Coinsurance
Home/Office/Outpatient Care	**Member Pays In-Network**	**Member Pays Out-of-Network**
Home/Office Visits	$20 copayment	Deductible and Coinsurance
Online Visits	$0 copayment	Deductible and Coinsurance
Urgent Care Center	$20 copayment	$20 copayment
Emergency Room/Facility (initial visit per occurrence)	$100 copayment (Waived if admitted within 24 hours)	$100 copayment (Waived if admitted within 24 hours)
Ambulatory Surgery[5]/ Outpatient Surgery	$0	Deductible and Coinsurance
Presurgical Testing, Anesthesia	$0	Deductible and Coinsurance
Chemotherapy, Radiation Therapy	$0	Deductible and Coinsurance
Routine Maternity Care	$0	Deductible and Coinsurance
Laboratory Tests, X-rays	$0	Deductible and Coinsurance
MRI[7]/MRA[7], CAT Scan[7], PET[7] & Nuclear Cardiology[7]	$0	Deductible and Coinsurance
Allergy Routine Testing and Treatment		Deductible and Coinsurance
– Office Visit	$20 copayment	Deductible and Coinsurance
– Routine Testing	$0	
– Allergy Injections/Immunotherapy	$0	
Acupuncture (Up to 30 visits per calendar year)	$20 copayment	Deductible and coinsurance
Chiropractic Care (Up to 30 visits per calendar year) [10]	$20 copayment	Deductible and Coinsurance
Home Healthcare (Up to 200 visits per calendar year)	$0	Coinsurance (no deductible)
Home Infusion Therapy	$0	Deductible and Coinsurance
Hospice Care (Unlimited Days	$0	Deductible and Coinsurance
Physical Therapy[5] (Up to 90 visits per calendar year combined in home, office or outpatient facility)	$20 copayment	Deductible and Coinsurance
Other Short-Term Rehabilitative Therapies – Speech/Language[5], Occupational[5] (Up to 60 visits per calendar year combined in home, office or outpatient facility)	$20 copayment	Deductible and Coinsurance
Vision Therapy	$20 copayment	Deductible and Coinsurance

Services provided by Empire HealthChoice Assurance, Inc.,
licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

Empire BCBS Summary of Benefits—PPO20 Plan

Benefit	In-Network[1]	Out-of-Network [2,3]
Cardiac Rehabilitation (Unlimited visits per calendar year)	$20 copayment	Deductible and Coinsurance
Second Surgical Opinion	$20 copayment (no copayment applies if arranged through the Medical Management Program)	Deductible and Coinsurance
Kidney Dialysis	$0	Deductible and Coinsurance
Inpatient Care[9]	**Member Pays In-Network**	**Member Pays Out-of-Network**
Inpatient Hospital (As many days as is medically necessary; semiprivate room and board)	$0	Deductible and Coinsurance
Surgery, Covered Surgical Assistant, Anesthesia	$0	Deductible and Coinsurance
Physical Therapy, Physical Medicine, or Rehabilitation (Up to 90 inpatient days per calendar year)	$0	Deductible and Coinsurance
Skilled Nursing Facility (Up to 60 days per calendar year)	$0	Deductible and Coinsurance
Mental Health[8]	**Member Pays In-Network**	
Outpatient Visits in Office	$20 copayment	Deductible and Coinsurance
Outpatient Visits in Facility	$0	Deductible and Coinsurance
Inpatient Care[9] (As many days as medically necessary; semiprivate room and board)	$0	Deductible and Coinsurance
Alcohol/Substance Abuse[8]	**Member Pays In-Network**	**Member Pays Out-of-Network**
Outpatient Visits in Office	$20 copayment	Deductible and Coinsurance
Outpatient Visits in Facility	$0	Deductible and Coinsurance
Inpatient Detoxification[9] (As many days as medically necessary; semiprivate room and board)	$0	Deductible and Coinsurance
Inpatient Rehabilitation[9]	$0	Deductible and Coinsurance
Other	**Member Pays In-Network**	**Member Pays Out-of-Network**
Medical Supplies	$0 when obtained through Empire's medical supplies vendor	In-network benefits apply
Durable Medical Equipment[6]	$0	Deductible and Coinsurance
Prosthetics & Orthotics[6]	$0	Deductible and Coinsurance
Ambulance (Land/Air ambulance)	$0	In-network benefits apply

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(1) Network provider delivers care. Empire's network provider must precertify in-network services; Empire network providers cannot bill members beyond the copayment for covered services.

(2) Out-of-network services (except Mental Health and Alcohol/Substance Abuse) are those from a provider that does not participate in Empire's PPO network, or with another Blue Cross and Blue Shield Plan through the BlueCard® PPO Program. (This does not apply to emergency benefits.) See (8) for Mental Health and Alcohol/Substance Abuse Services.

(3) Out-of-network (O-O-N) providers – those who do not participate in Empire's PPO network, or with another Blue Cross and Blue Shield Plan through the BlueCard® PPO Program. Out-of-network providers who do not participate with Empire or with another Blue Cross and Blue Shield Plan, may balance bill over Empire's allowed amount. Precertification is not required for out-of-network services, nor for out-of-area in-network BlueCard® PPO provider services.

(4) Preventive Care benefits not subject to copayment, deductible and coinsurance; when provided In-Network include; mammography screenings, cervical cancer screenings, colorectal cancer screenings, prostate cancer screenings, hypercholesterolemia screenings, diabetes screenings for pregnant women, bone density testing, annual physical examinations and annual obstetric and gynecological examinations. May also include other services as required under State and Federal Law. May be subject to age and frequency limits.

(5) You are responsible for obtaining precertification from Empire's Medical Management Program for these services. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained. For ambulatory surgery, precertification is required for reconstructive surgery, outpatient transplants and ophthalmological or eye-related procedures. Precertification is also required for cosmetic surgery, an excluded benefit except when medically necessary.

(6) For services received from an Empire PPO provider, the provider must precertify in-network services; Empire PPO providers cannot bill members beyond the copayment, deductible, or coinsurance for covered services. Outside Empire's network area, you or your provider must obtain precertification from Empire's Medical Management Program for services from in-network BlueCard® PPO providers.

(7) You are responsible for obtaining precertification from AIM for MRI, MRA, PET, CAT, Nuclear Cardiology, and Echocardiography services rendered by an Empire PPO provider. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained. Precertification is not required for these services when rendered from an in-network BlueCard® provider outside of Empire's network area or out-of-network providers.

(8) You are responsible for obtaining precertification from the Behavioral Healthcare Manager for these services. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained.

(9) Network providers must obtain precertification from Empire's Medical Management Program for Inpatient Facility Services received from an out-of-area BlueCard PPO Provider.

(10) Empire's network provider must obtain authorization for clinical/medical necessity for in-network services after 5th visit.

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This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Included are preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.

Empire BCBS Summary of Benefits—PPO25 Plan

Your Summary of Benefits

Empire BlueCross BlueShield
An Anthem Company

Benefit	In-Network [1]	Out-of-Network [2,3]
Deductible	N/A	$500/$1,250
Coinsurance	N/A	20%
Out-of-Pocket Maximum	$3,880 / $9,700 (All In-Network Cost Shares)	$5,000/$12,500 Coinsurance Stop Loss / ($1,000/$2,500 out-of-pocket)
Lifetime Maximum	Unlimited	Unlimited
Dependent Children (covered to the end of the month of the dependent's birthday)	Dependents to age 26	Dependents to age 26
Covered Preventive Care[4]	**Member Pays In-Network**	**Member Pays Out-of-Network**
Covered Adult Preventive Care	$0	Deductible and Coinsurance
Annual Physical Exam	$0	Covered in-network only
Well-Child Care (Up to age 19; including necessary covered immunizations)	$0	Deductible and Coinsurance
Preventive Well-Woman Care	$0	Deductible and Coinsurance
Home/Office/Outpatient Care	**Member Pays In-Network**	**Member Pays Out-of-Network**
Home/Office Visits (PCP/Specialist)	$25 / $40 copayment	Deductible and Coinsurance
Online Visits	$0 copayment	Deductible and Coinsurance
Urgent Care Center	$25 copayment	$25 copayment
Emergency Room/Facility (initial visit per occurrence)	$200 copayment (Waived if admitted within 24 hours)	$200 copayment (Waived if admitted within 24 hours)
Ambulatory Surgery[5]/ Outpatient Surgery	$100 copayment	Deductible and Coinsurance
Presurgical Testing, Anesthesia	$0	Deductible and Coinsurance
Chemotherapy, Radiation Therapy	$0	Deductible and Coinsurance
Routine Maternity Care	$0	Deductible and Coinsurance
Laboratory Tests,	$0	Deductible and Coinsurance
X-rays	$25 copayment	Deductible and Coinsurance
MRI[7]/MRA[7], CAT Scan[7], PET[7] & Nuclear Cardiology[7]	$75 copayment	Deductible and Coinsurance
Allergy Routine Testing and Treatment		Deductible and Coinsurance
– Office Visit	$25 copayment	Deductible and Coinsurance
– Routine Testing	$0	
– Allergy Injections/Immunotherapy	$0	
Acupuncture (Up to 30 visits per calendar year)	$25 copayment	Deductible and Coinsurance
Chiropractic Care (Up to 30 visits per calendar year) [10]	$25 copayment	Deductible and Coinsurance
Home Healthcare (Up to 200 visits per calendar year)	$0	Coinsurance (no deductible)
Home Infusion Therapy	$0	Deductible and Coinsurance
Hospice Care (unlimited days)	$0	Deductible and Coinsurance
Physical Therapy[5] (Up to 90 visits per calendar year combined in home, office or outpatient facility)	$25 copayment	Deductible and Coinsurance
Other Short-Term Rehabilitative Therapies – Speech/Language[5], Occupational[5] (Up to 60 visits per calendar year combined in home, office or outpatient facility)	$25 copayment	Deductible and Coinsurance
Vision Therapy	$25 copayment	Deductible and Coinsurance

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licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

Empire BCBS Summary of Benefits—PPO25 Plan

Benefit	In-Network[1]	Out-of-Network [2,3]
Cardiac Rehabilitation (Unlimited visits per calendar year)	$25 copayment	Deductible and Coinsurance
Second Surgical Opinion	$25 / $50 copayment (no copayment applies if arranged through the Medical Management Program)	Deductible and Coinsurance
Kidney Dialysis	$0	Deductible and Coinsurance
Inpatient Care[9]	**Member Pays In-Network**	**Member Pays Out-of-Network**
Inpatient Hospital (As many days as is medically necessary; semiprivate room and board)	$200 copayment	Deductible and Coinsurance
Surgery, Covered Surgical Assistant, Anesthesia	$0	Deductible and Coinsurance
Physical Therapy, Physical Medicine, or Rehabilitation (Up to 90 inpatient days per calendar year)	$0	Deductible and Coinsurance
Skilled Nursing Facility (Up to 60 days per calendar year)	$0	Deductible and Coinsurance
Mental Health[8]	**Member Pays In-Network**	
Outpatient Visits in Office	$25 copayment	Deductible and Coinsurance
Outpatient Visits in Facility	$25 copayment	Deductible and Coinsurance
Inpatient Care[9] (As many days as medically necessary; semiprivate room and board)	$200 copayment	Deductible and Coinsurance
Alcohol/Substance Abuse[8]	**Member Pays In-Network**	**Member Pays Out-of-Network**
Outpatient Visits in Office	$25 copayment	Deductible and Coinsurance
Outpatient Visits in Facility	$25 copayment	Deductible and Coinsurance
Inpatient Detoxification[9] (As many days as medically necessary; semiprivate room and board)	$200 copayment	Deductible and Coinsurance
Inpatient Rehabilitation[9]	$200 copayment	Deductible and Coinsurance
Other	**Member Pays In-Network**	**Member Pays Out-of-Network**
Medical Supplies	$0 when obtained through Empire's medical supplies vendor	In-network benefits apply
Durable Medical Equipment[6]	$0	Deductible and Coinsurance
Prosthetics & Orthotics[6]	$0	Deductible and Coinsurance
Ambulance (Land/Air ambulance)	$50 copayment	Deductible and Coinsurance

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(2) Out-of-network services (except Mental Health and Alcohol/Substance Abuse) are those from a provider that does not participate in Empire's PPO network, or with another Blue Cross and Blue Shield Plan through the BlueCard® PPO Program. (This does not apply to emergency benefits.) See (8) for Mental Health and Alcohol/Substance Abuse Services.
(3) Out-of-network (O-O-N) providers – those who do not participate in Empire's PPO network, or with another Blue Cross and Blue Shield Plan through the BlueCard® PPO Program. Out-of-network providers who do not participate with Empire or with another Blue Cross and Blue Shield Plan, may balance bill over Empire's allowed amount. Precertification is not required for out-of-network services, nor for out-of-area in-network BlueCard® PPO provider services.
(4) Preventive Care benefits not subject to copayment, deductible and coinsurance; when provided In-Network include; mammography screenings, cervical cancer screenings, colorectal cancer screenings, prostate cancer screenings, hypercholesterolemia screenings, diabetes screenings for pregnant women, bone density testing, annual physical examinations and annual obstetric and gynecological examinations. May also include other services as required under State and Federal Law. May be subject to age and frequency limits.
(5) You are responsible for obtaining precertification from Empire's Medical Management Program for these services. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained. For ambulatory surgery, precertification is required for reconstructive surgery, outpatient transplants and ophthalmological or eye-related procedures. Precertification is also required for cosmetic surgery, an excluded benefit except when medically necessary.
(6) For services received from an Empire PPO provider, the provider must precertify in-network services; Empire PPO providers cannot bill members beyond the copayment, deductible, or coinsurance for covered services. Outside Empire's network area, you or your provider must obtain precertification from Empire's Medical Management Program for services from in-network BlueCard® PPO providers.
(7) You are responsible for obtaining precertification from AIM for MRI, MRA, PET, CAT, Nuclear Cardiology, and Echocardiography services rendered by an Empire PPO provider. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained. Precertification is not required for these services when rendered from an in-network BlueCard® provider outside of Empire's network area or out-of-network providers.
(8) You are responsible for obtaining precertification from the Behavioral Healthcare Manager for these services. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained.
(9) Network providers must obtain precertification from Empire's Medical Management Program for Inpatient Facility Services received from an out-of-area BlueCard PPO Provider.
(10) Empire's network provider must obtain authorization for clinical/medical necessity for in-network services after the 5th visit.

