

October, 2011

Dear Valued Member,

Thank you for your membership in State of Kansas Advantra Freedom PPO.

We are providing important information about the Medicare health care and prescription drug coverage we will offer next year. Please review this information to help you decide what coverage to choose for 2012. Also, please note that Medicare has changed the dates for the annual enrollment period. Starting this year, **you can make changes to your coverage from October 15 until December 7, 2011.**

Here are two (2) documents with important information for you.

1. Please start by reading the **Annual Notice of Changes for 2012**. It gives you a summary of changes to your benefits and costs for next year. These changes will take effect on January 1, 2012.
 - **Please review this notice within a few days of receiving it** to see how the changes might affect you.
 - **If you decide to stay with Advantra Freedom PPO** for 2012 – you do not have to tell us or fill out any paperwork. You will automatically stay enrolled as a member of Advantra Freedom PPO.
 - **If you decide to leave Advantra Freedom PPO**, you can switch to a different Medicare health plan or to Original Medicare from October 15 through December 7 of 2011. The *Annual Notice of Changes* tells you more about how to do this. To learn more about your health plan options, you can visit <http://www.medicare.gov> or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

We're including a copy of State of Kansas Advantra Freedom PPO's **Evidence of Coverage** for 2012. It's the legal, detailed description of your benefits and costs for 2012 if you stay enrolled as a member of State of Kansas Advantra Freedom PPO. It also explains your rights and rules you need to follow when using your coverage for medical care and prescription drugs. Please look through this document so you know what's in it, then keep it handy for reference.

2. We're also including a copy of the Advantra Freedom PPO plan's **List of Covered Drugs (Formulary)**, effective January 1, 2012. The Drug List tells you what Part D prescription drugs are covered by the plan. It also lets you know if there are any rules that restrict coverage for a drug.

CHKS 51762

Y0022_CCP_2012_H5509_801_State of KS with RX Cvrltr
October 2011

If you have questions, we're here to help. Please call Customer Service at 1-800-727-9712 (TTY/TDD only, call 711 Telecommunications Relay Service). Hours are 8:00 am to 8:00 pm, Central Time, 7 days a week, and calls to these numbers are free. Customer Service also has free language interpreter services available for non-English speakers. You can also visit our website, (<http://member.coventry-medicare.com>).

We value your membership and hope to continue to serve you next year.

Sincerely,

Aaron Molitor

Aaron Molitor
Chief Operating Officer
Coventry Health and Life Insurance Company

A Coordinated Care Plan with a Medicare Advantage Contract

State of Kansas
Advantra Freedom PPO
Annual Notice of Changes for 2012

This booklet tells you how your benefits and costs will change next year if you stay in State of KS Advantra Freedom PPO. These changes will take effect on January 1, 2012 if you stay in this plan.

To decide what's best for you, compare this information with the benefits and costs of other Medicare health plans in your area, as well as the benefits and costs of Original Medicare.

This plan, State of KS Advantra Freedom PPO, is offered by Coventry Health and Life Insurance Company. (When this *Annual Notice of Changes* says "we," "us," or "our," it means Coventry Health and Life Insurance Company. When it says "plan" or "our plan," it means State of KS Advantra Freedom PPO.)

A Coordinated Care Plan with a Medicare Advantage Contract

Customer Service has free language interpreter services available for non-English speakers (phone numbers are on the back cover of this booklet).

CHKS 51761

Y0022_CCP_2012_H5509_801_State of KS
October 2011

Annual Notice of Changes for 2012

Table of Contents

Section 1. Important things to know.....	1
The Annual Enrollment Period ends on December 7 th	1
You are currently enrolled in State of KS Advantra Freedom PPO, which is a Medicare PPO	1
If you stay enrolled in State of KS Advantra Freedom PPO for 2012, there will be some changes to your benefits and to what you pay.....	1
This <i>Annual Notice of Changes</i> is only a summary (see your <i>Evidence of Coverage</i> for the details)	1
What should you do?	2
There are programs to help people with limited resources pay for their prescription drugs.....	2
What if you are currently getting help to pay for your drugs?.....	3
Section 2. Changes to your monthly premium	3
Section 3. Medical services: Changes to your benefits and cost sharing (“out-of-pocket” costs).....	4
Changes to your <u>benefits</u>	4
Changes to your cost sharing (“out-of-pocket” costs).....	4
Section 4. Part D prescription drugs: Changes to your benefits and “out-of-pocket” costs	5
Changes to the <i>List of Covered Drugs (Formulary)</i>	5
Changes to your <u>“out-of-pocket” costs</u>	5
What if changes for 2012 affect drugs you are taking now?	9
Section 5. What about changes to the plan’s network of providers?.....	10
Will your doctors and other providers still be in the plan’s network next year?.....	10

Section 6. What other plan changes will begin next year?..... 11

Section 7. Do you want to stay in the plan or make a change? 12

 Do you want to stay with State of KS Advantra Freedom PPO?.....12

 Do you want to make a change?12

Section 8. Do you need some help? Would you like more information? 14

 We have information and answers for you14

 You can get help and information from your State Health Insurance Assistance
 Program (SHIP)14

 You can get help and information from Medicare.....14

Section 1. Important things to know

The Annual Enrollment Period ends on December 7th

Starting this year, you have from October 15 **until December 7 to make a change** to your Medicare coverage.

You are currently enrolled in State of KS Advantra Freedom PPO, which is a Medicare PPO

You are currently enrolled as a member of State of KS Advantra Freedom PPO. This plan is a Medicare Advantage PPO (PPO stands for Preferred Provider Organization). Like all Medicare Advantage Plans, this Medicare PPO is approved by Medicare and run by a private company. We are pleased to be providing your Medicare health care coverage, including your prescription drug coverage.

If you stay enrolled in State of KS Advantra Freedom PPO for 2012, there will be some changes to your benefits and to what you pay

Each year, Medicare health plans may decide to change the premiums, cost-sharing amounts, and benefits they offer. These changes may include increasing or decreasing premiums, increasing or decreasing cost-sharing amounts, and adding or subtracting benefits.

We're sending you this *Annual Notice of Changes* to tell you how your benefits and costs as a member of State of KS Advantra Freedom PPO will change next year from your current benefits. The changes will take effect on January 1, 2012. Medicare has approved these changes.

This *Annual Notice of Changes* is only a summary (see your *Evidence of Coverage* for the details)

This *Annual Notice of Changes* gives you a summary of the changes in your benefits and what you will pay for these services in 2012. This notice is a brief summary, not a comprehensive description of benefits. For more information, contact the plan or look in your *Evidence of Coverage*.

- To get the details, you can look in the 2012 *Evidence of Coverage* for State of KS Advantra Freedom PPO. The *Evidence of Coverage* is the legal, detailed description of your benefits and costs for 2012. It explains your rights and the rules you need to follow to get your covered services and prescription drugs. (We have included a copy of the *Evidence of Coverage* in the same booklet with this *Annual Notice of Changes*.)
- If you have questions or need more information, you can always call Customer Service at 1-800-727-9712 (TTY/TDD only, call 711 Telecommunications Relay Service). Hours are 8:00 am to 8:00 pm, Central Time, 7 days a week, and calls to these numbers are free.

What should you do?

We want you to know what's ahead for next year, so **please read the rest of this document very soon to see how the changes in benefits and costs will affect you if you stay enrolled in State of KS Advantra Freedom PPO for 2012.** Starting this year, **you have only until December 7 to make a change** to your Medicare coverage. If you make a change, your new coverage will start on January 1, 2012.

To decide what's best for you, compare this information about the 2012 benefits and costs for State of KS Advantra Freedom PPO to what your benefits and costs would be if you switched to a different Medicare health plan or to Original Medicare.

If you have access to the Internet, you can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website at <http://www.medicare.gov>. The Plan Finder helps you compare your choices by giving you information about plans' benefits and costs and showing you how Medicare rates the plans. For example, these ratings let you compare how well plans are doing in different categories that include detecting and preventing illness, member satisfaction, and customer service. (To view the information about plans, go to <http://www.medicare.gov>. Click on the "Health & Drug Plans" button on the left and then choose "Compare Drug and Health Plans.") If you want us to mail you a copy of the ratings for State of KS Advantra Freedom PPO that are shown on the Medicare website, please call us at 1-800-727-9712, 8:00 am to 8:00 pm, Central Time, 7 days a week. TTY/TDD users call 711 Telecommunications Relay Service.

To get information about Original Medicare and about Medicare plans available in your area, you can also call Medicare or your State Health Insurance Assistance Program. For numbers to call, see Section 8 of this *Annual Notice of Changes*.

We value your membership in State of KS Advantra Freedom PPO and hope to keep you as a member. But if you want to make a change for 2012, see "*When can you change to a different plan?*" in Section 7 for time periods when you can make a change.

There are programs to help people with limited resources pay for their prescription drugs

You might qualify to get help in paying for your drugs. There are two basic kinds of help:

- **"Extra Help" from Medicare.** This program is also called the "low-income subsidy" or LIS. If your yearly income and resources are below certain limits, you may qualify for this help. To learn more about the Extra Help program, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. You can also look in Section III of the *Medicare & You 2012 Handbook* or call your State Health Insurance Assistance Program (the name and phone numbers for this organization are in Chapter 2, Section 3 of your *Evidence of Coverage*).

- **Help from Missouri Rx Plan, your state’s pharmaceutical assistance program.** Many states have State Pharmaceutical Assistance Programs (SPAPs) that help some people pay for prescription drugs based on financial need, age, or medical condition. In Missouri, the program is called Missouri Rx Plan. Each state has different rules. To learn more about the program in your state, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in Chapter 2, Section 3 of your *Evidence of Coverage*).

What if you are currently getting help to pay for your drugs?

If you already get help paying for your drugs, **some of the information about premiums and Part D drug costs in this *Annual Notice of Changes* is not correct for you.** We send you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider), which tells you about your drug coverage. If you don’t have this insert, please call Customer Service and ask for the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider). Phone numbers for Customer Service are on the back cover of this booklet.

Section 2. Changes to your monthly premium

For information about your 2012 State of KS Advantra Freedom (PPO) monthly premium, please contact your employer group plan benefits administrator.

Note:

- If you are required to pay a late enrollment penalty (because you went at least 63 days without Part D or other “creditable” prescription drug coverage anytime after the end of your Part D initial enrollment period), your monthly premium for 2012 will be the amount of your late enrollment penalty. For more information about this penalty, see Chapter 6 of your *Evidence of Coverage*.
- Most people pay a standard monthly Part D premium. However, some people pay an extra amount because of their yearly income. If your income is \$85,000 or above for an individual (or married individuals filing separately) or \$170,000 or above for married couples, you must pay an extra amount for your Medicare Part D coverage. If you have to pay an extra amount, the Social Security Administration, not your Medicare plan, will send you a letter telling you what that extra amount will be. For more information about Part D premiums based on income, go to Chapter 6, Section 11 of this booklet. You can also visit <http://www.medicare.gov> on the web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you may call the Social Security Administration at 1-800-772-1213. TTY users should call 1-800-325-0778.

Section 3. Medical services: Changes to your benefits and cost sharing (“out-of-pocket” costs)

Changes to your benefits

Our benefits will be exactly the same in 2012 as it is in 2011.

Changes to your cost sharing (“out-of-pocket” costs)

	2011 (this year)	2012 (next year)
Primary Care Provider (PCP) Visits	<u>In-Network</u> \$0 per visit	<u>In-Network</u> \$10 per visit
Specialist Visits	<u>In-Network</u> \$0 per visit	<u>In-Network</u> \$25 per visit
Inpatient hospital care	<u>In-Network</u> For inpatient hospital services: Days 1 – 5: \$100 copay per day.	<u>In-Network</u> For inpatient hospital services, Days 1 - 5: \$150 copay per day.
Inpatient Mental Health care	<u>In-Network</u> For inpatient mental health services: Days 1 – 5: \$100 copay per day.	<u>In-Network</u> For inpatient mental health services, Days 1 - 5: \$150 copay per day.

Section 4. Part D prescription drugs: Changes to your benefits and “out-of-pocket” costs

Changes to the *List of Covered Drugs (Formulary)*

State of KS Advantra Freedom PPO has a “*List of Covered Drugs (Formulary)*” – or “Drug List” for short. It tells which Part D prescription drugs are covered by the plan. (Chapter 5, Section 1.1 of your *Evidence of Coverage* explains about Part D drugs.)

We may make changes to the plan’s Drug List from time to time throughout the year. In addition, there are a number of changes to the Drug List that will take effect on January 1, 2012. Changes to the plan’s Drug List have been approved by Medicare.