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Included are preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.

Your Pharmacy Benefit Plan through Magellan Rx Management

Dedicated Partner

As your prescription benefits manager, Magellan Rx Management is dedicated to giving you the best information and resources to help you make better healthcare decisions to lead a healthy, vibrant life. Our wide range of prescription benefit programs emphasize quality and cost-effective solutions that lead to better drug therapy choices.

Using your ID card at retail pharmacies

Present your card at any of our 68,000+ retail pharmacies every time you fill your prescription. Access a participating pharmacy list at **magellanrx.com.**

If you need to fill a prescription prior to receiving your ID cards, provide this information to the pharmacy in addition to your ID number or social security number: **RXBIN: 017449; RXPCN: 6792000; RXGRP: PRXULS.**

Filling first home delivery prescription with Magellan Rx Pharmacy

If you already have a 90-day prescription:

Mail your 90-day prescription and home delivery order form with payment information to Magellan Rx Pharmacy, P.O. Box 620968, Orlando, FL 32862.

Home delivery order forms are available at magellanrx.com/member/forms

If you need a new prescription:

First, ask your doctor to write two prescriptions:

1. **30-day supply to fill right away at your local pharmacy**
2. **90-day supply with refills to start your home delivery service**

Next, ask your doctor to **e-prescribe** to Magellan Rx Pharmacy, LLC (Mail-ORL) or **fax** your prescription to 888-282-1349.

Online tools at magellanrx.com

Visit our website for a fast, easy and secure way to manage your pharmacy benefits. At **magellanrx.com** you can:

- View prescription history
- Find a pharmacy
- Watch medication videos
- Review your formulary/drug list
- Price a drug
- Download forms and ID cards

Formulary lookup tool

To find drugs that are covered by your plan, we offer an easy-to-use formulary drug lookup tool. The drugs in our formulary have been approved by the Food and Drug Administration (FDA) as safe and effective. They were selected by our team of expert health care professionals.

Visit **magellanrx.com/member/documents** to view formulary documents.

You are using the **Precision** formulary.

magellanrx.com

See the Magellan Formulary List and Exclusions posted in the AleraEdge Resource Library

Magellan Rx

Your Prescription Benefits

Copayments

Empire POS 20 Plan	Retail (30-day supply)	Mail (90-day supply)
Tier 1: Generic	$5	$10
Tier 2: Preferred Brand	$20	$40
Tier 3: Non-Preferred Brand	$40	$80

Empire PPO 20 & 25 Plans	Retail (30-day supply)	Mail (90-day supply)
Tier 1: Generic	$10	$20
Tier 2: Preferred Brand	$25	$50
Tier 3: Non-Preferred Brand	$40	$80

Prior Authorization/Step Therapy

Your plan may have prior authorization and/or step therapy requirements for coverage or limits for select drugs.

Prior Authorization: Your plan needs to approve before your doctor can prescribe a specific drug for you.

Step Therapy: You must first try one drug to treat your medical condition. If that one doesn't work, then your plan will cover another drug for that condition.

Questions?

Visit **magellanrx.com** or call 1.800.424.0472. Support is available to members, pharmacies and prescribers 24 hours a day, 7 days a week.

MRx Select Savings Specialty Drug Program

Your benefit plan now includes the MRx Select Savings program. This program lowers your healthcare costs and costs incurred by your plan by finding alternative funding sources for select high-cost specialty drugs. We have partnered with Payer Matrix to help secure these funds.

Key points of the program:

- Enrollment in the program can greatly reduce your specialty drug out-of-pocket cost—in many cases to no cost at all.
- We will help you enroll in the program to receive these benefits. Your specialty medication will not be covered if you do not enroll in this program.
- Costs paid by alternative funding sources will not count toward your deductible or out-of-pocket maximum amounts.

Because you have been prescribed a qualified specialty drug, you must engage with Payer Matrix before the pharmacy can fill your prescription:

- A Payer Matrix program case coordinator will contact you.
- Your case coordinator will tell you what you need to know about the program and will walk you through the enrollment process and requirements. They will also answer any questions you may have.
- Please be ready to provide personal and financial details, as many of the programs available through alternative funding sources are based on need.

You can contact Payer Matrix at 877.305.6202 or by email at customerservice@payermatrix.com.

Magellan Rx MANAGEMENT℠

See the Magellan Formulary List and Exclusions posted in the AleraEdge Resource Library

Urgent Care Facilities (In-Network) Ulster County Area

AMC EMURGENTCARE
2976 Route 9W
Saugerties, NY 12477
PH: 845-247-9100

AMC EMURGENTCARE
11835 State Route 9W
West Coxsackie, NY 12192
PH: 518-731-9000

ANDERSON MEDICAL PC
4274 Albany Post Rd
Hyde Park, NY 12538
PH: 845-229-2602

EMERGENCY ONE
40 Hurley Ave, Ste 4
Kingston, NY 12401
PH: 845-338-5600

EMERGENCY ONE
306 Windsor Hwy
New Windsor, NY 12553
PH: 845-787-1400

ANDERSON MEDICAL PC
2555 South Rd
Poughkeepsie, NY 12601
PH: 845-330-3200

EXCEL URGENT CARE FISHKILL
1004 Main St
Fishkill, NY 12524
PH: 845-765-2240

FIRST CARE MEDICAL PC
222 State Route 299
Highland, NY 12528
PH: 845-691-3627

FIRST CARE MEDICAL PC
222 State Route 299
Highland, NY 12528
PH: 845-691-3627

HQUMCP PC
1351 Route 55 Ste 200
Lagrangeville, NY 12540
PH: 845-297-2511

HQUMCP PC
1100 Route 55-Ste 101
Lagrangeville, NY 12540
PH: 845-485-4455

PULSE-MD URGENT CARE
900 Route 376-Ste H
Wappingers Falls, NY 12590
PH: 845-204-9260

MIDDLETOWN MEDICAL PC
112 Shoprite Blvd
Ellenville, NY 12428
PH: 845-647-6700

NUVANCE HEALTH MED PRACTICE
1240 Ulster Ave
Kingston, NY 12401
PH:845-443-8740

CANARx Prescription Program

CANARX is a voluntary international mail order prescription program that is available to eligible employees, retirees and their dependents of Ulster County, New York.

Brand name medications, in the original factory-sealed manufacturers packaging, are delivered DIRECT TO YOUR DOOR from certified pharmacies in Canada, the United Kingdom and Australia. YOU PAY NOTHING thanks to the savings CANARX brings to your plan.

SIMPLE.

SAFE.

SMART.

FREE Brand-Name Medications

No Shipping and Handling Charges to You!

ZERO COPAYS

Let's Get Started

JOINING IS EASY!

Visit our website today, for more information including:

- Additional Forms
- Frequently Asked Questions (FAQs)
- Video Overview
- List of Medications

Call 1-866-893-6337

OR

canarx.com

Scan to go to the website
WebID=ULSTER

Submit Your Completed and Signed Enrollment Form, Original Prescription and ID:

By Mail to:
CANARX
PO Box 3009
Windsor, ON Canada
N8N 2M3

By Fax to:
1-866-715-6337

Enrollment Form and ID can also be sent by secure upload to:
canarxdocs.com

Note: Prescriptions must be faxed directly from the physician's office.

Getting started is super easy!

1. Check to see if a medication is offered. Call **1-866-893-6337** and speak with a CANARx representative or view the complete formulary and print enrollment material at **www.canarx.com** (WebID: **ULSTER**).

2. Ask your doctor for a prescription for a 3-month supply, with 3 refills.

3. Submit documentation (completed enrollment form, prescription and a copy of your photo ID).

4. Sit back and relax…medication will be mailed direct to your home within 4 weeks!

For More Information: Call 1-866-893-6337 / CANARx

ABILIFY (G) 2MG
ABILIFY (G) 5MG
ABILIFY (G) 10MG
ABILIFY (G) 15MG
ABILIFY (G) 20MG
ABILIFY (G) 30MG
ACIPHEX 20MG
ACTIVELLA (G) 1MG/0.5MG
ACTONEL 35MG
ACTONEL 150MG
ACTOPLUS 15MG-850MG
ACULAR (G) 0.5%
ACULAR LS (G) 0.4%
ACZONE 5%
ADCIRCA (G) 20MG
ADVAIR DISKUS 100MCG
ADVAIR DISKUS 250MCG
ADVAIR DISKUS 500MCG
ADVAIR HFA 45/21MCG
ADVAIR HFA 115/21MCG
ADVAIR HFA 230/21MCG
AKLIEF 50MCG/G
ALOCRIL 2%
ALOMIDE 0.1%
ALPHAGAN-P 0.15%
ALREX 0.2%
ALVESCO 80MCG 100MCG
ALVESCO 160MCG 200MCG
ANAPROX DS 550MG
ANORO ELLIPTA 62.5/25MCG
APTIOM 200MG
APTIOM 400MG
APTIOM 600MG
APTIOM 800MG
ARAVA 10MG
ARAVA 20MG
ARNUITY ELLIPTA 100MCG
ARNUITY ELLIPTA 200MCG
AROMASIN 25MG
ARTHROTEC 50MG
ARTHROTEC 75MG
ASMANEX TWISTHALER 110MCG
ASMANEX TWISTHALER 220MCG
ASTAGRAF XL 1MG
ASTAGRAF XL 5MG
ATACAND 4MG
ATACAND 8MG
ATACAND 16MG
ATACAND 32MG
ATACAND HCT 16MG/12.5MG
ATACAND HCT 32MG/12.5MG
ATELVIA DR 35MG
ATROVENT HFA 20UG
AVODART (G) 0.5MG
AZELEX 20%
AZILECT 0.5MG
AZILECT 1MG
AZOPT 1%
AZOR 20/5MG
AZOR 40/5MG
AZOR 40/10MG
BANZEL 200MG
BANZEL 400MG
BECONASE AQ 42MCG
BENICAR 20MG
BENICAR 40MG
BENICAR HCT 20MG/12.5MG
BENICAR HCT 40MG/12.5MG
BENICAR HCT 40MG/25MG
BENZACLIN GEL
BEPREVE 1.5%
BETIMOL 0.25%
BETIMOL 0.5%
BETOPTIC S 0.25%
BEYAZ
BIJUVA 1MG-100MG
BIKTARVY 50MG-200MG-25MG
BINOSTO 70MG
BONIVA (G) 150MG
BREO ELLIPTA 100/25MCG
BREO ELLIPTA 200/25MCG
BRILINTA 60MG
BRILINTA 90MG
BYSTOLIC 2.5MG
BYSTOLIC 5MG
BYSTOLIC 10MG
BYSTOLIC 20MG
CADUET 5/10MG
CADUET 5/20MG
CADUET 5/40MG
CADUET 5/80MG
CADUET 10/10MG
CADUET 10/20MG
CADUET 10/40MG
CADUET 10/80MG
CAMBIA 50MG
CARDIZEM CD (G) 180MG
CARDIZEM CD (G) 240MG
CARDIZEM CD (G) 360MG
CARDURA XL 4MG
CARDURA XL 8MG
CELEBREX 100MG
CELEBREX 200MG
CLARINEX 5MG
CLIMARA PATCH 25MCG
CLIMARA PATCH 50MCG
CLIMARA PATCH 75MCG
CLIMARA PATCH 100MCG
COLAZAL 750MG
COMBIGAN 0.2-0.5%
COMBIVENT RESPIMAT
20MCG/100MCG
COMTAN 200MG
CORGARD 80MG
COSOPT PF 2%/0.5%
CRESTOR (G) 5MG
CRESTOR (G) 10MG
CRESTOR (G) 20MG
CRESTOR (G) 40MG
CRINONE GEL 8%
CYMBALTA (G) 20MG
CYMBALTA (G) 30MG
CYMBALTA (G) 60MG
CYTOTEC (G) 200MCG
DALIRESP 500MCG
DEPAKOTE 250MG
DEPAKOTE 500MG
DETROL 1MG
DETROL 2MG
DETROL LA 2MG
DETROL LA 4MG
DEXILANT DR 30MG
DEXILANT DR 60MG
DIFFERIN CREAM 0.1%
DIFFERIN GEL 0.3%
DIOVAN (G) 40MG
DIOVAN (G) 80MG
DIOVAN (G) 160MG
DIOVAN (G) 320MG
DIPENTUM 250MG
DIPROLENE OINT 0.05%
DIVIGEL 0.25MG
DIVIGEL 0.5MG
DIVIGEL 1MG
DUAVEE 0.45-20MG
DULERA 100MCG/5MCG
DULERA 200MCG/5MCG
DYMISTA 137/50MCG
EDARBI 40MG
EDARBI 80MG
EDARBYCLOR 40MG/12.5MG
EDARBYCLOR 40MG/25MG
EDECRIN 25MG
EDURANT 25MG
EFFIENT (G) 5MG
EFFIENT (G) 10MG
ELESTAT 0.05%
ELIDEL 1%
ELIQUIS 2.5MG
ELIQUIS 5MG
ELMIRON 100MG
ENABLEX 7.5MG
ENABLEX 15MG
ENTRESTO 24MG-26MG
ENTRESTO 49MG-51MG
ENTRESTO 97MG-103MG
EPIDUO FORTE 0.3%/2.5%
EPIDUO GEL PUMP 0.1%/2.5%
EPIPEN 0.3MG
EPIPEN JR 0.15MG
EPIVIR / HBV 100MG
ESTROGEL 0.06%
EUCRISA 2%
EVISTA 60MG
EXELON 4.6MG/24HR
EXELON 9.5MG/24HR
EXELON 13.3MG/24HR
EXFORGE 5/160MG
EXFORGE 5/320MG
EXFORGE 10/160MG
EXFORGE 10/320MG
EXFORGE HCT 160/12.5/5MG
EXFORGE HCT 160/12.5/10MG
EXFORGE HCT 160/25/5MG
EXFORGE HCT 160/25/10MG
EXFORGE HCT 320/25/10MG
FARESTON 60MG
FARXIGA 5MG
FARXIGA 10MG
FELDENE 10MG
FELDENE 20MG
FETZIMA 20MG
FETZIMA 40MG
FETZIMA 80MG
FETZIMA 120MG
FINACEA GEL 15%
FLAREX 0.1%
FLOVENT 44MCG 50MCG
FLOVENT 110MCG 125MCG
FLOVENT 220MCG 250MCG
FLOVENT DISKUS 100MCG
FLOVENT DISKUS 250MCG
FOSAMAX PLUS D 70MG-2800IU
FOSAMAX PLUS D 70MG-5600IU
FOSRENOL CHEW 500MG
FOSRENOL CHEW 750MG
FOSRENOL CHEW 1000MG
FOSRENOL POWDER 750MG
FOSRENOL POWDER 1000MG
FROVA 2.5MG
GENVOYA
GILENYA 0.5MG
GLUCAGEN HYPOKIT 1MG
GLUMETZA ER 1000MG
GLYXAMBI 10MG/5MG
GLYXAMBI 25MG/5MG
HEPSERA (G) 10MG
IBRANCE 75MG
IBRANCE 100MG
IBRANCE 125MG
ILEVRO 0.3%
IMITREX NASAL SPRAY 5MG
IMITREX NASAL SPRAY 20MG
IMITREX STATDOSE 6MG/0.5ML
INCRUSE ELLIPTA 62.5MCG
INVEGA 3MG
INVEGA 6MG
INVEGA 9MG
INVOKAMET 50MG-500MG
INVOKAMET 50MG-1000MG
INVOKAMET 150MG-500MG
INVOKAMET 150MG-1000MG
INVOKANA 100MG
INVOKANA 300MG
IRESSA 250MG
JAKAFI 5MG
JAKAFI 10MG
JAKAFI 15MG
JAKAFI 20MG
JALYN 0.5MG/0.4MG
JANUMET 50/500MG
JANUMET 50/1000MG
JANUMET XR 50MG/500MG
JANUMET XR 50MG/1000MG
JANUMET XR 100MG/1000MG
JANUVIA 25MG
JANUVIA 50MG
JANUVIA 100MG
JARDIANCE 10MG
JARDIANCE 25MG
JENTADUETO 2.5MG-500MG
JENTADUETO 2.5MG-850MG
JENTADUETO 2.5MG-1000MG
JUBLIA 10%
JULUCA 50MG-25MG
KAZANO 12.5/500MG
KAZANO 12.5/1000MG
KEPPRA (G) 250MG
KEPPRA (G) 500MG
KEPPRA (G) 750MG
KEPPRA (G) 1000MG
KISQALI 200MG
KOMBIGLYZE XR 2.5MG/1000MG
KOMBIGLYZE XR 5MG/500MG
KOMBIGLYZE XR 5MG/1000MG
LATUDA 20MG
LATUDA 40MG
LATUDA 60MG
LATUDA 80MG
LATUDA 120MG
LESCOL XL 80MG
LEXIVA 700MG
LIALDA 1.2GM
LINZESS 72MCG
LINZESS 145MCG
LINZESS 290MCG
LIPITOR (G) 10MG
LIPITOR (G) 20MG
LIPITOR (G) 40MG
LIPITOR (G) 80MG
LOTEMAX GEL 0.5%
LOTEMAX OINT 0.5%
LOTEMAX SUSP 0.5%
LOVENOX (G) 40MG
LOVENOX (G) 60MG
LOVENOX (G) 80MG
LOVENOX (G) 100MG
LUMIGAN 0.01%
MESTINON TS 180MG
METRO CREAM 0.75%
METROGEL PUMP 1%
MICARDIS HCT 40/12.5MG
MICARDIS HCT 80/12.5MG
MICARDIS HCT 80/25MG
MIGRANAL 4MG/ML
MIRAPEX ER 0.375MG
MIRAPEX ER 0.75MG
MIRAPEX ER 1.5MG
MIRAPEX ER 2.25MG
MIRAPEX ER 3MG
MIRAPEX ER 3.75MG
MIRAPEX ER 4.5MG
MIRVASO 0.33%
MOTEGRITY 1MG
MOTEGRITY 2MG
MULTAQ 400MG
MYRBETRIQ 25MG
MYRBETRIQ 50MG
NAMENDA 10MG
NATAZIA 3/2-2/2-3/1MG
NESINA 6.25MG
NESINA 12.5MG
NESINA 25MG
NEUPRO 1MG
NEUPRO 2MG
NEUPRO 3MG
NEUPRO 4MG
NEUPRO 6MG
NEUPRO 8MG
NEVANAC 3MG/ML
NEXIUM (G) 20MG
NEXIUM (G) 40MG
NEXIUM DR (G) 10MG
NEXLETOL 180MG
NEXLIZET 180MG-10MG
NORITATE CREAM 1%
ODEFSEY 200MG-25MG-25MG
OMNARIS 50MCG
ONGLYZA 2.5MG
ONGLYZA 5MG
ORILISSA 150MG
ORILISSA 200MG
OSPHENA 60MG
OTEZLA 30MG
PENTASA 500MG
PLAQUENIL 200MG
PRADAXA 75MG
PRADAXA 150MG
PRED FORTE 1%
PREMARIN 0.3MG
PREMARIN 0.625MG
PREMARIN 1.25MG
PREMARIN CREAM
0.625MG/GM
PREMPRO 0.3MG/1.5MG
PRESTALIA 3.5MG/2.5MG
PRESTALIA 7MG/5MG
PRESTALIA 14MG/10MG
PREVACID SOLUTAB 15MG
PREVACID SOLUTAB 30MG
PREZISTA 800MG
PRISTIQ 50MG
PRISTIQ 100MG
PROMETRIUM 100MG
PROSCAR (G) 5MG
PROTOPIC OINT 0.03%
PROTOPIC OINT 0.1%
QTERN 10-5MG
QVAR REDIHALER 40MCG
QVAR REDIHALER 80MCG
RANEXA 500MG
RAPAFLO 4MG
RAPAFLO 8MG
RAPAMUNE 0.5MG
RAPAMUNE 1MG
RAPAMUNE 2MG
RELPAX 20MG
RELPAX 40MG
RENAGEL 800MG
RENVELA (G) 800MG
RESTASIS MULTIDOSE 0.05%
RESTASIS VIALS 0.05%
RETIN A MICRO GEL PUMP 0.04%
RETIN-A MICRO GEL PUMP 0.1%
REXULTI 0.25MG
REXULTI 0.5MG
REXULTI 1MG
REXULTI 2MG
REXULTI 3MG
REXULTI 4MG
RINVOQ 15MG
RINVOQ 30MG
RYBELSUS 3MG
RYBELSUS 7MG
RYBELSUS 14MG
SAPHRIS 5MG
SAPHRIS 10MG
SEASONIQUE 0.15/0.03/0.01MG
SEGLUROMET 2.5MG-500MG
SEGLUROMET 2.5MG-1000MG
SEGLUROMET 7.5MG-500MG
SEGLUROMET 7.5MG-1000MG
SENSIPAR (G) 30MG
SENSIPAR (G) 60MG
SEREVENT DISKUS 50MCG
SEROQUEL XR (G) 50MG
SEROQUEL XR (G) 150MG
SEROQUEL XR (G) 200MG
SEROQUEL XR (G) 300MG
SEROQUEL XR (G) 400MG
SIMBRINZA 1%/0.2%
SOOLANTRA 1%
SPIRIVA 18MCG
SPIRIVA RESPIMAT 2.5MCG
STEGLATRO 5MG
STEGLATRO 15MG
STEGLUJAN 5MG-100MG
STEGLUJAN 15MG-100MG
STIOLTO RESPIMAT 2.5/2.5MCG
STRATTERA 10MG
STRATTERA 18MG
STRATTERA 25MG
STRATTERA 40MG
STRATTERA 60MG
STRATTERA 80MG
STRATTERA 100MG
STRIVERDI RESPIMAT 2.5MCG
SYNAREL NASAL
SYNJARDY 5MG/500MG
SYNJARDY 5MG/1000MG
SYNJARDY 12.5MG/500MG
SYNJARDY 12.5MG/1000MG
TASMAR 100MG
TAZORAC CREAM 0.05%
TAZORAC GEL 0.05%
TAZORAC GEL 0.1%
TECFIDERA (G) 120MG
TECFIDERA (G) 240MG
TEKTURNA 150MG
TEKTURNA 300MG
TIVICAY 50MG
TOBI PODHALER 28MG
TOBREX OINT 0.3%
TOPICORT CREAM 0.25%
TOVIAZ 4MG
TOVIAZ 8MG
TRADJENTA 5MG
TRAVATAN Z 0.004%
TRELEGY ELLIPTA 100-62.5-25MCG
TRELEGY ELLIPTA 200-62.5-25MCG
TRIBENZOR 20/5/12.5MG
TRIBENZOR 40/5/12.5MG
TRIBENZOR 40/5/25MG
TRIBENZOR 40/10/12.5MG
TRIBENZOR 40/10/25MG
TRINTELLIX 5MG
TRINTELLIX 10MG
TRINTELLIX 20MG
TRIUMEQ 600-50-300MG
TUDORZA PRESSAIR 400MCG
UCERIS 9MG
ULORIC 80MG
UROCIT-K 10MEQ
URSO 250MG
VAGIFEM 10MCG
VECTICAL 3MCG/GM
VELPHORO 500MG
VENTOLIN HFA 90MCG
VESICARE (G) 5MG
VESICARE (G) 10MG
VIIBRYD 10MG
VIIBRYD 20MG
VIIBRYD 40MG
VIMOVO 375/20MG
VIMOVO 500/20MG
VIREAD (G) 300MG
VIVELLE-DOT 25MCG
VIVELLE-DOT 37.5MCG
VIVELLE-DOT 50MCG
VIVELLE-DOT 75MCG
VIVELLE-DOT 100MCG
VRAYLAR 1.5MG
VRAYLAR 3MG
VRAYLAR 4.5MG
VRAYLAR 6MG
VYTORIN 10/10MG
VYTORIN 10/20MG
VYTORIN 10/40MG
VYTORIN 10/80MG
WELCHOL 625MG
WELCHOL PACKET 3.75G
WELLBUTRIN XL (G) 150MG
WELLBUTRIN XL (G) 300MG
XADAGO 50MG
XADAGO 100MG
XALATAN 50MCG/ML
XARELTO 2.5MG
XARELTO 10MG
XARELTO 15MG
XARELTO 20MG
XELJANZ 5MG
XELJANZ 10MG
XELJANZ XR 11MG
XENICAL 120MG
XIGDUO XR 5/1000MG
XIGDUO XR 10/500MG
XIGDUO XR 10/1000MG
XIIDRA 5%
YASMIN 28
YAZ 3/0.02MG
ZELAPAR 1.25MG
ZETIA (G) 10MG
ZIAGEN (G) 300MG
ZIANA 1.2%-0.025%
ZOMIG (G) 2.5MG
ZOMIG NASAL SPRAY 5MG
ZOMIG ZMT 2.5MG
ZOVIRAX CREAM 5%
ZYCLARA PACKET 3.75%
ZYCLARA PUMP 3.75%

NOTE: Medication names appearing with (G) are available in a Generic version from your local or U.S. mail order pharmacy. This list is subject to change. Please call 1-866-893-6337 toll free to verify the availability of your medication through this program.