- **We have added some new drugs to the list and removed others.** We have added some new drugs that became available. We have replaced some brand name drugs with new generic drugs. We have replaced some expensive drugs with less costly drugs that have been shown to work just as well or better. We have removed a few drugs due to safety concerns or because medical research has shown they are not effective.
- **We have added some new restrictions to certain drugs, and reduced the restrictions on others.** Restrictions can include a requirement to get plan approval in advance or to try a different drug first to see how well it works. Restrictions can also include limits on the quantity of the drug that the plan will cover for you.
 - If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If there is a restriction on the drug you want to take, you should contact Customer Service to learn what you or your provider would need to do to get coverage for the drug.

Please check to see if any of these changes to drug coverage affect the drugs you use.

- You can look for your drugs on the Drug List we sent with this *Annual Notice of Changes*. If you can’t find some of your drugs on this Drug List, you can call Customer Service for help finding your drugs.

Changes to your “out-of-pocket” costs

Every drug on the plan’s Drug List is in one of four (4) cost-sharing tiers. Medicare allows us to **change what you pay for a drug in each cost-sharing tier** only once a year. The changes shown below will take effect on January 1, 2012, and stay the same for the entire plan year.

Besides the changes to copayments and coinsurance you see below, there is another change that could affect what you pay for your drugs next year. **We have moved some of the drugs on the Drug List to a different cost-sharing tier.** Some drugs will be in a lower cost-sharing

tier, others will be in a higher cost-sharing tier. To see if any of your drugs have been moved to a different cost-sharing tier, look them up on the Drug List.

Changes to what you pay for your drugs during the Initial Coverage Stage

During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share (your copayment or coinsurance amount).

The chart below summarizes changes to what you will pay as your share of the cost of covered prescription drugs when you are in the Initial Coverage Stage. These changes affect Part D prescription drugs only.

The costs in the chart are for prescriptions filled at network pharmacies, network mail order pharmacies, network long-term care pharmacies and out-of-network pharmacies. Generally, we cover drugs filled at an out-of-network pharmacy only when you are not able to use a network pharmacy. There may be restrictions for prescriptions filled at out-of-network pharmacies, such as a limit on the amount of the drug you can receive. See Chapter 5, Section 2.5 of the *Evidence of Coverage* for more information.

	2011 (this year)	2012 (next year)
<p>Drugs in Cost-Sharing Tier 2 (Preferred Brand Drugs)</p> <p>For a one-month (30-day) supply of a drug in cost-sharing tier 2 that is filled at a network pharmacy</p>	You pay \$25 per prescription.	You pay \$30 per prescription.
<p>Drugs in Cost-Sharing Tier 2 (Preferred Brand Drugs)</p> <p>For a one-month (31-day) supply of a drug in cost-sharing tier 2 that is filled at a network long-term care pharmacy</p>	You pay \$25 per prescription.	You pay \$30 per prescription.
<p>Drugs in Cost-Sharing Tier 2</p> <p>For a three-month (90-day) supply of a drug in cost-sharing tier 2 that is filled at a network mail order pharmacy</p>	You pay \$50 per prescription.	You pay \$60 per prescription.

	2011 (this year)	2012 (next year)
<p>Drugs in Cost-Sharing Tier 3 (Non-Preferred Brand Drugs)</p> <p>For a one-month (30-day) supply of a drug in cost-sharing tier 3 that is filled at a network pharmacy</p>	You pay \$50 per prescription.	You pay \$60 per prescription.
<p>Drugs in Cost-Sharing Tier 3 (Non-Preferred Brand Drugs)</p> <p>For a one-month (31-day) supply of a drug in cost-sharing tier 3 that is filled at a network long-term care pharmacy</p>	You pay \$50 per prescription.	You pay \$60 per prescription.
<p>Drugs in Cost-Sharing Tier 3 (Non-Preferred Brand Drugs)</p> <p>For a one-month (90-day) supply of a drug in cost-sharing tier 3 that is filled at a network mail order pharmacy</p>	You pay \$100 per prescription.	You pay \$120 per prescription
<p>Drugs in Cost-Sharing Tier 4 (Specialty Drugs/Injectables)</p> <p>For a one-month (30-day) supply of a drug in cost-sharing tier 4 that is filled at a network pharmacy</p>	You pay 25% coinsurance per prescription.	You pay 33% coinsurance per prescription.

Changes to the plan's Drug Payment Stages

The chart below summarizes changes to the plan's Drug Payment Stages. These changes affect Part D prescription drugs only.

	2011 (this year)	2012 (next year)
<p>Initial Coverage Stage</p> <p>During the Initial Coverage Stage, the plan pays its share of the cost of your covered drugs, and you pay your share. (Changes to your share of the costs are described in the previous chart.)</p> <p>You stay in this stage until your year-to-date "total drug costs" total \$4,700. Once you reach this limit, you move on to the Catastrophic Coverage Stage.</p>	<p>\$2,840</p> <p>When the total costs for your Part D drugs reaches this amount, you move on to the Coverage Gap Stage.</p>	<p>\$2,930</p> <p>When the total costs for your Part D drugs reaches this amount, you move on to the Coverage Gap Stage.</p>
<p>Coverage Gap Stage</p> <p>You stay in the Coverage Gap Stage until your out-of-pocket costs for your Part D drugs reaches the amount that qualifies you for Catastrophic Coverage.</p>	<p>During the Coverage Gap Stage, the Plan provides Tier 1 Preferred Generic Drug Coverage. For all other Part D drugs, you receive a discount on brand name drugs and pay only 93% of the costs of generic drugs.</p> <p>You stay in this stage until your out-of-pocket costs reach:</p> <p>\$4,550</p> <p>This is the amount you must pay out-of-pocket to leave the Coverage Gap Stage and qualify for Catastrophic Coverage.</p>	<p>During the Coverage Gap Stage, the Plan provides Tier 1 Preferred Generic Drug Coverage. For all other Part D drugs, you receive a discount on brand name drugs and pay only 86% of the costs of generic drugs.</p> <p>You stay in this stage until your out-of-pocket costs reach:</p> <p>\$4,700</p> <p>This is the amount you must pay out-of-pocket to leave the Coverage Gap Stage and qualify for Catastrophic Coverage.</p>

	2011 (this year)	2012 (next year)
<p>Catastrophic Coverage Stage</p> <p>During the Catastrophic Coverage Stage, the plan will pay most of the cost for your Part D drugs.</p> <p>You will stay in this stage until the end of the calendar year.</p>	<p>You pay the greater of:</p> <ul style="list-style-type: none"> • A \$ 2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, <p>or</p> <ul style="list-style-type: none"> • 5% coinsurance. 	<p>You pay the greater of:</p> <ul style="list-style-type: none"> • \$2.60 copay for generic drugs (including brand drugs treated as generic) and a \$6.50 copay for all other drugs <p>or</p> <ul style="list-style-type: none"> • 5% coinsurance

What if changes for 2012 affect drugs you are taking now?

What if a drug you are taking now is not on the Drug List for 2012? What if it has been moved to a higher cost-sharing tier? What if a new restriction has been added to the coverage for this drug? If you are in any of these situations, here's what you can do:

- In some situations, the plan will cover a **one-time, temporary supply** of your drug when your current supply runs out. This temporary supply will be for a maximum of 30 days, or less if your prescription is written for fewer days. Chapter 5, Section 5.2 of the *Evidence of Coverage* explains when you can get a temporary supply and how to ask for one.

Meanwhile, you and your doctor will need to decide what to do before your temporary supply of the drug runs out.

- **Perhaps you can find a different drug** covered by the plan that might work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your doctor to find a covered drug that might work for you.
- **You and your doctor can ask the plan to make an exception for you** and cover the drug. You can ask for an exception in advance for next year and we will give you an answer to your request before the change takes effect. To learn what you must do to ask for an exception, see the *Evidence of Coverage* that was included in the mailing with this *Annual Notice of Changes*. Look for Chapter 9 of the *Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints))*.
- For current members who do not request an exception before January 1st, we will provide up to a 30-day temporary supply (unless your prescription is written for less than 30 days, in which case we will allow multiple fills to provide up to a total of a 30-day supply) of

the drug for the first 90 days of the new plan year starting on January 1st. This will give you time to discuss options with your prescribing physician regarding alternative drugs or requesting an exception.

- If you are changing from one treatment setting to another, for example entering a long-term care facility from a hospital or being discharged from a hospital to home, you will need to utilize our exception process if your drug is not on our formulary for 2012. You will be given a one-time emergency supply of a 31-day supply for medications if you have not already received a temporary supply. However, it is important that you use the exceptions process as defined in the *Evidence of Coverage* that was in the mailing with this *Annual Notice of Changes*.

Important Note: Please take advantage of filing your exception requests before January 1st. It will make for a very easy transition into the next calendar year for you. To learn what you must do to ask for an exception, see the *Evidence of Coverage* that was included in the mailing with this *Annual Notice of Changes*. Look for Chapter 9 of the *Evidence of Coverage* (*What to do if you have a problem or complaint*).

Section 5. What about changes to the plan's network of providers?

Will your doctors and other providers still be in the plan's network next year?

There are changes to the network of providers for 2012. In addition, it's possible for the network of plan providers to change at any time during the year.

- **Please check with your doctors and other providers you currently use** to make sure they will continue to be part of the provider network for State of KS Advantra Freedom PPO in 2012.
- For the most up-to-date information on the network of providers, check our website (<http://ProviderDirectory.coventry-medicare.com>) or call Customer Service (see phone numbers on the back cover of this booklet).

Section 6. What other plan changes will begin next year?

	2011 (this year)	2012 (next year)
<p>The contact information for Part D prescription drug requests for coverage determinations will change.</p> <p>See Chapter 9: <i>What to do if you have a problem or complaint (coverage decisions, appeals, complaints)</i> for more information on submitting Coverage Determinations.</p>	<p>Advantra Member Services, PO Box 7370, London, KY, 40742</p> <p>Phone: 1-800-727-9712</p> <p>TTY/TDD: 711 Telecommunications Relay Service</p> <p>Fax: 1-866-759-4415</p>	<p>State of KS Advantra Freedom PPO, Attention: Coverage Determinations, PO Box 7773, London, KY, 40742</p> <p>Phone: 1-800-551-2694</p> <p>TTY/TDD: 711 Telecommunications Relay Service</p> <p>Fax: 1-800-639-9158</p>
<p>The contact information for appeals and written grievances will change.</p> <p>See Chapter 9: <i>What to do if you have a problem or complaint (coverage decisions, appeals, complaints)</i> for more information on submitting appeals and grievances.</p>	<p><u>For Medical Care and Part D Prescription Drug Appeals and/or Written Grievances:</u></p> <p>Advantra Appeals and Grievances Unit, 4th Floor, 8320 Ward Parkway, Kansas City, MO, 64114</p> <p>Phone: 1-800-727-9712</p> <p>TTY/TDD: 711 Telecommunications Relay Service</p> <p>Fax: 1-866-769-2408</p>	<p><u>For Medical Care Appeals and/or Written Grievances:</u></p> <p>State of KS Advantra Freedom PPO Attention: Medicare Medical Appeals and Grievances Department, PO Box 7776, London, KY 40742</p> <p>Phone: 1-800-727-9712</p> <p>TTY/TDD: 711 Telecommunications Relay Service</p> <p>Fax: 1-855-788-3994</p> <p><u>For Part D Prescription Drug Appeals and/or Written Grievances:</u></p> <p>State of KS Advantra Freedom PPO, Attention: Part D Appeals and</p>

2011 (this year)	2012 (next year)
	<p>Grievances Department, PO Box 7773 London, KY, 40742</p> <p>Standard Appeals and Grievances Phone: 1-866-294-9803</p> <p>Expedited Appeals and Grievances Phone: 1-800-536-6167</p> <p>TTY/TDD: 711 Tele- communications Relay Service</p> <p>Fax: 1-800-535-4047</p>

Section 7. Do you want to stay in the plan or make a change?

Do you want to stay with State of KS Advantra Freedom PPO?

If you want to keep your membership in State of KS Advantra Freedom PPO for 2012, it's easy. You don't need to tell us or fill out any paperwork. **You will automatically remain enrolled as a member if you do not sign up for a different plan or Original Medicare.**

Do you want to make a change?

If you decide to leave State of KS Advantra Freedom PPO, you can switch to a different Medicare health plan (either with or without Medicare prescription drug coverage) or you can cancel your plan enrollment and switch to Original Medicare (either with or without a separate Medicare prescription drug plan).