August 2022

CANARx—Employee Enrollment Form

CANARX

MEMBER ENROLLMENT FORM

For more information, please call:
TOLL-FREE PHONE: 1-866-893-6337

Please return completed enrollment form by one of the following methods:
MAIL: CANARX, PO BOX 3009, WINDSOR, ONTARIO CANADA N8N 2M3
SECURE UPLOAD: CANARXDOCS.COM
FAX: 1-866-715-6337 (NOTE: Faxed ***prescriptions*** must be sent directly from the physician's office.)

WEBID *(CALL IF UNSURE)*

NAME OF EMPLOYER

PATIENT INFORMATION *(PLEASE PRINT)*

DATE OF BIRTH *(MM/DD/YYYY)*	MEMBER ID # *(IF AVAILABLE)*

HOME PHONE	MOBILE PHONE	WORK PHONE EXT.	EMAIL ADDRESS

FIRST NAME	INITIAL	LAST NAME

STREET ADDRESS

CITY	STATE	ZIP CODE	☐ SUBSCRIBER ☐ DEPENDENT

CURRENT MEDICATIONS / VITAMINS *THIS IS NOT A PRESCRIPTION.*

LIST ALL: **PRESCRIPTION, NON-PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS; HERBAL, NUTRITIONAL AND VITAMIN SUPPLEMENTS.**

NAME OF MEDICATION *Ex. JANUVIA*	DOSAGE *Ex. 50MG*	TIME(S) TO TAKE *Ex. TWICE DAILY*	DATE STARTED *Ex. 08/20/2019*	REASON FOR TAKING *Ex. DIABETES*

NEW-TO-YOU MEDICATIONS MUST BE DOMESTICALLY PRESCRIBED, FILLED AND TAKEN FOR A PERIOD OF NO LESS THAN 30 DAYS BEFORE ORDERING THROUGH THIS PROGRAM. *PLEASE ASK YOUR PHYSICIAN TO ISSUE A PRESCRIPTION FOR A 3-MONTH SUPPLY OF MEDICATION WITH 3 REFILLS.*

☐ PRESCRIPTION IS ATTACHED ☐ PRESCRIPTION WILL FOLLOW BY MAIL ☐ PRESCRIPTION WILL BE FAXED FROM PHYSICIAN'S OFFICE

MEDICAL HISTORY *(If you require more space, please attach a separate piece of paper.)*

☐ MALE ☐ FEMALE

1. OPERATIONS (EX. HYSTERECTOMY, GALL BLADDER, HEART OPERATIONS, ETC.):

2. HOSPITALIZATIONS (STAYS IN HOSPITAL DURING THE PAST 5 YEARS):

3. MEDICAL CONDITIONS (ONGOING – EX. TYPE 1 DIABETES MELLITUS, VASCULITIS, OSTEOPOROSIS, ETC.) – ***NOTE:*** *Please refrain from using generic terms such as **"heart disease"** as this could indicate any number of conditions such as valvular heart disease, heart failure, a bradyarrhythmia, a tachyarrhythmia, a ventricular conduction delay, etc.*

4. DRUG ALLERGIES: ☐ YES ☐ NO IF YES, PLEASE SPECIFY.

AUTHORIZATION – IF THE PATIENT IS A DEPENDENT CHILD UNDER AGE 18

I certify this to be a true and accurate statement of my Dependent's medical history. I confirm that he/she has been, and will be, regularly monitored by a U.S. Physician and has had a physical examination within the past 12 months. I verify that he/she has taken the above listed medications for a period of more than 30 days. I certify that I have read, understand and agree to the Terms of Agreement on the reverse, or in absence, confirm it was read and understood on the website prior to signature, and that the information provided above is accurate and true.

Parent's/Guardian's Signature: **Date:** *(MM/DD/YYYY)*

AUTHORIZATION – IF THE PATIENT IS THE SUBSCRIBER, SPOUSE OR A DEPENDENT CHILD AGE 18 AND OVER

I certify that I have read, understand and agree to the Terms of Agreement on the reverse, or in absence, confirm it was read and understood on the website prior to signature, and that the information provided by me is accurate and true.

Patient's Signature: **Date:** *(MM/DD/YYYY)*

CANARx —Enrollment Form / Agreement

TERMS OF AGREEMENT

CONFIRMATION AND REPRESENTATIONS

I enter into this agreement with CANARX Group Inc. at Christ Church, Barbados (referred to as "CANARX") so that I may obtain access to medically-necessary and lawfully prescribed drugs at low costs. I represent:

1. I am of the age of majority in the jurisdiction in which I ordinarily reside.
2. I am not restricted from making my own medical decisions under the laws of the jurisdiction in which I ordinarily reside.
3. I certify that I am a resident of the United States and not a resident of any other country.
4. I am under the care of a duly qualified and licensed physician in the United States (my "U.S. physician") and the medicine that I ask CANARX to assist me in obtaining was prescribed for me by my U.S. physician.
5. My U.S. physician has examined me within the last 12 months and will examine me at least once every 12 months while I am taking medicine.
6. Any medicine that I ask CANARX to assist me in obtaining is medicine that I have already taken, under my U.S. physician's orders and supervision, for at least 30 days prior to placing an order for the medicine through CANARX.
7. My care by my U.S. physician is ongoing and I do not seek and will not rely on any medical information from CANARX or any CANARX selected physician.
8. I have not violated any laws in the jurisdiction in which I ordinarily reside (or, if different, in the jurisdiction in which the prescription was issued) in obtaining the prescription for the ordered product.
9. The prescription issued by my U.S. physician has not been altered in any way nor has it been filled previously.
10. I will use any medications obtained for me through CANARX strictly in accordance with the instructions provided by my U.S. physician.
11. The medicine dispensed in accordance with my prescription will not be used in any way whatsoever except as directed by my U.S. physician.
12. I will not permit anyone else to use the prescription or any medications which I receive.
13. In the event that I suffer any side effects from any medication obtained for me by CANARX, I will immediately contact my U.S. physician.
14. All information that I give to CANARX is true.

AUTHORIZATION AND CONSENT

I consent to, and authorize, the following:

1. I hereby appoint CANARX and its delegates and contractors (collectively referred to as "CANARX") as my paid agents and attorneys-in-fact for the purposes of obtaining prescriptions which correspond to the prescriptions issued by my U.S. physician; selecting physicians, pharmacies, and other professionals as necessary to serve me outside the U.S.; and of arranging for pharmacies to dispense to me medications as prescribed.
2. CANARX may perform any act that I could myself perform in having my prescription reviewed by any physician, pharmacist, or pharmacy technician and in having the prescribed medication dispensed by a pharmacy and delivered to me by mail.
3. CANARX may arrange the purchase and delivery of the medications prescribed to me, on the terms set forth in this agreement, as if I personally took such actions.
4. I authorize and instruct my U.S. physician to release to CANARX (and any CANARX selected physician, pharmacist, and pharmacy technician) any and all personal medical information pertaining to me ("Personal Medical History"), including but not limited to all medical records, medical reports, progress notes, nurses' notes, reports on diagnostic tests, medical opinions, Xray records, imaging records, laboratory reports, and/or any other knowledge or information which my U.S. physician may possess.
5. I agree to instruct my U.S. physician to issue my prescription on paper (if necessary for dispensing by a pharmacy located outside my U.S. physician's jurisdiction) and to send (by mail, by fax, via the internet or otherwise) to CANARX from my U.S. physician's office the original signed copy of the prescription.
6. CANARX and its selected physicians, pharmacists, and pharmacy technicians may contact my U.S. physician to discuss my prescription if necessary.
7. CANARX selected physicians may issue prescriptions for medications I have ordered if they deem it advisable and appropriate.
8. CANARX may make payments on my behalf to pharmacies for dispensing medicine in accordance with my prescriptions and to physicians for services rendered on my behalf.
9. I request and authorize my employer or plan holder, as my appointed agent, to pay for all products and services relating to the prescription medicine that I obtain through CANARX in such amounts as are found appropriate by my employer or plan holder in accordance with the benefits plan.

ACKNOWLEDGEMENT AND RELEASE

I hereby make the following acknowledgements and releases to CANARX and all its employees, delegates, agents, and contractors, including physicians, pharmacists, pharmacy technicians, nurses, receptionists and staff:

1. My U.S. physician is my primary physician. Any CANARX selected physician is being asked to review the information contained in my Personal Medical History only for the purpose of authorizing the medicine prescribed for me by my U.S. physician to be dispensed to me by a CANARX selected pharmacy.
2. CANARX has made no representations or warranties to me, including, without limitation, representations or warranties regarding the use of fitness for any particular purpose of the medications delivered (including, without limitation, its appropriateness for curing or helping relieve any particular ailment, illness or disease, or its potential or actual side or adverse effects whether previously known or unknown).
3. I wish to obtain a prescription from a CANARX selected physician and have enlisted the services of CANARX to facilitate it. I understand that the physician will rely on the accuracy of the examination performed, and the prescription provided, by my U.S. physician.
4. I release CANARX and all of its officers and directors, agents, delegates, employees and contractors from any and all liability, claims, and causes of action with respect to errors or omissions by the company or agency responsible for transporting my order.
5. I acknowledge that I have purchased my medications internationally for personal use and understand that my medications may be subject to U.S. border inspection. I specifically confirm, acknowledge and agree that title to my medications passes to me when my medications are shipped from the CANARX selected pharmacy.
6. I acknowledge that CANARX, as my paid agent, requires payment in full prior to shipment and that my order may not be returned for a refund or an exchange.

PRIVACY NOTICE AND ACKNOWLEDGEMENT

I consent to the following terms regarding the collection and use of information about me, and I acknowledge that I can review the CANARX Privacy Policy in detail as provided below:

1. CANARX may receive and collect any and all information about me and my health, including but not limited to my full name, address, telephone number, e-mail address, Social Security Number, personal medical information, and payment information, and may maintain such information on file as necessary to verify and process future orders and to obtain payment and reimbursement for them. CANARX and CANARX selected physicians and pharmacists may share any and all information received from or about me with my U.S. physician, CANARX selected physicians and pharmacists, and my employer or benefits plan administrator, and their respective assistants and agents, for the purposes of obtaining medicine as prescribed for me and of obtaining proper payments for the medicine and related services.
2. I am aware that CANARX may transmit my personal information by electronic means (for example fax, or via the internet) to its agents, selected physicians and pharmacies. I understand that the use of electronic means will enhance the efficiency and timeliness of processing my order. I also understand that CANARX, as a custodian of my personal information, will take all appropriate precautions to protect my personal information from improper disclosure or use. I hereby consent to CANARX's transmission of my personal information by electronic means to its delegates, employees, selected physicians and pharmacies.
3. I acknowledge that CANARX will obtain health information about me, and is obligated in accordance with the CANARX Privacy Policy to protect such information. I can visit www.CANARX.com/privacy-policy/ at any time to view the most updated version of the CANARX Privacy Policy.

FURTHER ACKNOWLEDGEMENT & RELEASE

I hereby make the following further acknowledgement and release the plan holder, its employees, officers, agents, heirs and assigns:

1. I acknowledge that the plan holder has made no representations or warranties to me, including without limitation, representations or warranties regarding the use for any particular purpose the medication(s) delivered, including without limitation, its appropriateness for curing or helping relieve any particular ailment, illness or disease or its potential or actual side or adverse effects whether previously known or unknown.
2. I acknowledge that child protective packaging may not be used in filling my prescription. I promise that upon my receipt of the medicine I will take all steps necessary to prevent any child from having unauthorized access to the medicine. I hereby release CANARX and all its officers, directors, agents, delegates, employees, and contractors, including the pharmacy that fills my prescription, from any and all claims arising from or relating to the use of, or failure to use, child protective packaging.
3. I release the plan holder its officers, employees, agents, heirs and assigns from (i) any and all causes of actions with respect to errors or omissions by the company or agency responsible for transporting my order; (ii) any and all causes of actions with respect to errors or omissions by CANARX in obtaining the prescription medications to fill my order; (iii) any and all causes of actions regarding the use for any purpose whatsoever of any medications delivered through this program.