If you want to change to a different plan, there are many choices. If you have access to the Internet, you can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to <http://www.medicare.gov> and click on the "Health & Drug Plans" button on the left. Then choose "Compare Drug and Health Plans.") You can also get information about plans from Medicare or from your State Health Insurance Assistance Program. (For numbers to call, see Section 8 of this *Annual Notice of Changes*.)

When can you change to a different plan?

- During the **yearly enrollment period (called the “annual coordinated election period”)** from **October 15 through December 7, 2011**, you can change to another Medicare health plan (either with or without Medicare prescription drug coverage) or you can cancel your plan enrollment and switch to Original Medicare (either with or without a separate Medicare prescription drug plan). Your new coverage will begin on January 1, 2012.
- You also have **another, more limited enrollment period from January 1 through February 14, 2012**. During this period (called the annual “Medicare Advantage Disenrollment Period”), you could switch from State of KS Advantra Freedom PPO to Original Medicare. Your coverage will begin the first day of the month after we get your request to switch to Original Medicare
 - If you choose to switch to Original Medicare during this annual disenrollment period, you have until February 14 to join a separate Medicare prescription drug plan to add drug coverage. Your drug coverage will begin the first day of the month after the drug plan gets your enrollment form.
 - For more information about your choices during the January 1 through February 14 annual disenrollment period, please see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

Are these the only times of the year to choose a different plan?

For most people, yes. Certain individuals, such as those with Medicaid, those who get Extra Help paying for their drugs, or those who move out of the service area, can make changes at other times. There may be other situations in which you are allowed to change plans. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage*.

How do you make a change?

See Chapter 10 of the *Evidence of Coverage*. It tells what you need to do to make a change from State of KS Advantra Freedom PPO to another plan.

Check on these things before you make a change

- **Are you a member of an employer or retiree group plan?** If you are, please check with the benefits administrator of your employer or retiree group *before you change your plan*. This is important because you may lose benefits you currently receive under your employer or retiree group coverage if you switch plans.
- **Are you getting help with paying for your drugs from a State Pharmaceutical Assistance Program (SPAP)?** If you are, please check with this program before switching to another plan. The phone number for your State Pharmaceutical Assistance Program is listed in Chapter 2, Section 7 of the *Evidence of Coverage*.

Section 8. Do you need some help? Would you like more information?

We have information and answers for you

To learn more, read the information we sent in the same package with this *Annual Notice of Changes*. This includes a copy of the *Evidence of Coverage* and a copy of the *List of Covered Drugs (Formulary)*.

If you have any questions, we are here to help. Please call our Customer Service at 1-800-727-9712 (TTY/TDD only, call 711 Telecommunications Relay Service). We are available for phone calls 8:00 am to 8:00 pm, Central Time, 7 days a week. Calls to these numbers are free.

You can get help and information from your State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Kansas, the SHIP is called Senior Health Insurance Counseling for Kansas (SHICK). In Missouri, the SHIP is called Community Leaders Assisting the Insured in Missouri (CLAIM).

The State Health Insurance Assistance Program is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. State Health Insurance Assistance Program counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call Senior Health Insurance Counseling for Kansas at 1-800-860-5260. You can call Community Leaders Assisting the Insured in Missouri at 1-800-390-3330.

You can get help and information from Medicare

Here are three ways to get information directly from Medicare:

- **Call 1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- **Visit the Medicare website** (<http://www.medicare.gov>).
- **Read *Medicare & You 2012***. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (<http://www.medicare.gov>) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

January 1 – December 31, 2012

Evidence of Coverage:

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of State of KS Advantra Freedom PPO

This booklet gives you the details about your Medicare health care and prescription drug coverage from January 1 – December 31, 2012. It explains how to get the health care and prescription drugs you need covered. This is an important legal document. Please keep it in a safe place.

This plan, State of KS Advantra Freedom PPO, is offered by Coventry Health and Life Insurance Company. (When this *Evidence of Coverage* says “we,” “us,” or “our,” it means Coventry Health and Life Insurance Company. When it says “plan” or “our plan,” it means State of KS Advantra Freedom PPO.)

A Coordinated Care Plan with a Medicare Advantage Contract

Customer Service has free language interpreter services available for non-English speakers (phone numbers are on the back cover of this booklet).

Benefits, formulary, pharmacy network, premium, and/or copayments/coinsurance may change on January 1, 2013.

2012 Evidence of Coverage

Table of Contents

This list of chapters and page numbers is just your starting point. For more help in finding information you need, go to the first page of a chapter. **You will find a detailed list of topics at the beginning of each chapter.**

Chapter 1.	Getting started as a member.....	1
	Tells what it means to be in a Medicare health plan and how to use this booklet. Tells about materials we will send you, your plan premium, your plan membership card, and keeping your membership record up to date.	
Chapter 2.	Important phone numbers and resources	12
	Tells you how to get in touch with our plan (State of KS Advantra Freedom PPO) and with other organizations including Medicare, the State Health Insurance Assistance Program (SHIP), the Quality Improvement Organization, Social Security, Medicaid (the state health insurance program for people with low incomes), programs that help people pay for their prescription drugs, and the Railroad Retirement Board.	
Chapter 3.	Using the plan’s coverage for your medical services.....	30
	Explains important things you need to know about getting your medical care as a member of our plan. Topics include using the providers in the plan’s network and how to get care when you have an emergency.	
Chapter 4.	Medical Benefits Chart (what is covered and what you pay)	43
	Gives the details about which types of medical care are covered and <i>not</i> covered for you as a member of our plan. Tells how much you will pay as your share of the cost for your covered medical care.	
Chapter 5.	Using the plan’s coverage for your Part D prescription drugs	77
	Explains rules you need to follow when you get your Part D drugs. Tells how to use the plan’s <i>List of Covered Drugs (Formulary)</i> to find out which drugs are covered. Tells which kinds of drugs are <i>not</i> covered. Explains several kinds of restrictions that apply to coverage for certain drugs. Explains where to get your prescriptions filled. Tells about the plan’s programs for drug safety and managing medications.	

Chapter 6.	What you pay for your Part D prescription drugs	98
	Tells about the three (3) stages of drug coverage (<i>Initial Coverage Stage, Coverage Gap Stage, Catastrophic Coverage Stage</i>) and how these stages affect what you pay for your drugs. Explains the four (4) cost-sharing tiers for your Part D drugs and tells what you must pay for a drug in each cost-sharing tier. Tells about the late enrollment penalty.	
Chapter 7.	Asking us to pay our share of a bill you have received for covered medical services or drugs	119
	Tells when and how to send a bill to us when you want to ask us to pay you back for our share of the cost for your covered services or drugs.	
Chapter 8.	Your rights and responsibilities	126
	Explains the rights and responsibilities you have as a member of our plan. Tells what you can do if you think your rights are not being respected.	
Chapter 9.	What to do if you have a problem or complaint (coverage decisions, appeals, complaints)	140
	Tells you step-by-step what to do if you are having problems or concerns as a member of our plan. <ul style="list-style-type: none">• Explains how to ask for coverage decisions and make appeals if you are having trouble getting the medical care or prescription drugs you think are covered by our plan. This includes asking us to make exceptions to the rules or extra restrictions on your coverage for prescription drugs, and asking us to keep covering hospital care and certain types of medical services if you think your coverage is ending too soon.• Explains how to make complaints about quality of care, waiting times, customer service, and other concerns.	
Chapter 10.	Ending your membership in the plan	195
	Tells when and how you can end your membership in the plan. Explains situations in which our plan is required to end your membership.	
Chapter 11.	Legal notices	203
	Includes notices about governing law and about nondiscrimination.	

Chapter 12. Definitions of important words 205

Explains key terms used in this booklet.

Chapter 1. Getting started as a member

SECTION 1	Introduction	3
Section 1.1	You are enrolled in State of KS Advantra Freedom PPO, which is a Medicare PPO	3
Section 1.2	What is the <i>Evidence of Coverage</i> booklet about?	3
Section 1.3	What does this Chapter tell you?	3
Section 1.4	What if you are new to State of KS Advantra Freedom PPO?	3
Section 1.5	Legal information about the <i>Evidence of Coverage</i>	4
SECTION 2	What makes you eligible to be a plan member?	4
Section 2.1	Your eligibility requirements	4
Section 2.2	What are Medicare Part A and Medicare Part B?.....	4
Section 2.3	Here is the plan service area for State of KS Advantra Freedom PPO	5
SECTION 3	What other materials will you get from us?	5
Section 3.1	Your plan membership card – Use it to get all covered care and prescription drugs.....	5
Section 3.2	The <i>State of KS Advantra Freedom PPO Provider/Pharmacy Directory</i> : Your guide to all providers and pharmacies in the plan’s network	6
Section 3.3	The plan’s <i>List of Covered Drugs (Formulary)</i>	7
Section 3.4	The <i>Explanation of Benefits</i> (the “EOB”): Reports with a summary of payments made for your Part D prescription drugs	7
SECTION 4	Your monthly premium for State of KS Advantra Freedom PPO	8
Section 4.1	How much is your plan premium?.....	8
SECTION 5	Please keep your plan membership record up to date	9

Section 5.1 How to help make sure that we have accurate information about you9

SECTION 6 We protect the privacy of your personal health information 10

Section 6.1 We make sure that your health information is protected10

SECTION 7 How other insurance works with our plan 10

Section 7.1 Which plan pays first when you have other insurance?.....10

SECTION 1 Introduction

Section 1.1	You are enrolled in State of KS Advantra Freedom PPO, which is a Medicare PPO
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You are covered by Medicare, and you have chosen to get your Medicare health care and your prescription drug coverage through our plan, State of KS Advantra Freedom PPO.

There are different types of Medicare health plans. State of KS Advantra Freedom PPO is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company.

Section 1.2	What is the <i>Evidence of Coverage</i> booklet about?
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This *Evidence of Coverage* booklet tells you how to get your Medicare medical care and prescription drugs covered through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

This plan, State of KS Advantra Freedom PPO, is offered by Coventry Health and Life Insurance Company. (When this *Evidence of Coverage* says “we,” “us,” or “our,” it means Coventry Health and Life Insurance Company. When it says “plan” or “our plan,” it means State of KS Advantra Freedom PPO.)

The word “coverage” and “covered services” refers to the medical care and services and the prescription drugs available to you as a member of State of KS Advantra Freedom PPO.

Section 1.3	What does this Chapter tell you?
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Look through Chapter 1 of this *Evidence of Coverage* to learn:

- What makes you eligible to be a plan member?
- What is your plan’s service area?
- What materials will you get from us?
- What is your plan premium and how can you pay it?
- How do you keep the information in your membership record up to date?

Section 1.4	What if you are new to State of KS Advantra Freedom PPO?
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If you are a new member, then it’s important for you to learn how the plan operates – what the rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* booklet.

If you are confused or concerned or just have a question, please contact our plan's Customer Service (contact information is on the back cover of this booklet).

Section 1.5 Legal information about the *Evidence of Coverage*

It's part of our contract with you

This *Evidence of Coverage* is part of our contract with you about how State of KS Advantra Freedom PPO covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs (Formulary)*, and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for months in which you are enrolled in State of KS Advantra Freedom PPO between January 1, 2012 and December 31, 2012.

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve State of KS Advantra Freedom PPO each year. You can continue to get Medicare coverage as a member of our plan only as long as we choose to continue to offer the plan for the year in question and the Centers for Medicare & Medicaid Services renews its approval of the plan.

SECTION 2 What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

You are eligible for membership in our plan as long as:

- You live in our geographic service area (section 2.3 below describes our service area)
- -- *and* -- you are entitled to Medicare Part A
- -- *and* -- you are enrolled in Medicare Part B
- -- *and* -- you do *not* have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different plan that was terminated.

Section 2.2 What are Medicare Part A and Medicare Part B?

When you originally signed up for Medicare, you received information about how to get Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally covers services furnished by institutional providers such as hospitals, skilled nursing facilities, or home health agencies.

- Medicare Part B is for most other medical services (such as physician's services and other outpatient services) and certain items (such as durable medical equipment and supplies).

Section 2.3 Here is the plan service area for State of KS Advantra Freedom PPO

Although Medicare is a Federal program, State of KS Advantra Freedom PPO is available only to individuals who live in our plan service area. To remain a member of our plan, you must keep living in this service area. The service area is described below.

Our service area includes all counties in Kansas and Missouri

If you plan to move out of the service area, please contact Customer Service. When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

SECTION 3 What other materials will you get from us?

Section 3.1 Your plan membership card – Use it to get all covered care and prescription drugs

While you are a member of our plan, you must use your membership card for our plan whenever you get any services covered by this plan and for prescription drugs you get at network pharmacies. Here's a sample membership card to show you what yours will look like:



As long as you are a member of our plan **you must not use your red, white, and blue Medicare card** to get covered medical services (with the exception of routine clinical research studies and hospice services). Keep your red, white, and blue Medicare card in a safe place in case you need it later.

Here's why this is so important: If you get covered services using your red, white, and blue Medicare card instead of using your State of KS Advantra Freedom PPO membership card while you are a plan member, you may have to pay the full cost yourself.

If your plan membership card is damaged, lost, or stolen, call Customer Service right away and we will send you a new card.

Section 3.2	The State of KS Advantra Freedom PPO Provider/Pharmacy Directory: Your guide to all providers and pharmacies in the plan's network
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Every year that you are a member of our plan, we will send you either a new *State of KS Advantra Freedom PPO Provider/Pharmacy Directory* or an update to your *State of KS Advantra Freedom PPO Provider/Pharmacy Directory*. This directory lists our network providers and network pharmacies.

What are “network providers”?

Network providers are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full. We have arranged for these providers to deliver covered services to members in our plan.

Why do you need to know which providers are part of our network?

As a member of our plan, you can choose to receive care from out-of-network providers. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and medically necessary. However, if you use an out-of-network provider, your share of the costs for your covered services may be higher. See Chapter 3 (*Using the plan's coverage for your medical services*) for more specific information.

If you don't have your copy of the *State of KS Advantra Freedom PPO Provider/Pharmacy Directory*, you can request a copy from Customer Service. You may ask Customer Service for more information about our network providers, including their qualifications. You can also find information about our network providers on our website at <http://ProviderDirectory.coventry-medicare.com>. Both Customer Service and the website can give you the most up-to-date information about changes in our network providers.

What are “network pharmacies”?

Our *State of KS Advantra Freedom PPO Provider/Pharmacy Directory* gives you a complete list of our network pharmacies – that means all of the pharmacies that have agreed to fill covered prescriptions for our plan members.

Why do you need to know about network pharmacies?

You can use the *Provider/Pharmacy Directory* to find the network pharmacy you want to use. This is important because, with few exceptions, you must get your prescriptions filled at one of our network pharmacies if you want our plan to cover (help you pay for) them.

If you don't have the *Provider/Pharmacy Directory*, you can get a copy from Customer Service (phone numbers are on the back cover of this booklet). At any time, you can call Customer Service to get up-to-date information about changes in the pharmacy network. You can also find this information on our website at <http://PharmacyLocator.coventry-medicare.com>. We update our website "Pharmacy Locator" whenever a new network pharmacy is added or a pharmacy leaves our network. For the most up-to-date pharmacy listing, log on to our website. Or you can call Customer Service at the telephone number listed on the back cover of this booklet.

Section 3.3 The plan's *List of Covered Drugs (Formulary)*

The plan has a *List of Covered Drugs (Formulary)*. We call it the "Drug List" for short. It tells which Part D prescription drugs are covered by State of KS Advantra Freedom PPO. The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the State of KS Advantra Freedom PPO Drug List.

The Drug List also tells you if there are any rules that restrict coverage for your drugs.

We will send you a copy of the Drug List. To get the most complete and current information about which drugs are covered, you can visit the plan's website (<http://KSFormulary.coventry-medicare.com>) or call Customer Service (phone numbers are on the back cover of this booklet).

Section 3.4 The *Explanation of Benefits* (the "EOB"): Reports with a summary of payments made for your Part D prescription drugs

When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the *Explanation of Benefits* (or the "EOB").

The *Explanation of Benefits* tells you the total amount you have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. Chapter 6 (*What you pay for your Part D prescription drugs*) gives more information about the *Explanation of Benefits* and how it can help you keep track of your drug coverage.

An *Explanation of Benefits* summary is also available upon request. To get a copy, please contact Customer Service.

SECTION 4 Your monthly premium for State of KS Advantra Freedom PPO

Section 4.1 How much is your plan premium?
--

Your coverage is provided through contract with your current employer or former employer or union. Please contact the employer's or union's benefits administrator for information about your premium.

In some situations, your plan premium could be more

In some situations, your plan premium could be more than the amount listed above in Section 4.1. These situations are described below.

- Most people pay a standard monthly Part D premium. However, some people pay an extra amount because of their yearly income. If your income is \$85,000 or above for an individual (or married individuals filing separately) or \$170,000 or above for married couples, you must pay an extra amount for your Medicare Part D coverage. If you have to pay an extra amount, the Social Security Administration, not your Medicare plan, will send you a letter telling you what that extra amount will be. For more information about Part D premiums based on income, you can visit <http://www.medicare.gov> on the web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You may also call the Social Security Administration at 1-800-772-1213. TTY users should call 1-800-325-0778.
- Some members are required to pay a **late enrollment penalty** because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of 63 days or more when they didn't have "creditable" prescription drug coverage. ("Creditable" means the drug coverage is at least as good as Medicare's standard drug coverage.) For these members, the late enrollment penalty is added to the plan's monthly premium. Their premium amount will be the monthly plan premium plus the amount of their late enrollment penalty.
 - If you are required to pay the late enrollment penalty, the amount of your penalty depends on how long you waited before you enrolled in drug coverage or how many months you were without drug coverage after you became eligible. Chapter 6, Section 10 *explains the late enrollment penalty.*

Many members are required to pay other Medicare premiums

As explained in Section 2 above, in order to be eligible for our plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B. For that reason, some plan members will be paying a premium for Medicare Part A and most plan members will be paying a premium for Medicare Part B. You must continue paying your Medicare Part B premium to remain a member of the plan.

- Your copy of *Medicare & You 2012* gives information about these premiums in the section called “2012 Medicare Costs.” This explains how the Part B premium differs for people with different incomes.
- Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2012* from the Medicare website (<http://www.medicare.gov>). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

SECTION 5 Please keep your plan membership record up to date

Section 5.1 How to help make sure that we have accurate information about you

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage.

The doctors, hospitals, pharmacists, and other providers in the plan’s network need to have correct information about you. **These network providers use your membership record to know what services and drugs are covered for you.** Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse’s employer, workers’ compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study

If any of this information changes, please let us know by calling Customer Service (phone numbers are on the back cover of this booklet).

Read over the information we send you about any other insurance coverage you have

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see Section 7 in this chapter.)

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Customer Service (phone numbers are on the back cover of this booklet).

SECTION 6 We protect the privacy of your personal health information

Section 6.1 We make sure that your health information is protected

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

For more information about how we protect your personal health information, please go to Chapter 8, Section 1.4 of this booklet.

SECTION 7 How other insurance works with our plan

Section 7.1 Which plan pays first when you have other insurance?

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that pays second, called the "secondary payer," only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the size of the employer, and whether you have Medicare based on age, disability, or End-stage Renal Disease (ESRD):
 - If you're under 65 and disabled and you or your family member is still working, your plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan has more than 100 employees.

-
- If you're over 65 and you or your spouse is still working, the plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.
 - If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Customer Service (phone numbers are on the back cover of this booklet.) You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

Chapter 2. Important phone numbers and resources

SECTION 1	State of KS Advantra Freedom PPO contacts (how to contact us, including how to reach Customer Service at the plan)	13
SECTION 2	Medicare (how to get help and information directly from the Federal Medicare program).....	19
SECTION 3	State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)	21
SECTION 4	Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare).....	22
SECTION 5	Social Security	23
SECTION 6	Medicaid (a joint Federal and state program that helps with medical costs for some people with limited income and resources).....	24
SECTION 7	Information about programs to help people pay for their prescription drugs	25
SECTION 8	How to contact the Railroad Retirement Board	28
SECTION 9	Do you have “group insurance” or other health insurance from an employer?	29

SECTION 1 State of KS Advantra Freedom PPO contacts
(how to contact us, including how to reach Customer Service at the plan)

How to contact our plan's Customer Service

For assistance with claims, billing or member card questions, please call or write to State of KS Advantra Freedom PPO Customer Service. We will be happy to help you.

Customer Service	
CALL	1-800-727-9712 Calls to this number are free. 8:00 am to 8:00 pm, Central Time, 7 days a week. After hours, our automated system will allow you to check the status of a claim, check the status of an authorization request, or request a replacement member ID Card. Customer Service also has free language interpreter services available for non-English speakers.
TTY/TDD	711 Telecommunication Relay Service This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8:00 am to 8:00 pm, Central Time, 7 days a week.
FAX	1-866-759-4415
WRITE	State of KS Advantra Freedom PPO PO Box 7370 London, KY 40742
WEBSITE	http://member.coventry-medicare.com

How to contact us when you are asking for a coverage decision about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For more information on asking for coverage decisions about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

You may call us if you have questions about our coverage decision process.

Coverage Decisions for Medical Care	
CALL	1-800-727-9712 Calls to this number are free. 8:00 am to 8:00 pm, Central Time, 7 days a week.
TTY/TDD	711 Telecommunications Relay Service This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8:00 am to 8:00 pm, Central Time, 7 days a week.
FAX	1-866-759-4415
WRITE	State of KS Advantra Freedom PPO PO Box 7370 London, KY 40742
WEBSITE	http://member.coventry-medicare.com

How to contact us when you are making an appeal about your medical care

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Appeals for Medical Care	
CALL	1-800-727-9712 Calls to this number are free. 8:00 am to 8:00 pm, Central Time, 7 days a week.
TTY/TDD	711 Telecommunications Relay Service This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8:00 am to 8:00 pm, Central Time, 7 days a week.
FAX	1-855-788-3994
WRITE	State of KS Advantra Freedom PPO Attention: Medicare Medical Appeals and Grievances Department PO Box 7776 London, KY 40742
WEBSITE	http://Appeals-Grievance.coventry-medicare.com

How to contact us when you are making a complaint about your medical care

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If you have a problem about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Complaints about Medical Care	
CALL	1-800-727-9712 Calls to this number are free. 8:00 am to 8:00 pm, Central Time, 7 days a week.
TTY/TDD	711 Telecommunications Relay Service This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8:00 am to 8:00 pm, Central Time, 7 days a week.
FAX	1-855-788-3994
WRITE	State of KS Advantra Freedom PPO Attention: Medicare Medical Appeals and Grievances Department PO Box 7776 London, KY 40742

How to contact us when you are asking for a coverage decision about your Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your Part D prescription drugs. For more information on asking for coverage decisions about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Coverage Decisions for Part D Prescription Drugs	
CALL	1-800-551-2694 Calls to this number are free. 8:00 am to 8:00 pm, Central Time, 7 days a week.

Coverage Decisions for Part D Prescription Drugs	
TTY/TDD	711 Telecommunications Relay Service This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8:00 am to 8:00 pm, Central Time, 7 days a week.
FAX	1-800-639-9158
WRITE	State of KS Advantra Freedom PPO Attention: Coverage Determinations PO Box 7773 London, KY 40742
WEBSITE	http://Appeals-Grievance.coventry-medicare.com

How to contact us when you are making an appeal about your Part D prescription drugs

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Appeals for Part D Prescription Drugs	
CALL	Standard Appeals: 1-866-294-9803 Expedited Appeals: 1-800-536-6167 Calls to these numbers are free. 24 hours a day, 7 days a week.
TTY/TDD	711 Telecommunications Relay Service This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 24 hours a day, 7 days a week.

Appeals for Part D Prescription Drugs	
FAX	1-800-535-4047
WRITE	State of KS Advantra Freedom PPO Attention: Part D Appeals and Grievances Department PO Box 7773 London, KY 40742
WEBSITE	http://Appeals-Grievance.coventry-medicare.com

How to contact us when you are making a complaint about your Part D prescription drugs

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Complaints about Part D prescription drugs	
CALL	1-866-294-9803 Calls to this number are free. 24 hours a day, 7 days a week.
TTY/TDD	711 Telecommunications Relay Service This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 24 hours a day, 7 days a week.
FAX	1-800-535-4047
WRITE	State of KS Advantra Freedom PPO Attention: Part D Appeals and Grievances Department PO Box 7773 London, KY 40742

Where to send a request asking us to pay for our share of the cost for medical care or a drug you have received

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) for more information.

Payment Requests		
WRITE	Requests for Medical Claims: State of KS Advantra Freedom PPO PO Box 7370 London, KY 40742	Requests for Drug Claims: Medco Health Solutions, Inc. PO Box 14724 Lexington, KY 40512
WEBSITE	http://KSForms.coventry-medicare.com	

SECTION 2 Medicare (how to get help and information directly from the Federal Medicare program)

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called “CMS”). This agency contracts with Medicare Advantage organizations including us.