Dental Plan—MetLife

Group ID Number: 217284

PROVIDER: METLIFE **ELIGIBILITY**	Primary enrollee, spouse and eligible dependent children to the end of the month that dependent turns 26
Deductibles	$50 per person / $150 per family each calendar year
Waived for Diagnostic & Preventive & Orthodontics	Yes
Maximums	$2,000 per person each calendar year
Diagnostic & Preventive counts toward maximum	Yes

Benefits & Covered Services*	**In-Network Providers** Negotiated Fee Schedule	**Out-of-Network* Providers** R & C 90th Percentile
Diagnostic & Preventive Services Exams & cleanings (2x / calendar year) x-rays, sealants	100%	100%
Basic Services-Fillings	80%	80%
Endodontics (root canals)	80%	80%
Periodontics (gum treatment)	80%	80%
Oral Surgery	80%	80%
Major Services-Crowns, inlays, onlays & cast restorations	50%	50%
Prosthodontics-Bridges, dentures, implants, TMJ	50%	50%
Orthodontic Benefits-dependent children to age 19	50%	50%
Orthodontic Maximums	$1500 Lifetime	$1500 Lifetime

* **Out of Network benefits** are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary (R & C) charge is based on the lowest of (1) the dentist's actual charge (the 'Actual Charge'), (2) the dentist's usual charge for the same or similar services (the 'Usual Charge') or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). Services must be necessary in terms of generally accepted dental standards.

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

Understanding Your Dental Benefits Plan

The Preferred Dentist Program is designed to provide the dental coverage you need with the features you want. Like the freedom to visit the dentist of your choice —in or out of the network.

- Your plan benefits are based on the percentage of the negotiated fee – the fee that the participating dentists have agreed to accept as payment in full for covered services.

Take advantage of online self-service capabilities with MyBenefits.

- Check the status of your claims
- Locate a participating PDP dentist
- Access MetLife's Oral Health Library
- Elect to view your Explanation of Benefits online

If you are not already registered, just go to **www.metlife.com/mybenefits** and follow the easy registration instructions.

Dental Plan—MetLife / Find a Dental Provider

Select: PDP Plus Network

With MetLife Dental insurance, you can choose from thousands of general dentists and specialists nationwide. You can find the names, addresses, languages spoken and phone numbers of participating dentists by searching our online **Find a Dentist** directory.

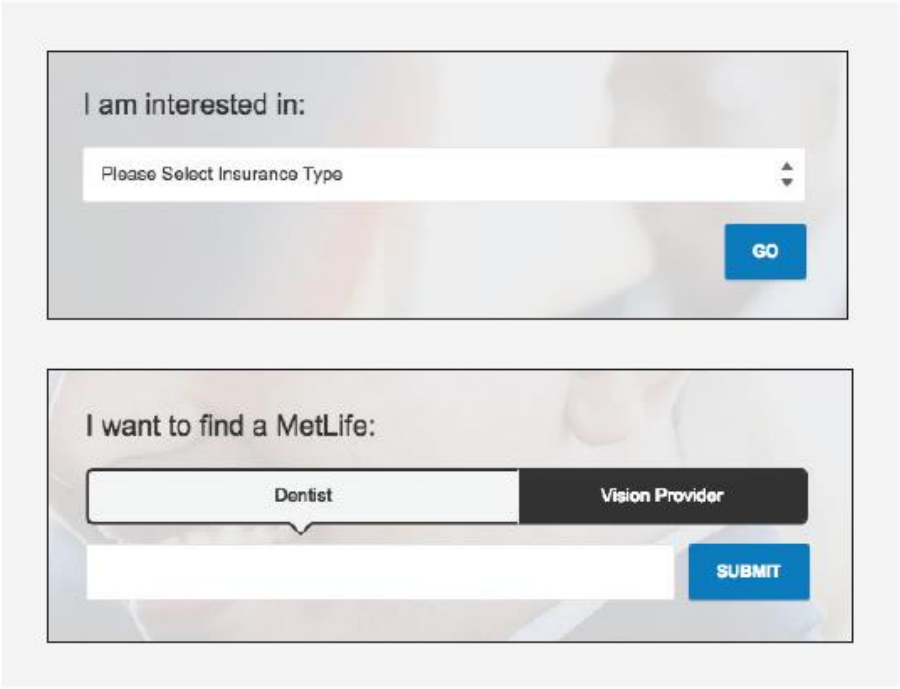
Step 1:
Go to metlife.com

Step 2:
Select "I want to find a MetLife:"

Click "Dentist" and enter your ZIP Code, and select your network.

Step 3:
Advanced Search

Use the Advanced Search option to locate a dentist by name, language spoken, specialty or gender.



MetLife Network: Preferred Dentist Plus Network (PDP Plus)
Group ID Number: 217284

Vision Plan—Davis Vision

We are pleased to provide you with information on your vision benefit to help you care for your vision and eye health - a key part of overall health and wellness!

If you are not currently enrolled, please visit our member site at davisvision.com or call 1.877.923.2847 and enter client code 2769 to locate providers or for additional information.

DavisVision™

Using your benefits is easy! Just log on to our Member site at davisvision.com and click "Find a Provider," or call us at 1.800.999.5431.

Make an appointment. Tell your provider you are a Davis Vision member with coverage through County of Ulster. Provide your member ID number, name and date of birth, and do the same for your covered dependents seeking vision services. Your provider will take care of the rest!

Your Davis Vision Premier Plan Benefits

Benefit	Frequency Once Every-	In-Network Copay	In-Network Coverage	
Eye Examination	Calendar Year	$0	Covered in full. *Includes dilation when professionally indicated.*	
Spectacle Lenses	Calendar Year	$0	Clear plastic lenses in any single vision, bifocal, trifocal or lenticular prescription. Covered in full. *(See below for additional lens options and coatings.)*	
Frame	Calendar Year	$0	**Covered in Full Frames:**	Any Fashion, Designer or Premier level frame from Davis Vision's Collection[12] (retail value, up to $195).
			OR Frame Allowance	$150 toward any frame from provider plus 20% off any balance.[11] No copay required.
Contact Lens Evaluation, Fitting & Follow Up Care	Calendar Year	$0	**Davis Vision Collection Contacts** **Standard, Soft Contacts** **Specialty Contacts**	Covered in full 15% discount[11] 15% discount[1]
Contact Lenses (in lieu of eyeglasses)	Calendar Year	$0	**Covered in Full Contacts:** Planned Replacement Disposable **OR, Contact Lens Allowance** **OR, Visually Required Contacts**	From Davis Vision's Collection[12], up to Two boxes/multipacks* Four boxes/multipacks* $150 allowance toward any contacts from provider's supply plus 15% off balance.[11] No copay required. Covered in full with prior approval.

'Number of contact lens boxes may vary based on manufacturer's packaging.

Significant savings on optional frames, lens types & coatings!

	Member Price
Davis Vision Collection Frames: Fashion I Designer I Premier	$0 I $0 I $0
Tinting of Plastic Lenses	$0
Scratch-Resistant Coating	$0
Premium Scratch-Resistant Coating	$30
Ultraviolet Coating	$0
Anti-Reflective Coating: Standard I Premium I Ultra I Ultimate	$351 $481 $60 I $85
Polycarbonate Lenses	$0
High-Index Lenses 1.6711.74	$55 I $120
Progressive Lenses: Standard I Premium I Ultra I Ultimate	$0 I $40 I $90 I $125
Polarized Lenses	$75
Photochromic Lenses (i.e. Transitions®, etc.)'4	$65
Scratch Protection Plan: Single Vision I Multifocal Lenses	$20 I $40
Trivex Lenses	$50
Blue Light Filtering	$15

[11] Some limitations apply to additional discounts, discounts not applicable at all in- network providers.

[21] The Davis Vision Collection is available at most participating independent provider locations. Collection is subject to change. Collection is inclusive of select toric and multifocal contacts.

[31] Including, but not limited to toric, multifocal and gas permeable contact lenses.

[41] Transitions® is a registered trademark of Transitions Optical Inc.

Please note: Your provider reserves the right to not dispense materials until all applicable member costs, fees and copayments have been collected. Contact lenses: Routine eye examinations do not include professional services for contact lens evaluations. Any applicable fees above the evaluation and fitting allowance are the responsibility of the member. ff contact lenses are selected and fitted, they may not be exchanged for eyeglasses. Progressive lenses: If you are unable to adapt to progressive addition lenses you have purchased, conventional bifocals will be supplied at no additional cost; however, your copayment is nonrefundable. May not be combined with other discounts or offers. Please be advised these lens options and copayments apply to in-network benefits.

Vision Plan—Davis Vision

Frequently Asked Questions

How can I contact Member Services?
Call 1.800.999.5431 for automated help 24/7. Live help is also available seven days a week: Monday-Friday, 8 a.m.-11 p.m. I Saturday, 9 a.m.-4 p.m. I Sunday, 12 p.m.-4 p.m. (Eastern Time). (TTY services: 1.800.523.2847.)

What frames are in Davis Vision's Collection?
Our Collection offers a great selection of fashionable and designer frames, most of which are covered in full. No wonder 8 out of 10 members select a Collection frame. Log on to our member Web site at davisvision.com and take a look!

When will I receive my eyewear?
Your eyewear will be delivered to your network provider generally within five business days of order receipt. Special prescriptions, lens coatings, provider frames or out-of-stock frames may delay the standard turnaround time.

Do I need a claim form?
Claim forms are only required if you visit an out-of-network provider. Claim forms are available on our member Web site.

Can I split my benefits?
You may split your benefits by receiving your eye examination and eyeglasses or contact lenses on different dates or through different provider locations. Complete eyeglasses must be obtained at one time, from one provider. You may not split between a network and out-of-network provider. To maximize your benefit value we recommend that all services be obtained from a network provider.

Can I use an out-of-network provider?
Yes; however, you receive the greatest value by staying in-network. If you go out-of-network, pay the provider at the time of service, then submit a claim to Davis Vision for reimbursement, up to the following amounts: eye exam - $40 I single vision lenses - $40 I bifocal - $60 I trifocal - $80 I lenticular - $100 I frame - $50 I elective contacts - $105 I visually required contacts - $225. Claim forms may be submitted online.

Are there any exclusions to the vision benefits?
Your vision plan does not cover medical treatment of eye disease or injury; vision therapy; special lens designs or coatings, other than those described herein; replacement of lost eyewear; non- prescription (piano) lenses; contact lenses and eyeglasses in the same benefit cycle; services not performed by licensed personnel; two pair of eyeglasses in lieu of bifocals.

DAVIS VISION EXTRAS!

One Year Breakage Warranty Repair or replacement of your plan covered spectacle lenses, Collection frame or frame from a network retail location where the Collection is not displayed.

Additional Savings Members will receive 50% off of additional complete pairs of eyeglasses and sunglasses at Visionworks and 30% off at other participating providers on the same transaction. Otherwise, a 20% discount off the provider's usual and customary rate is available. Contact lenses are available at a 10% discount.'[5]

Shop Online Members can shop online using your plan benefits through Visionworks.com. Select the insurance option from the bar on top of the screen, next select member look up and follow the instructions to order your eyewear to be shipped to your home.

Mail Order Contact Lenses Replacement contacts (after initial benefit) through www.DavisVisionContacts.com mail-order service ensures easy, convenient, purchasing online and quick, direct shipping to your door. Log on to our member Web site for details.

Laser Vision Correction Davis Vision provides you and your eligible dependents with the opportunity to receive discounted laser vision correction, often referred to as LASIK. For more information, visit www.davisvision.com.

Low Vision Services Comprehensive low vision evaluation once every five years and low vision aids up to the plan maximum. Covers up to four follow-up visits in five years.

Eye Health & **Wellness** Log on and learn more about your eyes, health and wellness; common eye conditions that can impair vision; and what you can do to ensure healthy eyes and a healthier life.

For more details... about your vision benefits, patient rights and responsibilities about Davis Vision or to obtain a copy of Davis Vision's Privacy Practices Notice, please log on to our member Web site or contact us at 1.800.999.5431.

Davis Vision has made every effort to correctly summarize your vision plan features herein. In the event of a conflict between this information and your organization's contract with Davis Vision, the terms of the contract will prevail.

[5]Some *limitations apply to additional discounts, discounts not applicable at all in-network providers.*

Fully insured product Underwritten by HM Life Insurance Company. Administered by Davis Vision, which may operate as Davis Vision Insurance Administrators in California.

Important Notice (Medicare Part D)

Important Notice about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Ulster County and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan.