Medicare	
CALL	<p>1-800-MEDICARE, or 1-800-633-4227</p> <p>Calls to this number are free.</p> <p>24 hours a day, 7 days a week.</p>
TTY	<p>1-877-486-2048</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free.</p>
WEBSITE	<p>http://www.medicare.gov</p> <p>This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state by selecting “Help and Support” and then clicking on “Useful Phone Numbers and Websites.”</p> <p>The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:</p> <ul style="list-style-type: none"> • Medicare Eligibility Tool: Provides Medicare eligibility status information. Select “Find Out if You’re Eligible.” • Medicare Plan Finder: Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. Select “Health & Drug Plans” and then “Compare Drug and Health Plans” or “Compare Medigap Policies.” These tools provide an <i>estimate</i> of what your out-of-pocket costs might be in different Medicare plans. <p>If you don’t have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare at the number above and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you.</p>

SECTION 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. Here is a list of the State Health Insurance Assistance Programs in each state we serve:

- In Kansas, the SHIP is called Senior Health Insurance Counseling for Kansas (SHICK).
- In Missouri, the SHIP is called Community Leaders Assisting the Insured in Missouri (CLAIM).

The State Health Insurance Assistance Program is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

State Health Insurance Assistance Program counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. State Health Insurance Assistance Program counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

Senior Health Insurance Counseling for Kansas (SHICK)	
CALL	1-800-860-5260
WRITE	SHICK Kansas Department of Aging 503 S Kansas Ave Topeka, KS 66603
WEBSITE	http://www.agingkansas.org/SHICK/shick_index.html

Community Leaders Assisting the Insured in Missouri (CLAIM)	
CALL	1-800-390-3330
WRITE	CLAIM 200 N Keene St Columbia, MO 65201
WEBSITE	http://www.missouricclaim.org

SECTION 4 Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare)

There is a Quality Improvement Organization for each state. Here is a list of the Quality Improvement Organizations in each state we serve:

- For Kansas, the Quality Improvement Organization is called Kansas Foundation for Medical Care.
- For Missouri, the Quality Improvement Organization is called Primaris.

The Quality Improvement Organization has a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. The Quality Improvement Organization is an independent organization. It is not connected with our plan.

You should contact the Quality Improvement Organization in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

Kansas Foundation for Medical Care	
CALL	1-800-432-0407
WRITE	Kansas Foundation for Medical Care 2947 SW Wanamaker Dr Topeka, KS 66614
WEBSITE	http://www.kfmc.org

Primaris (Missouri's Quality Improvement Organization)	
CALL	1-800-347-1016
WRITE	Primaris 200 N Keene St, Suite 101 Columbia, MO 65201
WEBSITE	http://www.primaris.org

SECTION 5 Social Security

The Social Security Administration is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security	
CALL	<p>1-800-772-1213</p> <p>Calls to this number are free.</p> <p>Available 7:00 am to 7:00 pm, Monday through Friday.</p> <p>You can use Social Security’s automated telephone services to get recorded information and conduct some business 24 hours a day.</p>
TTY	<p>1-800-325-0778</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free.</p> <p>Available 7:00 am to 7:00 pm, Monday through Friday.</p>
WEBSITE	http://www.ssa.gov

SECTION 6 Medicaid

(a joint Federal and state program that helps with medical costs for some people with limited income and resources)

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid.

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These programs help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments).
- **Specified Low-Income Medicare Beneficiary (SLMB) and Qualifying Individual (QI):** Helps pay Part B premiums.

- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact Medicaid.

Kansas Medical Assistance Program	
CALL	1-800-766-9012
WRITE	Kansas Medical Assistance Program PO Box 3571 Topeka, KS 66601
WEBSITE	https://www.kmap-state-ks.us

Missouri HealthNet	
CALL	1-800-392-2161
WRITE	Missouri HealthNet PO Box 6500 Jefferson City, MO 65102
WEBSITE	http://dss.mo.gov/mhd

SECTION 7 Information about programs to help people pay for their prescription drugs

Medicare’s “Extra Help” Program

Medicare provides “Extra Help” to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan’s monthly premium, yearly deductible, and prescription copayments. This Extra Help also counts toward your out-of-pocket costs.

People with limited income and resources may qualify for Extra Help. Some people automatically qualify for Extra Help and don’t need to apply. Medicare mails a letter to people who automatically qualify for Extra Help.

You may be able to get Extra Help to pay for your prescription drug premiums and costs. To see if you qualify for getting Extra Help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 7 am to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778; or
- Your State Medicaid Office. (See Section 6 of this chapter for contact information)

If you believe you have qualified for Extra Help and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has established a process that allows you to either request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us.

- You should contact Customer Service at the phone number provided on the back cover as soon as possible.

Let our Customer Service Representative know that you believe you have paid an incorrect amount for your prescription drugs. Our Customer Service Representative will review with you a listing of acceptable documents that can help confirm that you have qualified for “extra help”. If you have any of these documents, you will be asked to fax a copy of the document to our attention at the fax number provided below. If you do not have a fax machine, you will be asked to mail a copy to the Plan at the address provided below.

State of KS Advantra Freedom PPO
Best Available Evidence
PO Box 7770
London, KY 40742-7770

Phone: 1-800-727-9712 (TTY/TDD users should call 711 Telecommunications Relay Services), 8:00 am to 8:00 pm Central Time, 7 days a week
Fax: 1-888-554-7668

When you submit this evidence of “extra help”, please make sure you include your name and member identification number located on your Member Identification Card. If you do not have any of these forms of evidence, but believe you are receiving “extra help”, we will work directly with CMS to confirm your eligibility. This normally takes 24 to 48 hours. Once we receive a response from CMS, we will make at least four (4) attempts to reach you, three (3) by phone and one by letter to inform you of the response we have received from CMS regarding your eligibility.

- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will

forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Customer Service if you have questions.

Medicare Coverage Gap Discount Program

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs to Part D enrollees who have reached the coverage gap and are not already receiving "Extra Help." A 50% discount on the negotiated price (excluding the dispensing fee and vaccine administration fee, if any) is available for those brand name drugs from manufacturers that have agreed to pay the discount.

If you reach the coverage gap, we will automatically apply the discount when your pharmacy bills you for your prescription and your Explanation of Benefits (EOB) will show any discount provided. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the coverage gap.

You also receive some coverage for generic drugs. If you reach the coverage gap, the plan pays 14% of the price for generic drugs and you pay the remaining 86% of the price. The coverage for generic drugs works differently than the 50% discount for brand name drugs. For generic drugs, the amount paid by the plan (14%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap. Also, the dispensing fee is included as part of the cost of the drug.

If you have any questions about the availability of discounts for the drugs you are taking or about the Medicare Coverage Gap Discount Program in general, please contact Customer Service (phone numbers are on the back cover of this booklet).

What if you have coverage from a State Pharmaceutical Assistance Program (SPAP)?

If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (other than Extra Help), you still get the 50% discount on covered brand name drugs. The 50% discount is applied to the price of the drug before any SPAP or other coverage.

What if you get Extra Help from Medicare to help pay your prescription drug costs? Can you get the discounts?

No. If you get Extra Help, you already get coverage for your prescription drug costs during the coverage gap.

What if you don't get a discount, and you think you should have?

If you think that you have reached the coverage gap and did not get a discount when you paid for your brand name drug, you should review your next *Explanation of Benefits* (EOB) notice. If the discount doesn't appear on your *Explanation of Benefits*, you should contact us to make sure that your prescription records are correct and up-to-date. If we don't agree that you are owed a discount, you can appeal. You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP) (telephone numbers are in Section 3 of this Chapter) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

State Pharmaceutical Assistance Programs

Many states have State Pharmaceutical Assistance Programs that help some people pay for prescription drugs based on financial need, age, or medical condition. Each state has different rules to provide drug coverage to its members.

These programs provide limited income and medically needy seniors and individuals with disabilities financial help for prescription drugs. Here is a list of the State Pharmaceutical Assistance Programs in each state we serve:

- In Missouri, the State Pharmaceutical Assistance Program is Missouri Rx Plan.

Missouri Rx Plan	
CALL	1-800-375-1406
WRITE	Missouri Rx Plan PO Box 6500 Jefferson City, MO 65102
WEBSITE	http://www.morx.mo.gov

SECTION 8 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board	
CALL	1-877-772-5772 Calls to this number are free. Available 9:00 am to 3:30 pm, Monday through Friday If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are <i>not</i> free.
WEBSITE	http://www.rrb.gov

SECTION 9 Do you have “group insurance” or other health insurance from an employer?

If you (or your spouse) get benefits from your (or your spouse’s) employer or retiree group, call the employer/union benefits administrator or Customer Service if you have any questions. You can ask about your (or your spouse’s) employer or retiree health benefits, premiums, or the enrollment period.

If you have other prescription drug coverage through your (or your spouse’s) employer or retiree group, please contact **that group’s benefits administrator**. The benefits administrator can help you determine how your current prescription drug coverage will work with our plan.

Chapter 3. Using the plan's coverage for your medical services

SECTION 1	Things to know about getting your medical care covered as a member of our plan.....	32
Section 1.1	What are “network providers” and “covered services”?.....	32
Section 1.2	Basic rules for getting your medical care covered by the plan	32
SECTION 2	Using network and out-of-network providers to get your medical care	33
Section 2.1	You may choose a Primary Care Provider (PCP) to provide and oversee your medical care.....	33
Section 2.2	What kinds of medical care can you get without getting approval in advance from your PCP?	34
Section 2.3	How to get care from specialists and other network providers.....	34
Section 2.4	How to get care from out-of-network providers	35
SECTION 3	How to get covered services when you have an emergency or urgent need for care	36
Section 3.1	Getting care if you have a medical emergency	36
Section 3.2	Getting care when you have an urgent need for care.....	37
SECTION 4	What if you are billed directly for the full cost of your covered services?	38
Section 4.1	You can ask the plan to pay our share of the cost of your covered services.....	38
Section 4.2	If services are not covered by our plan, you must pay the full cost.....	38
SECTION 5	How are your medical services covered when you are in a “clinical research study”?.....	39
Section 5.1	What is a “clinical research study”?	39
Section 5.2	When you participate in a clinical research study, who pays for what?	40

SECTION 6	Rules for getting care covered in a “religious non-medical health care institution”	41
Section 6.1	What is a religious non-medical health care institution?	41
Section 6.2	What care from a religious non-medical health care institution is covered by our plan?	41
SECTION 7	Rules for ownership of durable medical equipment	42
Section 7.1	Will you own your durable medical equipment after making a certain number of payments under our plan?	42

SECTION 1 Things to know about getting your medical care covered as a member of our plan

This chapter tells things you need to know about using the plan to get your medical care coverage. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, and other medical care that are covered by the plan.

For the details on what medical care is covered by our plan and how much you pay as your share of the cost when you get this care, use the benefits chart in the next chapter, Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*).

Section 1.1 What are “network providers” and “covered services”?
--

Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our plan:

- **“Providers”** are doctors and other health care professionals licensed by the state to provide medical services and care. The term “providers” also includes hospitals and other health care facilities.
- **“Network providers”** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network generally bill us directly for care they give you. When you see a network provider, you usually pay only your share of the cost for their services.
- **“Covered services”** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4.

Section 1.2 Basic rules for getting your medical care covered by the plan

As a Medicare health plan, State of KS Advantra Freedom PPO must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

State of KS Advantra Freedom PPO will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this booklet).
- **The care you receive is considered medically necessary.** “Medically necessary” means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

- **You receive your care from a provider who participates in Medicare.** As a member of our plan, you can receive your care from either a network provider or an out-of-network provider (for more about this, see Section 2 in this chapter).
 - The providers in our network are listed in the *State of KS Advantra Freedom PPO Provider/Pharmacy Directory*.
 - If you use an out-of-network provider, your share of the costs for your covered services may be higher.
 - **Please note:** While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. We cannot pay a provider who is not eligible to participate in Medicare. If you go to provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.

SECTION 2 Using network and out-of-network providers to get your medical care

Section 2.1 You may choose a Primary Care Provider (PCP) to provide and oversee your medical care

What is a “PCP” and what does the PCP do for you?

A PCP (Primary Care Physician) is a physician who meets state requirements and is trained to give you basic medical care, such as a Family Practice or Internal Medicine physician. You are not required to choose a PCP; however, we feel you should have a relationship with a non-specialist plan physician, as we believe a strong doctor-patient relationship is essential to good health.