If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Ulster County has determined that the prescription drug coverage offered by the Ulster County is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Ulster County coverage may be affected. If you do decide to join a Medicare drug plan and drop your current Ulster County coverage, be aware that you and your dependents will not be able to get this coverage back until the next open enrollment period.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current Ulster County coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

Important Notice (Medicare Part D)

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage.

For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Ulster County changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year you are eligible from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call **1-800-MEDICARE** (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at **1-800-772-1213** (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. *If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).*

Date:	January 1, 2023
Name of Entity/Sender:	Ulster County
Contact - Position/Office:	Ulster County, Human Resources Department
Address:	244 Fair Street Kingston, New York 12401
Phone Number:	(845) 340-3545

Need Help?

Benefits: www.aleraedge.com / AleraGray

Customer Service at Alera Edge

support@aleracare.zendesk.com

1-800-836-0026, x7400 | 8am-4:30pm

Medical Benefits | EmpireBlue

Member Service:

See your ID Card for a phone number

OR **1-800-331-1476 |** 8:00am-5pm

Dental Benefits | MetLife

Customer Service: 1-800-942-0854

Group #: 217284

Vision Benefits | Davis Vision

Customer Service:1-877-923-2847

Group #: 2769

Addendum-MagellanRx Quick Formulary Reference Guide

View your plan's drug list from anywhere.

The prescription drug benefit is one of the most important and commonly used elements of health plan coverage. To find drugs that are covered by your plan, we offer an easy to use formulary drug lookup tool. The drugs in our formulary have been approved by the Food and Drug Administration (FDA) as safe and effective. They were also selected by our team of expert health care professionals so you can focus on living a healthier, more vibrant life!

What is a formulary?
A formulary is a list of brand names and generic drugs covered by your prescription drug benefit.

Can the formulary change?
We regularly review the drugs on our formulary to ensure they are safe, effective, and low-cost. The list is subject to change, and drugs may be added or removed.

Are there any restrictions?
Some covered drugs may have additional requirements or limits. If a drug has requirements or limits, it will be noted in the formulary.

Access your formulary in 4 easy steps

Step 1:	Step 2:	Step 3:	Step 4:
Visit **magellanrx.com** and click on Portal Access: **Member** in the top right corner.	Scroll down to the **Prescription benefits portal** section and click **Log in.**	Click **Tools & Resources** and select **Formulary and Clinical Documents.**	Find your formulary and select **Drug Look Up.** You are using the **Precision Formulary.**

Click here or scan the QR code to pull it up instantly!

Questions?

At Magellan Rx, our goal is help you live a healthy, vibrant life. If you have questions, call us at **800.424.3312**. We are here 24 hours a day, 7 days a week.

Addendum-MagellanRx Precision Plus+Formulary Exclusion List

3Q2021 / No changes for 2023 Plan Year

Therapeutic Category	Excluded Medications	Preferred Alternatives
ALLERGIC REACTIONS		
Anaphylaxis Treatment	Auvi-Q, Epipen Jr 2-Pak 0.15 mg	Epipen, epinephrine
ANALGESICS		
Non-Steroidal Anti-Inflammatory Agents (Oral)	Cambia, Zipsor, Zorvolex	celecoxib, diflunisal, flurbiprofen, ibuprofen, indomethacin, ketorolac, meloxicam, piroxicam, sulindac
	Relafen, Relafen DS	nabumetone
	Qmiiz ODT	meloxicam
Non-Steroidal Anti-Inflammatory (Topical)	Pennsaid, Voltaren gel	diclofenac solution, diclofenac gel
	Flector, Licart	diclofenac patch
Non-Steroidal Anti-Inflammatory (Other)	Ketorolac Nasal Spray, Sprix Nasal Spray	diclofenac, ibuprofen, meloxicam
Skeletal Muscle Relaxant Combinations	Norgesic Forte, Orphengesic Forte	orphenadrine tab, aspirin
	Ozobax	baclofen
Oral Long-Acting Opioid Analgesics	Kadian ER, Nucynta ER, Zohydro ER, Arymo ER, Hysingla ER, Oxycontin, Embeda, Exalgo ER, MS Contin, oxycodone ER, oxycodone powder	hydromorphone HCl ER, morphine sulfate ER, oxymorphone HCl ER, Xtampza ER
	Conzip, tramadol ER 100mg, 200mg and 300mg capsules	tramadol ER tablets
Oral Short-Acting Opioid Analgesics	Nucynta, Oxaydo, Qdolo	codeine sulfate, hydromorphone hcl, morphine sulfate, oxycodone hcl, oxymorphone hcl, tramadol
Transmucosal Fentanyl Analgesics	Abstral, Fentora, Lazanda, Subsys, fentanyl citrate buccal tab	fentanyl citrate lozenge
Opioid Combinations	Apadaz, benzhydrocodone/acetaminophen	hydrocodone/acetaminophen, oxycodone/acetaminophen
ANTICONVULSANTS		
Seizure Disorders	Oxtellar XR	oxcarbazepine IR
	Lamictal ODT kit	lamotrigine ODT, lamotrigine XR
ANTIDEPRESSANTS		

magellanrx.com

Addendum-MagellanRx Precision Plus+Formulary Exclusion List

Therapeutic Category	Excluded Medications	Preferred Alternatives
Antidepressants	bupropion 450mg XL, Forfivo XL	bupropion XL
ANTIPSYCHOTICS		
Schizophrenia	Secuado, Saphris	aripiprazole, olanzapine, quetiapine, quetiapine ER, risperidone, asenapine
ANTIBACTERIALS, ORAL		
Oral Antibiotics	Doryx, doxycycline hyclate DR 80mg, Minolira	doxycycline, minocycline
ANTIFUNGALS, ORAL		
Oral Antifungals	Tolsura	itraconazole cap
AUTONOMIC & CENTRAL NERVOUS SYSTEM		
Attention Deficit Disorder	Adhansia XR	Vyvanse, methylphenidate ER
CARDIOVASCULAR		
Statins	Zypitamag, Livalo	atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, simvastatin
Hypertension	Inderal XL, Innopran XL	propranolol ER
	Kapspargo	metoprolol ER
	Conjupri, Katerzia	amlodipine
Hypertension with Osteoarthritis	Consensi	amlodipine/celecoxib
CONTRACEPTIVES		
Oral	Lo Loestrin	junel FE, larin FE, microgestin FE, tarina FE
	Slynd	Camila,Incassia, Nora-Be, norethindrone, Norlyda, Norlyroc
Vaginal Ring	Annovera	etonogestrel-ethinyl estradiol vaginal ring, Nuvaring
Gel	Phexxi	Talk to your doctor about clinically appropriate options.
Patch	Twirla	Xulane, Zafemy, levonorgestrel/ethinyl estradiol combined generic oral contraceptive
CORTICOSTEROIDS		
Oral Anti-Inflammatory Agents	Hemady	dexamethasone
	Rayos DR	prednisone
ENDOCRINE		

Addendum-MagellanRx Precision Plus+Formulary Exclusion List

Therapeutic Category	Excluded Medications	Preferred Alternatives
Nocturia	Noctiva	desmopressin, Nocdurna
Testosterone Replacement	Aveed, Jatenzo, Natesto, Testopel	testosterone, Androderm
DERMATOLOGICAL AGENTS		
Topical Acne Treatment	Acanya, Aczone 5%, Aktipak, Benzaclin, Benzaclin Pump, Clindagel, clindamycin phosphate 1% gel, Benzamycin, Duac, Epiduo, Veltin, Ziana, Aklief, dapsone 7.5%	Onexton, Epiduo Forte, adapalene, adapalene/benzoyl peroxide, clindamycin gel/lotion/solution, clindamycin/benzoyl peroxide, erythromycin/benzoyl peroxide, tretinoin cream
	adapalene lotion, Differin lotion	adapalene
	Avita	tretinoin cream/gel
	Arazlo, Fabior, Tazorac	tazarotene cream
Topical Anesthetics	Ztlido	lidocaine patch
Topical Antifungals	Jublia	terbinafine, Kerydin
Topical Corticosteroids	ALA Scalp lotion, Micort-HC cream	hydrocortisone
	Apexicon E cream	fluocinonide, betamethasone
Topical Corticosteroids	Capex shampoo	Derma-Smoothe/FS, fluocinolone acetonide scalp oil
	Cordran tape	flurandrenolide
	Pandel cream	flurandrenolide, hydrocortisone valerate, triamcinolone acetonide
	Halobetasol foam(M), Lexette	betamethasone, clobetasol, halobetasol cream/ointment
	Halog ointment	betamethasone, mometasone, triamcinolone
	Impoyz cream	clobetasol
	Psorcon cream, Verdeso foam	betamethasone, fluocinolone
	Trianex	hydrocortisone valerate, triamcinolone acetonide
	Ultravate lotion	clobetasol proprionate, fluocinonide, halobetasol proprionate
Topical Immune Response Modifier	imiquimod cream pump 3.75% Zyclara, Zyclara Pump	imiquimod 5% cream
Topical Plaque Psoriasis	Duobrii Lotion	clobetasol, fluocinonide, halobetasol, tazarotene, Enstilar

Addendum-MagellanRx Precision Plus+Formulary Exclusion List

Therapeutic Category	Excluded Medications	Preferred Alternatives
	Calcipotriene Foam 0.005% (M), Sorilux	calcipotriene
Rosacea Treatment	Noritate, Metrogel	metronidazole cream/gel/lotion, Finacea foam, Soolantra
DIABETES		
Blood Glucose Meters & Strips	All other blood glucose meters and strips. **Examples:** Abbott (FreeStyle, Precision), Arkray (Glucocard), Bayer (Breeze), Nipro (TRUEtest, TRUEtrack), Roche (Accu-Chek), Lifescan (One Touch)	Ascensia Diabetes Care (Contour/Contour Next)
Continuous Glucose Monitoring (CGM)	FreeStyle Libre, FreeStyle Libre 2	Dexcom
Dipeptidyl Peptidase-4 (DPP4) Inhibitors & Combinations	alogliptin, alogliptin/metformin, alogliptin/pioglitazone, Kazano, Kombiglyze XR, Nesina, Onglyza, Oseni	Janumet, Janumet XR, Januvia, Jentadueto, Jentadueto XR, Tradjenta
Sodium-glucose co-transporter (SGLT2) Inhibitors & Combinations	Invokamet, Invokamet XR, Invokana, Steglatro, Segluromet, Steglujan, Qtern	Farxiga, Xigduo XR, Jardiance, Synjardy, Synjardy XR, Glyxambi, Trijardy XR
Glucagon-Like Peptide-1 Agonists	Adlyxin, Tanzeum	Bydureon, Bydureon Bcise, Byetta, Trulicity, Victoza, Ozempic, Rybelsus
Insulins	Novolin	Humulin
Rapid-acting insulin	Admelog, Apidra, Fiasp, insulin lispro, insulin aspart, Novolog	Humalog, Lyumjev
Basal insulin	Basaglar, Levemir, Tresiba, Semglee	Lantus, Toujeo
Biguanides	Glumetza, Fortamet, Riomet suspension, metformin HCl 24hr ER osmotic release, metformin HCl 24hr ER modified release	metformin ER (Glucophage generic), metformin IR
GASTROINTESTINAL		
Anti-Diarrheal Agents	Motofen	diphenoxylate/atropine, loperamide
Antiemetics	Sancuso patch	granisetron solution/tablet, ondansetron ODT
Anti-Inflammatory/Anti-Ulcer Agents	Duexis, Vimovo, naproxen/esomeprazole	famotidine PLUS ibuprofen, omeprazole PLUS naproxen
Pancreatic Enzymes	Pancreaze, Pertzye, Viokace	Creon, Zenpep
Inflammatory Bowel Disease	Asacol HD, Delzicol, Dipentum, Lialda, mesalamine DR 800 mg	Apriso, mesalamine