Your PCP will provide most of your care and will help arrange or coordinate the rest of the covered services you get as a plan member, such as x-rays, laboratory tests, therapies, hospital admissions, and follow-up care. Coordinating your care may include consulting with other plan providers about your care and checking to see how your health is progressing. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office. If you need certain types of services or tests, in some cases your PCP will need to get approval in advance from State of KS Advantra Freedom PPO (this is called getting “prior authorization”). For services and items requiring prior authorization, refer to the Medical Benefits Chart in Chapter 4 of this booklet.

Although it is highly recommended that you have one PCP who will help coordinate all of your care, you are not required to choose a PCP because you are enrolled in a PPO plan. You have access to any provider of your choice without any referral or care coordination requirements; however, when you access care by a non-contracted provider you may pay a higher amount.

How do you choose your PCP?

You can select your PCP by using the *State of KS Advantra Freedom PPO Provider/Pharmacy Directory* or getting help from Customer Service (phone numbers are on the back cover of this booklet). You can change your PCP for any reason at any time. If there is a particular specialist or hospital that you want to use, check first to make sure your PCP makes referrals to that specialist or admits patients to that hospital. The address and office telephone number of contracted PCP's are included in the *State of KS Advantra Freedom PPO Provider/Pharmacy Directory*.

Changing your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP in our plan or you will pay more for covered services.

If you change your PCP, you do not need to notify us or wait to begin seeing your new PCP. To get help choosing a new PCP or to find out if a PCP is accepting new patients, call Customer Service at the number listed on the back cover of this booklet.

Section 2.2	What kinds of medical care can you get without getting approval in advance from your PCP?
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You can get the services listed below without getting approval in advance from your PCP.

- Routine women's health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams.
- Flu shots and pneumonia vaccinations.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed care from in-network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible, e.g., when you are temporarily outside of the plan's service area.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area.
- Any other covered service described in Chapter 4 of this *Evidence of Coverage*.

Section 2.3	How to get care from specialists and other network providers
--------------------	---

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- Oncologists, who care for patients with cancer.
- Cardiologists, who care for patients with heart conditions.

- Orthopedists, who care for patients with certain bone, joint, or muscle conditions.

When you or your doctor believes that you need specialized treatment, you may use your *State of KS Advantra Freedom PPO Provider/Pharmacy Directory* to locate a network specialist, or call Customer Service for help with locating a network specialist (phone numbers for Customer Service are on the back cover of this booklet). For some types of services and tests, your PCP or specialist may need to get approval in advance from State of KS Advantra Freedom PPO (this is called getting “prior authorization”). For information about which services require prior authorization, please refer to the Medical Benefits Chart in Chapter 4 of this *Evidence of Coverage*.

As an State of KS Advantra Freedom PPO member, you can see any specialist or network provider without a referral from your PCP. You can also see providers outside of our network; however, you may pay a higher cost for covered services. Out-of-network providers are not required to receive prior authorization; however, you should call Customer Service (phone numbers are on the back cover of this booklet) to confirm that the services you are getting are covered and are medically necessary. If we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost.

What if a specialist or another network provider leaves our plan?

Sometimes a specialist, clinic, hospital or other network provider you are using might leave the plan. When this occurs, State of KS Advantra Freedom PPO will notify members who are being actively treated by the provider. If your provider leaves the plan, you will have to switch to another provider who is part of our plan or you may pay more for covered services. If you are undergoing active treatment for a chronic or acute medical condition, you may have access to your provider at the in-network copay or coinsurance for up to 90 days or through the current period of active treatment, whichever is shorter. This continuation of access is subject to our review and approval in accordance with our Continuity of Care Policy. Otherwise, if you continue to access care from the provider who left our network, you may have higher out-of-pocket costs. Please contact our Customer Service department at the number listed on the back cover of this booklet, and they can assist you in finding a plan provider to replace the one leaving the plan.

Section 2.4	How to get care from out-of-network providers
--------------------	--

As a member of our plan, you can choose to receive care from out-of-network providers. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and are medically necessary. However, **if you use an out-of-network provider, your share of the costs for your covered services may be higher.** Here are other important things to know about using out-of-network providers:

- You can get your care from an out-of-network provider, however, that provider must be eligible to participate in Medicare. We cannot pay a provider who is not eligible to

participate in Medicare. If you receive care from a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.

- You don't need to get a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers you may want to ask for a pre-visit coverage decision to confirm that the services you are getting are covered and are medically necessary. (See Chapter 9, Section 4 for information about asking for coverage decisions.) This is important because:
 - Without a pre-visit coverage decision, if we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. See Chapter 9 (*What to do if you have a problem or complaint*) to learn how to make an appeal.
- It is best to ask an out-of-network provider to bill the plan first. But, if you have already paid for the covered services, we will reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill that you think we should pay, you can send it to us for payment. See Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*) for information about what to do if you receive a bill or if you need to ask for reimbursement.
- If you are using an out-of-network provider for emergency care, urgently needed care, or out-of-area dialysis, you may not have to pay a higher cost-sharing amount. See Section 3 for more information about these situations.

SECTION 3 How to get covered services when you have an emergency or urgent need for care

Section 3.1 Getting care if you have a medical emergency
--

What is a “medical emergency” and what should you do if you have one?

A “**medical emergency**” is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room, hospital, or urgent care center. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP.

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the Medical Benefits Chart in Chapter 4 of this booklet.

Our plan includes worldwide coverage for medical emergencies. For more information, see the Medical Benefits Chart in Chapter 4 of this booklet.

If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by our plan. If you get your follow-up care from out-of-network providers, you will pay the higher out-of-network cost sharing.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all. If it turns out that it was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor has said that it was *not* an emergency, the amount of cost sharing that you pay will depend on whether you get the care from network providers or out-of-network providers. If you get the care from network providers, your share of the costs will usually be lower than if you get the care from out-of-network providers.

Section 3.2	Getting care when you have an urgent need for care
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What is "urgently needed care"?

"Urgently needed care" is a non-emergency, unforeseen medical illness, injury, or condition, that requires immediate medical care, but the plan's network of providers is temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have (for example, a flare-up of a chronic skin condition).

What if you are in the plan's service area when you have an urgent need for care?

In most other situations, if you are in the plan's service area and you use an out-of-network provider, you will pay a higher share of the costs for your care. However, if the circumstances

are unusual or extraordinary, and network providers are temporarily unavailable or inaccessible, we will allow you to get covered services from an out-of-network provider at the lower in-network cost-sharing amount.

What if you are outside the plan's service area when you have an urgent need for care?

When you are outside the service area and cannot get care from a network provider, our plan will cover urgently needed care that you get from any provider at the lower in-network cost-sharing amount.

Our plan does not cover urgently needed care or any other non-emergency care if you receive the care outside of the United States.

SECTION 4 What if you are billed directly for the full cost of your covered services?

Section 4.1	You can ask the plan to pay our share of the cost of your covered services
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If you have paid more than your share for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*) for information about what to do.

Section 4.2	If services are not covered by our plan, you must pay the full cost
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State of KS Advantra Freedom PPO covers all medical services that are medically necessary, are listed in the plan's Medical Benefits Chart (this chart is in Chapter 4 of this booklet), and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan covered services, or plan rules were not followed.

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Customer Service at the number on the back cover of this booklet to get more information about how to do this.

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. Any amounts you pay for

services after a benefit limit has been reached do not count toward your out-of-pocket maximum. You can call Customer Service when you want to know how much of your benefit limit you have already used.

SECTION 5 How are your medical services covered when you are in a “clinical research study”?

Section 5.1 What is a “clinical research study”?
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A clinical research study is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Not all clinical research studies are open to members of our plan. Medicare first needs to approve the research study. If you participate in a study that Medicare has *not* approved, *you will be responsible for paying all costs for your participation in the study.*

Once Medicare approves the study, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study *and* you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in a Medicare-approved clinical research study, you do *not* need to get approval from us. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers.

Although you do not need to get our plan's permission to be in a clinical research study, **you do need to tell us before you start participating in a clinical research study.** Here is why you need to tell us:

1. We can let you know whether the clinical research study is Medicare-approved.
2. We can tell you what services you will get from clinical research study providers instead of from our plan.

If you plan on participating in a clinical research study, contact Customer Service (see Chapter 2, Section 1 of this *Evidence of Coverage*).

Section 5.2	When you participate in a clinical research study, who pays for what?
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Once you join a Medicare-approved clinical research study, you are covered for routine items and services you receive as part of the study, including:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure if it is part of the research study.
- Treatment of side effects and complications of the new care.

Original Medicare pays most of the cost of the covered services you receive as part of the study. After Medicare has paid its share of the cost for these services, our plan will also pay for part of the costs. We will pay the difference between the cost sharing in Original Medicare and your cost sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan.

Here's an example of how the cost sharing works: Let's say that you have a lab test that costs \$100 as part of the research study. Let's also say that your share of the costs for this test is \$20 under Original Medicare, but would be only \$10 under our plan's benefits. In this case, Original Medicare would pay \$80 for the test and we would pay another \$10. This means that you would pay \$10, which is the same amount you would pay under our plan's benefits.

In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the study and how much you owe. Please see Chapter 7 for more information about submitting requests for payment.

When you are part of a clinical research study, **neither Medicare nor our plan will pay for any of the following:**

- Generally, Medicare will *not* pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were *not* in a study.
- Items and services the study gives you or any participant for free.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your condition would usually require only one CT scan.

Do you want to know more?

You can get more information about joining a clinical research study by reading the publication "Medicare and Clinical Research Studies" on the Medicare website (<http://www.medicare.gov>). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 6 Rules for getting care covered in a “religious non-medical health care institution”

Section 6.1 What is a religious non-medical health care institution?
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A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility care. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. You may choose to pursue medical care at any time for any reason. This benefit is provided only for Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

Section 6.2 What care from a religious non-medical health care institution is covered by our plan?
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To get care from a religious non-medical health care institution, you must sign a legal document that says you are conscientiously opposed to getting medical treatment that is “non-excepted.”

- “Non-excepted” medical care or treatment is any medical care or treatment that is *voluntary* and *not required* by any federal, state, or local law.
- “Excepted” medical treatment is medical care or treatment that you get that is *not* voluntary or *is required* under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in your home, our plan will cover these services only if your condition would ordinarily meet the conditions for coverage of services given by home health agencies that are not religious non-medical health care institutions.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
 - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
 - – *and* – you must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

Medicare Inpatient Hospital coverage limits apply (see Medical Benefits Chart in Chapter 4, Section 2.1).

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1	Will you own your durable medical equipment after making a certain number of payments under our plan?
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Durable medical equipment includes items such as oxygen equipment and supplies, wheelchairs, walkers, and hospital beds ordered by a provider for use in the home. Certain items, such as prosthetics, are always owned by the enrollee. In this section, we discuss other types of durable medical equipment that must be rented.

In Original Medicare, people who rent certain types of durable medical equipment own the equipment after paying copayments for the item for 13 months. As a member of State of KS Advantra Freedom PPO, however, you usually will not acquire ownership of rented durable medical equipment items no matter how many copayments you make for the item while a member of our plan. Under certain limited circumstances we will transfer ownership of the durable medical equipment item. Call Customer Service (phone numbers are on the back cover of this booklet) to find out about the requirements you must meet and the documentation you need to provide.

What happens to payments you have made for durable medical equipment if you switch to Original Medicare?

If you switch to Original Medicare after being a member of our plan: If you did not acquire ownership of the durable medical equipment item while in our plan, you will have to make 13 new consecutive payments for the item while in Original Medicare in order to acquire ownership of the item. Your previous payments while in our plan do not count toward these new 13 consecutive payments.

If you made payments for the durable medical equipment item under Original Medicare *before* you joined our plan, these previous Original Medicare payments also do not count toward the new 13 consecutive payments. You will have to make 13 new consecutive payments for the item under Original Medicare in order to acquire ownership. There are no exceptions to this case when you return to Original Medicare.

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

SECTION 1	Understanding your out-of-pocket costs for covered services	44
Section 1.1	Types of out-of-pocket costs you may pay for your covered services	44
Section 1.2	What is the most you will pay for covered medical services?.....	44
Section 1.3	Our plan does not allow providers to “balance bill” you.....	45
SECTION 2	Use the <i>Medical Benefits Chart</i> to find out what is covered for you and how much you will pay	46
Section 2.1	Your medical benefits and costs as a member of the plan.....	46
SECTION 3	What benefits are not covered by the plan?	74
Section 3.1	Benefits we do <i>not</i> cover (exclusions).....	74

SECTION 1 Understanding your out-of-pocket costs for covered services

This chapter focuses on your covered services and what you pay for your medical benefits. It includes a Medical Benefits Chart that gives a list of your covered services and tells how much you will pay for each covered service as a member of State of KS Advantra Freedom PPO. Later in this chapter, you can find information about medical services that are not covered. It also tells about limitations on certain services.