Addendum-MagellanRx Precision Plus+Formulary Exclusion List

Therapeutic Category	Excluded Medications	Preferred Alternatives
Chronic Idiopathic Constipation, Irritable bowel syndrome with constipation	Trulance, Amitiza, lubiprostone, Zelnorm	Linzess
Opioid-Induced Constipation	Movantik, Amitiza, Relistor	Symproic
Proton Pump Inhibitors	omeppi, omeprazole with sodium bicarbonate (cap, powder pak), rabeprazole sprinkle cap, esomeprazole mag DR capsules	lansoprazole, omeprazole, pantoprazole, Aciphex Sprinkle caps, Dexilant
Laxatives	Golytely packets	Gavilyte-C, Gavilyte-H, PEG 3350
	Moviprep, Plenvu, Osmoprep	Clenpiq, Prepopik, Suprep
IMMUNOMODULATORS		
Autoimmune Agents[3]	Cosentyx, Olumiant, Ilumya, Remicade, Renflexis	Cimzia, Humira, Inflectra, Actemra, Orencia, Otezla, Avsola, Rinvoq ER, Simponi, Simponi Aria, Skyrizi, Stelara, Taltz, Tremfya, Xeljanz/XR
MUSCULOSKELETAL		
Muscle Relaxants	Amrix	cyclobenzaprine
ANTIMIGRAINES		
CGRP Antagonists	Ajovy	Aimovig, Emgality
	Reyvow	Nurtec ODT, Ubrelvy
Serotonin Receptor Agonists	Onzetra XSAIL, Zembrace Symtouch, Imitrex, Maxalt/MLT, Relpax, Zomig, Treximet, Tosymra,	sumatriptan injection, sumatriptan, rizatriptan, eletriptan, zolmitriptan
OPHTHALMIC		
Antiglaucoma Drugs	Vyzulta, Zioptan, Xalatan	latanoprost ophthalmic solution, travoprost ophthalmic solution, Lumigan, Rhopressa, Rocklatan, Xelpros
	Timoptic Ocudose	timolol ophthalmic solution
Anti-Inflammatory	Bromsite, Ilevro, Nevanac	Prolensa, diclofenac, ketorolac, flurbiprofen
Antihistamines	Bepreve, Lastacaft, Pazeo, Zerviate	azelastine ophthalmic solution, olopatadine ophthalmic solution
Dry Eye Disease	Cequa	Restasis, Xiidra
RESPIRATORY		
Anticholinergic/Long-Acting Beta Agonist Combination Inhalers	Bevespi, Utibron, Duaklir Pressair	Anoro Ellipta, Stiolto Respimat

Addendum-MagellanRx Precision Plus+Formulary Exclusion List

Therapeutic Category	Excluded Medications	Preferred Alternatives
Anti-Inflammatory/ Long-Acting Beta Agonist Combination Inhalers	AirDuo Respiclick, Airduo Digihaler, Dulera, budesonide/formoterol	Advair Diskus, Advair HFA, Breo Ellipta, Symbicort, fluticasone/salmeterol, Wixela Inhub
Short-Acting Beta-2 Adrenergic Inhalers	levalbuterol HFA, Proventil HFA, Xopenex HFA, Proair Digihaler, Proair HFA, Proair Respiclick, albuterol HFA (Prasco), Ventolin HFA	albuterol HFA (Perrigo, Teva, Par, Cipla, Lupin, Sandoz)
Pulmonary Anti-Inflammatory Inhalers	Alvesco, Armonair Respiclick, Armonair Digihaler, Asmanex, Asmanex HFA, QVAR Redihaler	Arnuity Ellipta, Flovent Diskus, Flovent HFA, Pulmicort Flexhaler
Chronic Obstructive Pulmonary Disease (inhaled anticholinergics)	Tudorza, Seebri, Incruse Ellipta	Spiriva
UROLOGICAL		
Erectile Dysfunction Oral Agents	Stendra	sildenafil
Interstitial Cystitis	Elmiron	amitriptyline, hydroxyzine
OTHER		
Antigout Agents	Colcrys, Mitigare, Gloperba, colchicine capsule	colchicine tablet
Antihistamine	Clarinex Syrup	desloratadine
	Carinex-D	desloratadine with pseudoephedrine
Corticosteroid nasal sprays	Xhance	mometasone furoate
Multivitamins, Dietary Supplements, Iron Replacements	Corvita 150, Corvite 150, Corvite Fe, Dermacinrx Vitrexate/Fe, Dermacinrx Vitranol/Fe, Dermacinrx Foltrexyl, Dermacinrx Venexa, Dexifol, Folic-K, Folika-T, Folika-V, Genicin Vita-Q, Genicin Vita-S, Hylavite, Hylazinc, Lorid, Multi Pro, Nicadan, Nicazel/Forte, Nicomide, Quflora Fe, Remedient, Tronvite, Vitasure, Vitrexyl, Vitrexyl plus iron, Xvite, Zyvana	Any preferred multivitamin

Addendum-MagellanRx Precision Plus+Formulary Exclusion List

Therapeutic Category	Excluded Medications	Preferred Alternatives
Prenatal Vitamins	Azesco, Citranatal, Dermacinrx Prenatrix, Dermacinrx Prenatryl, Duet DHA, Natachew, Nestabs (DHA, One), OB Complete (One, Petite, Premier), PNV Tabs, Pregenna, Prenate, Primacare, Select-OB, Trinaz, Tristart DHA, Vitafol (Fe Plus, -OB caplet, gummies), VitamedMD, Vitatrue, Vitapearl, Zalvit	Any preferred prenatal vitamin
Thyroid Agents	Tirosint, Thyquidity, levothyroxine capsules	levothyroxine tablets
Obesity	Contrave	Qsymia, Saxenda
Opioid Reversal Agents	naloxone auto-injector (M), Evzio	Narcan
Platelet-Modifying Agent	aspirin/omeprazole, Yosprala	aspirin with omeprazole

Required Prior Authorization[2]

Therapeutic Class	Non-Preferred Medications	Preferred Medications
Erythropoiesis-Stimulating Agents	All other products non-preferred with prior authorization	Aranesp, Retacrit
Growth Hormones	All other products non-preferred with prior authorization	Norditropin
Hepatitis C[1]	All other products non-preferred with prior authorization	Epclusa, Harvoni, Sovaldi, Mavyret, Vosevi, ledipasvir/sofosbuvir, sofosbuvir/velpatasvir
Multiple Sclerosis	All other products non-preferred with prior authorization	Avonex, Betaseron, Copaxone, dimethyl fumarate, Gilenya, glatiramer, Kesimpta, Mayzent, Plegridy, Vumerity

Addendum-MagellanRx Precision Plus+Formulary Exclusion List

Excluded medications with generic alternatives

The medications listed below are excluded on the formulary. These medications have been identified as having available generic alternatives covered on the formulary.

ABILIFY	AZOR	CONCERTA	DUAC
ACANYA	BENICAR	COREG	DURAGESIC
ACIPHEX DR TABLET	BENICAR HCT	COREG CR	DYAZIDE
ACTICLATE	BENZACLIN	CORTEF	EFFEXOR XR
ACZONE 5%	BENZAMYCIN	COSOPT	ELIDEL
ADDERALL	BEYAZ	COSOPT PF	EPIDUO
ADDERALL XR	BRISDELLE	COZAAR	ESTRACE
ADIPEX-P	BUTRANS	CRESTOR	EVEKEO
ALKINDI SPRINKLE	CANASA	CYMBALTA	EXALGO
ALPHAGAN P	CARAFATE	CYTOMEL	EXFORGE
ALTACE	CARBATROL	DELESTROGEN	EXFORGE HCT
AMBIEN	CARDIZEM LA	DELZICOL	FIORICET
AMBIEN CR	CARNITOR	DEPAKOTE SPRINKLE	FIORICET WITH CODEINE
AMRIX	CARNITOR SF	DEPAKOTE	FLOMAX
ANDROGEL	CATAPRES-TTS PATCH	DEPAKOTE ER	FOCALIN
ARIMIDEX	CELEBREX	DEPO-TESTOSTERONE	FOCALIN XR
ARTHROTEC	CELEXA	DESONATE GEL	FORTAMET
ASACOL HD	CIALIS	DICLOFENAC 35 MG CAP	FORTESTA
ATACAND	CIPRODEX	DIFFERIN	GENERESS FE
ATIVAN	CLARINEX	DILANTIN	GLUCOPHAGE
AVAPRO	CLIMARA	DILAUDID	GLUCOPHAGE XR
AVODART	CLOBEX	DIOVAN	GLUMETZA
AXIRON	CLODERM	DIOVAN HCT	GOCOVRI
AZESCHEW CHEW	COLESTID	DORYX	GOLYTELY

Addendum-MagellanRx Precision Plus+Formulary Exclusion List

HALOG
HYZAAR
IMITREX
IMPEKLO
INDERAL LA
INTUNIV
KADIAN
KENALOG SPRAY
KENALOG-40
KEPPRA
KEPPRA XR
KLONOPIN
K-TAB ER
LAMICTAL
LAMICTAL ODT
LAMICTAL STARTER KIT
LAMICTAL XR
LASIX
LATISSE
LESCOL XL
LEVITRA
LEXAPRO
LIALDA
LIDODERM
LIPITOR
LOESTRIN 21
LOESTRIN FE
LOTEMAX SUSPENSION
LOTREL
LOVAZA
LUNESTA
LYRICA
MAXALT
MAXALT MLT
MICARDIS
MICARDIS HCT
MINASTRIN
MOBIC
MS CONTIN
NALFON
NASONEX
NATROBA
NEEVODHA
NEURONTIN
NEXIUM CAPSULE
NIASPAN ER
NITROSTAT
NORCO
NORVASC
NULYTELY WITH FLAVOR
NULYTELY SOLUTION
NUVIGIL
OMNIPRED
ONFI
ORACEA
ORTHO MICRONOR
ORTHO TRI-CYCLEN
ORTHO-TRI-CYCLEN LO
ORTHO-CYCLEN
ORTHO-NOVUM
ORTIKOS ER
PATADAY
PATANOL
PAXIL
PAXIL CR
PERCOCET
PLAQUENIL
PLAVIX
PRAVACHOL
PRED FORTE
PREVACID
PRINIVIL
PRISTIQ
PROMETRIUM
PROPECIA
PROTONIX TABLET
PROVIGIL
PROZAC
PULMICORT RESPULE
QUDEXY XR
QUESTRAN LIGHT
QUESTRAN
RANEXA
RELPAX
RENAGEL
RESTORIL
RETIN-A
RETIN-A MICRO GEL
RETIN-A MICRO PUMP
RISPERDAL TAB, SOLUTION
RITALIN
RITALIN LA
ROXICODONE
SAFYRAL
SEASONIQUE
SENSIPAR
SEROQUEL
SEROQUEL XR
SILVADENE
SINGULAIR
SKELAXIN
SOLODYN
SOMA
STAXYN
STRATTERA
SUBOXONE
SYNTHROID
TACLONEX OINTMENT
TAMIFLU
TARGADOX
TEGRETOL
TEGRETOL XR
TENORMIN
TESTIM GEL
TIKOSYN
TIMOPTIC
TIMOPTIC-XE
TOBRADEX SUSPENSION
TOPAMAX TABLET
TOPAMAX SPRINKLE CAP
TOPICORT SPRAY
TOPROL XL
TREXIMET
TRIBENZOR
TRICOR
TRILEPTAL
TYLENOL-CODEINE NO.3
TYLENOL-CODEINE NO.4
UCERIS
ULTRACET
ULTRAM
VAGIFEM
VALIUM
VALTREX
VANADOM
VECTICAL
VESICARE
VIAGRA
VIGAMOX
VIMOVO
VIVELLE-DOT
VOGELXO
VOLTAREN
VYTORIN
WELCHOL
WELLBUTRIN SR
WELLBUTRIN XL
XALATAN
XANAX
XANAX XR
YASMIN 28
YAZ

Addendum-MagellanRx Precision Plus+Formulary Exclusion List

ZANAFLEX	ZIANA	ZOMIG	ZYPREXA
ZEGERID	ZOCOR	ZOMIG ZMT	
ZESTRIL	ZOHYDRO ER	ZONEGRAN	
ZETIA	ZOLOFT	ZOVIRAX	

(M) Co-branded product

** This list is not inclusive of all formulary strategies. Please check the formulary listing for specific drug coverage. All therapeutic classes do not allow grandfathering, unless specifically mentioned.

[1] Grandfathering allowed; no duration limit. All other therapeutic classes do not allow Grandfathering, no exceptions.

[2] All medications require a Prior Authorization. Use of a non-preferred medication requires clinical failure or intolerance of one or more preferred medications prior to beginning therapy. The number and type of preferred alternative(s) will depend on the indication

[3] Grandfathering varies depending on which formulary the plan is enrolled in. The number and type of preferred alternative(s) will depend on the indication

Addendum-MagellanRx Step Therapy Program

Precision Plus+ Formulary

Physician Guidelines

Failure of previous steps in the Step Therapy Program:

- For most therapies, Magellan Rx Management will review the most recent claim history available. Historical review timeframe may change based on therapy class or client request. (OR)
- Access the appropriate Magellan Rx Management Prior Authorization (PA) form online to begin the Step Therapy process: https://magellanrx.com/provider/.

Note: Step Therapy Guidelines may be updated on an ongoing basis due to changes in the pharmacy industry. Failure to accurately complete the PA form or submit required documentation may result in a delay in the member's therapy.