Section 1.1 Types of out-of-pocket costs you may pay for your covered services
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To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

- A **“copayment”** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)
- **“Coinsurance”** is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)

Some people qualify for State Medicaid programs to help them pay their out-of-pocket costs for Medicare. (These “Medicare Savings Programs” include the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualifying Individual (QI), and Qualified Disabled & Working Individuals (QDWI) programs.) If you are enrolled in one of these programs, you may still have to pay a copayment for the service, depending on the rules in your state.

Section 1.2 What is the most you will pay for covered medical services?

Under our plan, there are two different limits on what you have to pay out-of-pocket for covered medical services:

- Your **in-network maximum out-of-pocket amount** is \$1,000. This is the most you pay during the calendar year for covered services received from in-network providers. The amounts you pay for copayments and coinsurance for covered services from in-network providers count toward this in-network maximum out-of-pocket amount. (The amounts you pay for Part D prescription drugs and services from out-of-network providers do not count toward your in-network maximum out-of-pocket amount.) If you have paid \$1,000 for covered services from in-network providers, you will not have any out-of-pocket costs for the rest of the year when you see our network providers. However, you must

continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

- Your **combined maximum out-of-pocket amount** is \$10,000. This is the most you pay during the calendar year for covered services received from both in-network and out-of-network providers. The amounts you pay for copayments and coinsurance for covered services count toward this combined maximum out-of-pocket amount. (The amount you pay for your Part D prescription drugs does not count toward your combined maximum out-of-pocket amount.) If you have paid \$10,000 for covered services, you will have 100% coverage and will not have any out-of-pocket costs for the rest of the year for covered services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3	Our plan does not allow providers to “balance bill” you
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As a member of State of KS Advantra Freedom PPO, an important protection for you is that, after you meet any deductibles, you only have to pay the plan’s cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges such as “balance billing.” This protection (that you never pay more than the plan cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don’t pay certain provider charges.

Here is how this protection works.

- If your cost sharing is a copayment (a set amount of dollars, for example, \$15.00), then you pay only that amount for any services from a network provider. You will generally have higher copays when you obtain care from out-of-network providers.
- If your cost sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
 - If you obtain covered services from a network provider, you pay the coinsurance percentage multiplied by the plan’s reimbursement rate (as determined in the contract between the provider and the plan).
 - If you obtain covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
 - If you obtain covered services from an out-of-network provider who does not participate with Medicare, then you pay the coinsurance amount multiplied by the Medicare payment rate for non-participating providers.

SECTION 2 Use the *Medical Benefits Chart* to find out what is covered for you and how much you will pay

Section 2.1 Your medical benefits and costs as a member of the plan

The Medical Benefits Chart on the following pages lists the services State of KS Advantra Freedom PPO covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, and equipment) *must* be medically necessary. “Medically necessary” means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- Some of the services listed in the Medical Benefits Chart are covered as in-network services *only* if your doctor or other network provider gets approval in advance (sometimes called “prior authorization”) from State of KS Advantra Freedom PPO.
 - Covered services that need approval in advance to be covered as in-network services are marked by an asterisk in the Medical Benefits Chart.
 - You never need approval in advance for out-of-network services from out-of-network providers.
 - While you don’t need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.
- For benefits where your cost-sharing is a coinsurance percentage, the amount you pay depends on what type of provider you receive the services from:
 - If you receive the covered services from a network provider, you will pay the coinsurance percentage multiplied by the total provider rate in the provider’s contract,
 - If you receive the covered services from an out-of-network provider who participates with Medicare, you will pay the coinsurance percentage times the Medicare allowable,
 - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you will pay the coinsurance percentage multiplied by the Original Medicare Limiting charge.
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.

Medical Benefits Chart

Services that are covered for you	What you must pay when you get these services
Inpatient Care	
<p>Inpatient hospital care*</p> <p>No limit to the number of days covered by the plan each hospital stay. Covered services include:</p> <ul style="list-style-type: none"> • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech/language therapy • Inpatient substance abuse services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. If State of KS Advantra Freedom PPO provides transplant services at a distant location (farther away than the normal community patterns of care) and you chose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. 	<p>In-Network</p> <p>No limit to the number of days covered by the plan each benefit period. For Medicare-covered hospital stays:</p> <ul style="list-style-type: none"> – Days 1 – 5: \$150 copay per day – Days 6 – 90: \$0 copay per day – \$0 copay for additional hospital days <p>\$1,000 copay for all related Medicare covered transplant services.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>Out-of-Network</p> <p>20% of the Medicare allowable cost for each hospital stay. If you get authorized inpatient care at an</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> Physician services <p>Note: To be an inpatient, your provider must write an order to admit you to the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an inpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	<p>out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.</p>
<p>Inpatient mental health care*</p> <ul style="list-style-type: none"> Covered services include mental health care services that require a hospital stay. You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. 	<p>In-Network For Medicare-covered hospital stays:</p> <ul style="list-style-type: none"> – Days 1 – 5: \$150 copay per day – Days 6 – 90: \$0 copay per day – \$0 copay for additional hospital days Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. <p>Out-of-Network 20% of the Medicare-allowable cost for each hospital</p>

Services that are covered for you	What you must pay when you get these services
<p>Skilled nursing facility (SNF) care*</p> <p>(For a definition of “skilled nursing facility care,” see Chapter 12 of this booklet. Skilled nursing facilities are sometimes called “SNFs.”)</p> <p>Plan covers up to 100 days each benefit period. No prior hospital stay is required. Covered services include:</p> <ul style="list-style-type: none"> • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Regular nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician services <p>Generally, you will get your SNF care from plan facilities. However, under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn’t a plan provider, if the facility accepts our plan’s amounts for payment.</p> <ul style="list-style-type: none"> • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care). 	<p>stay.</p> <p>General Authorization rules may apply.</p> <p>In-Network Plan covers up to 100 days each benefit period No prior hospital stay is required. For Medicare-covered SNF stays: – Days 1 – 7: \$0 copay per day – Days 8 – 100: \$50 copay per day</p> <p>Out-of-Network 20% of the Medicareallowable cost for each SNF stay. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven’t been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> A SNF where your spouse is living at the time you leave the hospital. 	<p>is no limit to the number of benefit periods you can have.</p>
<p>Inpatient services covered during a non-covered inpatient stay</p> <p>If you have exhausted your skilled nursing facility (SNF) benefits or if your inpatient stay is not reasonable and necessary, we will not cover your SNF or inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the (SNF) stay. Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> Physician services Diagnostic tests (like lab tests) X-ray, radium, and isotope therapy including technician materials and services* Surgical dressings Splints, casts and other devices used to reduce fractures and dislocations* Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices* Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition* Physical therapy, speech therapy, and occupational therapy 	<p>In-Network</p> <p>\$0 copay for each primary care doctor visit for Medicare covered benefits.</p> <p>\$0 copay for each specialist visit for Medicare-covered benefits.</p> <p>\$0 copay for Medicare-covered:</p> <ul style="list-style-type: none"> lab services diagnostic procedures and tests <p>\$0 copay for Medicare-covered Xrays.</p> <p>\$75 copay for Medicare-covered diagnostic radiology services (not including x-rays).</p> <p>20% of our contracted rate for Medicare covered therapeutic radiology services.</p> <p>20% of our contracted rate for Medicare covered</p>

Services that are covered for you	What you must pay when you get these services
	<p>prosthetic devices or durable medical equipment items.</p> <p>\$0 copay for Medicare-covered Occupational Therapy visits.</p> <p>\$0 copay for Medicare-covered Physical and/or Speech and Language Therapy visits.</p> <p>\$0 copay for Medicare-covered Cardiac Rehab services.</p> <p>Out-of-Network 20% of the Medicare allowable cost for each primary care doctor visit. 20% of the Medicare allowable cost for each specialist visit. 20% of the Medicare allowable cost for diagnostic procedures, tests, and lab services.</p> <p>20% of the Medicare allowable cost for outpatient x-rays.</p> <p>20% of the Medicare allowable cost for</p>

Services that are covered for you	What you must pay when you get these services
	<p>diagnostic radiology services.</p> <p>20% of the Medicare allowable cost for therapeutic radiology services.</p> <p>20% of the Medicare allowable cost for Medicare-covered prosthetic devices or durable medical equipment items.</p> <p>20% of the Medicare allowable cost for Occupational Therapy benefits.</p> <p>20% of the Medicare allowable cost for Physical and/or Speech and Language Therapy visits.</p> <p>20% of the Medicare allowable cost for Cardiac Rehab services.</p>
<p>Home health agency care*</p> <p>Covered services include:</p> <ul style="list-style-type: none"> Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) Physical therapy, occupational therapy, and speech therapy 	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for Medicare-covered home health visits.</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • Medical and social services • Medical equipment and supplies 	<p>20% of our contracted cost for Medicare covered durable medical equipment.</p> <p>Out-of-Network \$0 copay for home health visits.</p> <p>20% of the Medicare allowable cost for Medicare-covered durable medical equipment.</p>
<p>Hospice care</p> <p>You may receive care from any Medicare-certified hospice program. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal condition. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Drugs for symptom control and pain relief • Short-term respite care • Home care <p>You are still a member of our plan. If you need non-hospice care (care that is not related to your terminal condition), you have two options:</p> <ul style="list-style-type: none"> • You can obtain your non-hospice care from plan providers. In this case, you only pay plan allowed cost sharing • --or-- You can get your care covered by Original Medicare. In this case, you must pay the cost-sharing amounts under Original 	<p>When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal condition are paid for by Original Medicare, not State of KS Advantra Freedom PPO.</p>

Services that are covered for you	What you must pay when you get these services
<p>Medicare, except for emergency or urgently needed care. However, after payment, you can ask us to pay you back for the difference between the cost sharing in our plan and the cost sharing under Original Medicare.</p> <p>Note: If you need non-hospice care (care that is not related to your terminal condition), you should contact us to arrange the services. Getting your non-hospice care through our network providers will lower your share of the costs for the services.</p> <p>Our plan covers hospice consultation services for a terminally ill person who hasn't elected the hospice benefit.</p>	
<p>Outpatient Services</p>	
<p>Physician services, including doctor's office visits</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Medically-necessary medical or surgical services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location* • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment. • Telehealth office visits including consultation, diagnosis and treatment by a specialist • Second opinion prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)* 	<p>In-Network</p> <p>\$10 copay for each primary care doctor visit for Medicare covered benefits.</p> <p>\$30 copay for each in area, network urgent care Medicare covered visit.</p> <p>\$25 copay for each specialist visit for Medicare-covered benefits.</p> <p>\$150 copay for each Medicare-covered ambulatory surgical center or outpatient hospital facility visit.</p> <p>\$0 copay for Medicare-covered</p>

Services that are covered for you	What you must pay when you get these services
	<p>diagnostic hearing exams.</p> <p>\$0 to \$150 copay for Medicare-covered dental benefits.</p> <ul style="list-style-type: none">– \$0 copay for Services performed in a physician’s office– \$150 copay for services performed in an ambulatory surgical center or outpatient hospital facility <p>Out-of-Network 20% of the Medicare allowable cost for each primary care doctor visit.</p> <p>\$30 copay for each urgent care Medicare covered visit. 20% of the Medicare allowable cost for each specialist visit.</p> <p>20% of the Medicare allowable cost for each Medicare covered ambulatory surgical center or outpatient hospital facility visit. 20% of the Medicare</p>

Services that are covered for you	What you must pay when you get these services
	<p>allowable cost for Medicare-covered diagnostic hearing exams.</p> <p>20% of the Medicare allowable cost for Medicare-covered dental benefits.</p>
<p>Chiropractic services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> We cover only manual manipulation of the spine to correct subluxation 	<p>In-Network \$30 copay for each Medicare-covered visit.</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p> <p>Out-of-Network 20% of the Medicare allowable cost for chiropractic benefits.</p>
<p>Podiatry services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). Routine foot care for members with certain medical conditions 	<p>In-Network \$30 copay for each Medicare-covered visit.</p> <p>\$15 copay for each</p>

Services that are covered for you	What you must pay when you get these services
<p>affecting the lower limbs</p>	<p>visit for routine foot care.</p> <p>Out-of-Network 20% of the Medicare allowable cost for podiatry benefits.</p>
<p>Outpatient mental health care*</p> <p>Covered services include:</p> <p>Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$30 copay for each Medicare-covered individual therapy visit.</p> <p>\$15 copay for each Medicare-covered group therapy visit.</p> <p>Out-of-Network 20% of the Medicare allowable cost for Mental Health benefits.</p> <p>20% of the Medicare allowable cost for Mental Health benefits with a psychiatrist.</p>
<p>Partial hospitalization services*</p> <p>“Partial hospitalization” is a structured program of active psychiatric treatment provided in a hospital outpatient setting or by a community</p>	<p>General Authorization rules may apply.</p>