ANALGESICS AND ANTIPYRETICS	**Target Drug(s)**	**Step Requirement**
	GRALISE TAB24HDSPK, GRALISE TAB ER 24H	Must try gabapentin
ANTI-INFECTIVES	**Target Drug(s)**	**Step Requirement**
	CETRAXAL DROPERETTE, CIPRO HC DROPS SUSP, OTOVEL VIAL	Must try ciprofloxacin-dexamethasone otic suspension (generic Ciprodex)
	EURAX CREAM (G), EURAX LOTION, NATROBA SUSPENSION, OVIDE LOTION, SKLICE LOTION, ULESFIA LOTION	Must try permethrin
ANTI-INFLAMMATORY AGENTS	**Target Drug(s)**	**Step Requirement**
	ZILEUTON ER TBMP 12HR, ZYFLO TABLET	Must try montelukast or zafirlukast
	EUCRISA OINT. (G)	Must try one generic corticosteroid (topical)
ANTIBACTERIALS	**Target Drug(s)**	**Step Requirement**
	MINOCYCLINE HCL TABLET	Must try minocycline IR capsules
	DOXYCYCLINE HYCLATE TABLET	Must try two doxycycline generics
	COREMINO TAB ER 24H, MINOCYCLINE HCL ER TAB ER 24H	Must try two immediate release generic tetracycline products
ANTICONVULSANTS	**Target Drug(s)**	**Step Requirement**
	ELEPSIA XR TAB ER 24H	Must try generic levetiracetam
	TROKENDI XR CAP ER 24H	T/F topiramate IR
ANTIDEPRESSANTS	**Target Drug(s)**	**Step Requirement**
	APLENZIN TAB ER 24H	Must try generic bupropion XL 150 mg or 300 mg
	TRINTELLIX TABLET	Must try two generics: SSRIs, SNRIs, bupropion, or mirtazapine
	FETZIMA CAP24H DSPK, FETZIMA CAP SA 24H	Must try two preferred SNRIs
ANTIDIABETIC AGENTS	**Target Drug(s)**	**Step Requirement**
	BYDUREON BCISE AUTO INJCT, BYDUREON PEN INJCTR, BYETTA PEN INJCTR, GLYXAMBI TABLET, JARDIANCE TABLET, JANUMET TABLET, JANUMET XR TBMP 24HR, JANUVIA TABLET, JENTADUETO TABLET, JENTADUETO XR TAB BP 24H, FARXIGA TABLET, RYBELSUS TABLET, TRIJARDY XR TAB BP 24H, XIGDUO XR TAB BP 24H, OZEMPIC PEN INJCTR, SYNJARDY TABLET, SYNJARDY XR TAB BP 24H, TRADJENTA TABLET, TRULICITY PEN INJCTR, VICTOZA 2-PAK PEN INJCTR, VICTOZA 3-PAK PEN INJCTR	Must try any one of the following: metformin, metformin ER, glipizide-metformin, glyburide-metformin, pioglitazone-metformin
	ACTOPLUS MET XR TBMP 24HR	Must try one of the following generics: metformin or thiazolidinedione
ANTIFUNGALS	**Target Drug(s)**	**Step Requirement**
	NAFTIFINE HCL CREAM (G), NAFTIFINE HCL GEL(GRAM), OXICONAZOLE NITRATE CREAM (G)	Must try ciclopirox, clotrimazole, econazole, ketoconazole, luliconazole, or OTC antifungals (butenafine, miconazole, terbinafine, tolnaftate)

Addendum-MagellanRx Step Therapy Program

Precision Plus+ Formulary

ANTIGLAUCOMA AGENTS	**Target Drug(s)**	**Step Requirement**
	TRAVATAN Z DROPS, XALATAN DROPS	Must try one of the following: latanoprost, travoprost, Lumigan, Xelpros
ANTILIPEMIC AGENTS	**Target Drug(s)**	**Step Requirement**
	ALTOPREV TAB ER 24H, FLOLIPID ORAL SUSP, LESCOL CAPSULE, SIMVASTATIN ORAL SUSP	Must try one generic statin
ANTIMIGRAINE AGENTS	**Target Drug(s)**	**Step Requirement**
	AMERGE TABLET, FROVA TABLET, IMITREX CARTRIDGE, IMITREX PEN INJCTR, IMITREX SPRAY, IMITREX TABLET, IMITREX VIAL, MAXALT MLT TAB RAPDIS, MAXALT TABLET, RELPAX TABLET, TOSYMRA SPRAY, ZOLMITRIPTAN SPRAY, ZOMIG SPRAY, ZOMIG TABLET, ZOMIG ZMT TAB RAPDIS, ONZETRA XSAIL AER POW BA, ZEMBRACE SYMTOUCH PEN INJCTR	Must try two preferred serotonin 5HT1 Agonists
ANTINEOPLASTIC AGENTS	**Target Drug(s)**	**Step Requirement**
	PICATO GEL (EA)	Must try topical fluorouracil or imiquimod
ANTIPARKINSONIAN AGENTS	**Target Drug(s)**	**Step Requirement**
	EMSAM PATCH TD24	Must try two generic antidepressants: bupropion, citalopram, desvenlafaxine ER, duloxetine, escitalopram, fluoxetine, mirtazapine, paroxetine, paroxetine ER, sertraline, venlafaxine, venlafaxine ER
ANTIPSYCHOTIC AGENTS	**Target Drug(s)**	**Step Requirement**
	VRAYLAR CAP DS PK, VRAYLAR CAPSULE	Must try one generic atypical antipsychotic
	FANAPT TAB DS PK, FANAPT TABLET, GEODON CAPSULE, GEODON VIAL, CLOZARIL TABLET, INVEGA TAB ER 24, ZYPREXA ZYDIS TAB RAPDIS	Must try two: unique generic atypicals, Latuda, or Vraylar
ANTIRETROVIRALS	**Target Drug(s)**	**Step Requirement**
	CIMDUO TABLET	Must try Temixys
	ATRIPLA TABLET, EFAVIRENZ-EMTRIC-TENOFOV DISOP TABLET	Must try brand or generic Symfi/Symfi Lo
	COMPLERA TABLET	Must try one of the following: efavirenz/emtricitabine/tenofovir disoproxil fumarate (generic Atripla), efavirenz/lamivudine/tenofovir disoproxil fumarate (generic Symfi/Symfi Lo), Atripla, Symfi, Symfi Lo, Delstrigo, Odefsey
ANTIULCER AGENTS AND ACID SUPPRESSANTS	**Target Drug(s)**	**Step Requirement**
	DEXILANT CAP DR BP	Must try one generic proton pump inhibitor
	ACIPHEX SPRINKLE CAP DR SPR, ACIPHEX TABLET DR, ESOMEPRAZOLE STRONTIUM CAPSULE DR, NEXIUM CAPSULE DR, NEXIUM SUSPDR PKT, OMEPRAZOLE-SODIUM BICARBONATE CAPSULE, OMEPRAZOLE-SODIUM BICARBONATE PACKET, PREVACID CAPSULE DR, PREVACID TAB RAP DR, PRILOSEC SUSPDR PKT, PROTONIX GRAN PKT DR, PROTONIX TABLET DR, ZEGERID CAPSULE, ZEGERID PACKET	Must try two generic proton pump inhibitors
ANXIOLYTICS, SEDATIVES AND HYPNOTICS	**Target Drug(s)**	**Step Requirement**
	AMBIEN TABLET, AMBIEN CR TAB MPHASE	Must try eszopiclone AND (zolpidem or zaleplon)
	BELSOMRA TABLET, DAYVIGO TABLET, ROZEREM TABLET	Must try eszopiclone, zolpidem, or zaleplon
	EDLUAR TAB SUBL, INTERMEZZO TAB SUBL	Must try generic zolpidem or Ambien
BETA-3-ADRENERGIC AGONISTS	**Target Drug(s)**	**Step Requirement**
	GEMTESA TABLET	Must try TWO of the following: Myrbetriq, generic darifenacin ER, generic oxybutynin IR/ER, generic solifenacin, generic tolterodine IR/ER, generic trospium IR/ER
BETA-ADRENERGIC AGONISTS	**Target Drug(s)**	**Step Requirement**
	ARCAPTA NEOHALER CAP W/DEV	Must try two of the following: Advair HFA/Diskus, Breo Ellipta, Serevent, Symbicort, Wixela inhub, fluticasone/salmeterol inh, Striverdi
CARDIOVASCULAR DRUGS	**Target Drug(s)**	**Step Requirement**
	CARDURA XL TAB ER 24	Must try alfuzosin, doxazosin, dutasteride, finasteride, silodosin, terazosin, or tamsulosin
	INDERAL XL CAP ER 24H, INNOPRAN XL CAP ER 24H	Must try propranolol ER generics

Addendum-MagellanRx Step Therapy Program

Precision Plus+ Formulary

CENTRAL NERVOUS SYSTEM AGENTS	**Target Drug(s)**	**Step Requirement**
	SAVELLA TAB DS PK, SAVELLA TABLET	Must try any one of the following (generic only): tricyclic antidepressants, cyclobenzaprine, duloxetine, pregabalin
	QELBREE CAP ER 24H	Must try any two preferred CNS stimulants
	NAMZARIC CAP24 DSPK, NAMZARIC CAP SPR 24	Must try generic memantine AND donepezil
CNS STIMULANTS	**Target Drug(s)**	**Step Requirement**
	ADHANSIA XR CPBP 20-80, APTENSIO XR CSBP 40-60, AZSTARYS CAPSULE, CONCERTA TAB ER 24, JORNAY PM CPDR ER SP, METHYLIN SOLUTION, METHYLPHENIDATE ER CSBP 40-60, COTEMPLA XR-ODT TAB RAP BP, DAYTRANA PATCH TD24, DESOXYN TABLET, FOCALIN TABLET, FOCALIN XR CPBP 50-50, ADDERALL TABLET, ADDERALL XR CAP ER 24H, DEXEDRINE CAPSULE ER, MYDAYIS CPTP 24HR, ZENZEDI TABLET, PROCENTRA SOLUTION, QUILLIVANT XR SU ER RC24, RITALIN LA CPBP 50-50, RITALIN TABLET, ADZENYS ER SUS BP 24H, ADZENYS XR-ODT TAB RAP BP, AMPHETAMINE SUS BP 24H, DYANAVEL XR SUS BP 24H, QUILLICHEW ER TAB CBP24H	Must try any two preferred CNS stimulants
ESTROGENS AND ANTIESTROGENS	**Target Drug(s)**	**Step Requirement**
	ALORA PATCH TDSW, MENOSTAR PATCH TDWK, MINIVELLE PATCH TDSW	Must try generic in class
	FEMRING VAG RING	Must try two of the following: Imvexxy, Osphena, Premarin vaginal cream
EYE, EAR, NOSE AND THROAT	**Target Drug(s)**	**Step Requirement**
	PATADAY DROPS, PATANOL DROPS	Must try generic azelastine or olopatadine
	AZELASTINE-FLUTICASONE SPRAY/PUMP	Must try nasal fluticasone and nasal azelastine
FIRST GENERATION ANTIHISTAMINES	**Target Drug(s)**	**Step Requirement**
	RYVENT TABLET	Must try generic carbinoxamine or preferred antihistamine (Rx only)
GASTROINTESTINAL DRUGS	**Target Drug(s)**	**Step Requirement**
	LINZESS CAPSULE	For patients greater than 18 years old, must try: polyethylene glycol or lactulose
GENITOURINARY SMOOTH MUSCLE RELAXANTS	**Target Drug(s)**	**Step Requirement**
	GELNIQUE GEL PACKET, OXYTROL PATCH TDSW	Must try TWO of the following: Myrbetriq, generic darifenacin ER, generic oxybutynin IR/ER, generic solifenacin, generic tolterodine IR/ER, generic trospium IR/ER
HORMONES AND SYNTHETIC SUBSTITUTES	**Target Drug(s)**	**Step Requirement**
	TAYTULLA CAPSULE	Must try generic Taytulla first
HYPOTENSIVE AGENTS	**Target Drug(s)**	**Step Requirement**
	KAPVAY TAB ER 12H	Must try any two preferred CNS stimulants
MISCELLANEOUS THERAPEUTIC AGENTS	**Target Drug(s)**	**Step Requirement**
	ATELVIA TABLET DR	Must try alendronate or alendronate solution
	FEBUXOSTAT TABLET, ULORIC TABLET	Must try generic allopurinol
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS	**Target Drug(s)**	**Step Requirement**
	DICLOFENAC CAPSULE, DICLOFENAC SODIUM GEL(GRAM)	Must try generic Rx oral NSAID
RENIN-ANGIOTENSIN-ALDOSTERONE SYS.INHIB	**Target Drug(s)**	**Step Requirement**
	PRESTALIA TABLET	Must try amlodipine or perindopril
	EDARBI TABLET, EDARBYCLOR TABLET	Must try any one of the following (generics only): ACE inhibitor/combination, ARB/combination, amlodipine-benazepril, trandolapril-verapamil
SKIN AND MUCOUS MEMBRANE AGENTS	**Target Drug(s)**	**Step Requirement**
	ELIDEL CREAM (G), PIMECROLIMUS CREAM (G), PROTOPIC OINT. (G), TACROLIMUS OINT. (G)	In patients greater than 2 years of age, must try one corticosteroid (topical)