Services that are covered for you	What you must pay when you get these services
<p>mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.</p>	<p>In-Network \$0 copay per day for each Medicare covered partial hospitalization.</p> <p>Out-of-Network 20% of the Medicare allowable cost for partial hospitalization benefits.</p>
<p>Outpatient substance abuse services*</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$30 copay for Medicare-covered individual visits.</p> <p>\$15 copay for Medicare-covered group visits.</p> <p>Out-of-Network 20% of the Medicare allowable cost for outpatient substance abuse benefits.</p>
<p>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers*</p> <p>Note: If you are having surgery in a hospital, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient."</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$150 copay for each Medicare-covered ambulatory surgical center visit.</p>

Services that are covered for you	What you must pay when you get these services
	<p>\$150 copay for each Medicare-covered outpatient hospital facility visit.</p> <p>Out-of-Network 20% of the Medicare allowable cost for ambulatory surgical center benefits.</p> <p>20% of the Medicare allowable cost for outpatient hospital facility benefits.</p>
<p>Ambulance services</p> <ul style="list-style-type: none"> Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation are contraindicated (could endanger the person's health) or if authorized by the plan. The member's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation are contraindicated (could endanger the person's health) and that transportation by ambulance is medically required.* 	<p>General Authorization rules may apply.</p> <p>In-Network \$100 copay per one-way trip for Medicare-covered ambulance benefits.</p> <p>Out-of-Network \$100 copay per one-way trip for ambulance benefits.</p>
<p>Emergency care</p> <p>Emergency care is care that is needed to evaluate or stabilize an</p>	<p>General \$50 copay for Medicare-covered</p>

Services that are covered for you	What you must pay when you get these services
<p>emergency medical condition.</p> <p>A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.</p> <p>Worldwide coverage.</p>	<p>emergency room visits.</p> <p>Worldwide coverage. If you are admitted to the hospital within 72-hour(s) for the same condition, you pay \$0 for the emergency room visit</p> <p>If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital in order to pay the in-network cost-sharing amount for the part of your stay after you are stabilized. If you stay at the out-of-network hospital, your stay will be covered but you will pay the out-of-network cost-sharing amount for the part of your stay after you are stabilized.</p>
<p>Urgently needed care</p> <p>Urgently needed care is care provided to treat a non-emergency, unforeseen medical illness, injury, or condition, that requires</p>	<p>General</p> <p>\$30 copay for Medicare-covered urgently needed care</p>

Services that are covered for you	What you must pay when you get these services
<p>immediate medical care, but the plan's network of providers is temporarily unavailable or inaccessible.</p> <p>Coverage within the United States.</p>	<p>visits.</p>
<p>Outpatient rehabilitation services</p> <p>Covered services include: physical therapy, occupational therapy, speech language therapy, cardiac rehabilitation services, intensive cardiac rehabilitation services, pulmonary rehabilitation services, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered Occupational Therapy visits.</p> <p>\$0 copay for Medicare-covered Physical and/or Speech and Language Therapy visits.</p> <p>\$0 copay for Medicare-covered Cardiac Rehab services.</p> <p>Out-of-Network 20% of the Medicare allowable cost for Occupational Therapy benefits.</p> <p>20% of the Medicare allowable cost for Physical and/or Speech and Language Therapy visits.</p>

Services that are covered for you	What you must pay when you get these services
	20% of the Medicare allowable cost for Cardiac Rehab services.
<p>Durable medical equipment and related supplies*</p> <p>(For a definition of “durable medical equipment,” see Chapter 12 of this booklet.)</p> <p>Covered items include, but are not limited to: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker.</p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% of our contracted cost for Medicare covered items</p> <p>Out-of-Network 20% of the Medicare allowable cost for durable medical equipment.</p>
<p>Prosthetic devices and related supplies*</p> <p>Devices (other than dental) that replace a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see “Vision Care” later in this section for more detail.</p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% of our contracted cost for Medicare covered items.</p> <p>Out-of-Network 20% of the Medicare allowable cost for prosthetic devices.</p>
<p>Diabetes self-management training, diabetic services and supplies*</p> <p>For all people who have diabetes (insulin and non-insulin users). Covered services include:</p>	<p>In-Network \$0 copay for Diabetes self-monitoring training.</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions 	<p>\$0 copay for Nutrition Therapy for Diabetes.</p> <p>\$0 copay for Diabetes supplies.</p> <p>20% of our contracted cost for Medicare covered prosthetic devices including therapeutic shoes or inserts.</p> <p>Out-of-Network 20% of the Medicare allowable cost for Diabetes self monitoring training.</p> <p>20% of the Medicare allowable cost for Nutrition Therapy for Diabetes</p> <p>20% of the Medicare allowable cost for Diabetes supplies.</p> <p>20% of the Medicare allowable cost for Medicare-covered prosthetic devices.</p>
<p>Outpatient diagnostic tests and therapeutic services and supplies*</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • X-rays • Radiation (radium and isotope) therapy including technician 	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for</p>

Services that are covered for you	What you must pay when you get these services
<p>materials and supplies</p> <ul style="list-style-type: none"> • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood. Coverage begins with the first pint of blood that you need. Coverage of storage and administration begins with the first pint of blood that you need. • Other outpatient diagnostic tests 	<p>Medicare-covered:</p> <ul style="list-style-type: none"> – lab services – diagnostic procedures and tests <p>\$0 copay for Medicare-covered Xrays.</p> <p>\$75 copay for Medicare-covered diagnostic radiology services (not including x-rays).</p> <p>20% of our contracted cost for Medicare covered therapeutic radiology services.</p> <p>20% of our contracted cost for Medicare covered prosthetic devices or durable medical equipment items.</p> <p>Out-of-Network 20% of the Medicare allowable cost for diagnostic procedures, tests, and lab services.</p> <p>20% of the Medicare allowable cost for outpatient x-rays.</p> <p>20% of the Medicare</p>

Services that are covered for you	What you must pay when you get these services
	<p>allowable cost for diagnostic radiology services.</p> <p>20% of the Medicare allowable cost for therapeutic radiology services.</p> <p>20% of the Medicare allowable cost for Medicare-covered prosthetic devices or durable medical equipment items.</p>
<p>Vision care</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Outpatient physician services for the diagnosis and treatment of diseases and conditions of the eye. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. • For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year. • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. • One routine eye exam 	<p>In-Network Non-Medicare covered eyeglasses not covered.</p> <p>\$0 copay for one pair of eyeglasses or contact lenses after cataract surgery</p> <p>\$0 copay for exams to diagnose and treat diseases and conditions of the eye.</p> <p>\$0 copay for each routine eye exam.</p> <p>Out-of-Network 20% of the Medicare allowable cost for eye exams.</p>

Services that are covered for you	What you must pay when you get these services
	20% of the Medicare allowable cost for eye wear.
Preventive Services	
Note: For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you.	
<p>Abdominal aortic aneurysm screening</p> <p>A one-time screening ultrasound for people at risk. The plan only covers this screening if you get a referral for it as a result of your “Welcome to Medicare” physical exam.</p>	<p>In-Network \$0 copay for Medicare-covered abdominal aortic aneurysm screenings.</p> <p>Out-of-Network 20% of the Medicare allowable cost for Medicare-covered abdominal aortic aneurysm screenings.</p>
<p>Bone mass measurement</p> <p>For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician’s interpretation of the results.</p>	<p>In-Network \$0 copay for Medicare-covered bone mass measurement.</p> <p>Out-of-Network 20% of the Medicare allowable cost for Medicare-covered bone mass measurement.</p>
<p>Colorectal cancer screening</p> <p>For people 50 and older, the following are covered:</p>	<p>In-Network \$0 copay for Medicare-covered</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months • Fecal occult blood test, every 12 months <p>For people at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> • Screening colonoscopy (or screening barium enema as an alternative) every 24 months <p>For people not at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy 	<p>colorectal screenings.</p> <p>Out-of-Network 20% of the Medicare allowable cost for colorectal screenings.</p>
<p>HIV screening</p> <p>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:</p> <ul style="list-style-type: none"> • One screening exam every 12 months <p>For women who are pregnant, we cover:</p> <ul style="list-style-type: none"> • Up to three screening exams during a pregnancy 	<p>In-Network \$0 copay for each Medicare-covered HIV screening.</p> <p>HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy.</p> <p>Out-of-Network 20% of the Medicare allowable cost for HIV screening.</p>

Services that are covered for you	What you must pay when you get these services
<p>Immunizations</p> <p>Covered Medicare Part B services include:</p> <ul style="list-style-type: none"> • Pneumonia vaccine • Flu shots, once a year in the fall or winter • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • Other vaccines if you are at risk and they meet Medicare Part B coverage rules <p>We also cover some vaccines under our Part D prescription drug benefit.</p>	<p>In-Network \$0 copay for Flu and Pneumonia vaccines.</p> <p>• \$0 copay for Hepatitis B vaccine. No referral needed for Flu and pneumonia vaccines.</p> <p>Out-of-Network 20% of the Medicare allowable cost for immunizations.</p>
<p>Breast cancer screening (mammograms)</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months 	<p>For Medicare-covered services:</p> <p><u>In-Network</u> \$0 copay.</p> <p>Out-of-Network 20% of the Medicare allowable cost for screening mammograms.</p>
<p>Cervical and vaginal cancer screening</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • For all women: Pap tests are covered once every 12 months and pelvic exams are covered once every 24 months 	<p>For Medicare-covered services:</p> <p><u>In-Network</u> \$0 copay.</p> <p><u>Out-of-Network</u> 20% coinsurance.</p>

Services that are covered for you	What you must pay when you get these services
<p>Prostate cancer screening exams</p> <p>For men age 50 and older, covered services include the following - once every 12 months:</p> <ul style="list-style-type: none"> • Digital rectal exam • Prostate Specific Antigen (PSA) test 	<p>In-Network \$0 copay for: – Medicare covered prostate cancer screening</p> <p>Out-of-Network 20% of the Medicare allowable cost for prostate cancer screening.</p>
<p>Cardiovascular disease testing</p> <p>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).</p>	<p>In-Network \$0 copay for: – Medicare-covered cardiovascular disease testing.</p> <p>Out-of-Network 20% of the Medicare allowable cost for Medicare-covered cardiovascular disease testing.</p>
<p>“Welcome to Medicare” physical exam</p> <p>The plan covers a one-time “Welcome to Medicare” physical exam, which includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed.</p> <p>Important: You must have the physical exam within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor’s office know you would like to schedule your “Welcome to Medicare” physical exam.</p>	<p>In-Network \$0 copay for routine exams.</p> <p>Limited to 1 exam(s) every year.</p> <p>Out-of-Network 20% of the Medicare allowable cost for routine exams.</p>

Services that are covered for you	What you must pay when you get these services
<p>Annual wellness visit</p> <p>If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months.</p> <p>Note: Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" exam. However, you don't need to have had a "Welcome to Medicare" exam to be covered for annual wellness visits after you've had Part B for 12 months.</p>	<p>In-Network \$0 copay for routine exams. Limited to 1 exam(s) every year.</p> <p>Out-of-Network 20% of the Medicare allowable cost for routine exams.</p>
<p>Diabetes screening</p> <p>We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes.</p> <p>Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.</p>	<p>For Medicare-covered services:</p> <p><u>In-Network</u> \$0 copay.</p> <p><u>Out-of-Network</u> 20% coinsurance.</p>
<p>Medical nutrition therapy</p> <p>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a transplant when ordered by your doctor.</p> <p>We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into another calendar year.</p>	<p>For Medicare-covered services:</p> <p><u>In-Network</u> \$0 copay.</p> <p><u>Out-of-Network</u> 20% coinsurance.</p>

Services that are covered for you	What you must pay when you get these services
<p>Smoking and tobacco use cessation (counseling to stop smoking)</p> <p>If you use tobacco, but do not have signs or symptoms of tobacco-related disease: we cover two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits.</p> <p>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: we cover cessation counseling services. We cover two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits, however, you will pay the applicable inpatient or outpatient cost sharing.</p>	<p>For Medicare-covered services:</p> <p><u>In-Network</u></p> <p>If you haven't been diagnosed with an illness caused or complicated by tobacco use:</p> <p>\$0 copay.</p> <p>If you have been diagnosed with an illness caused or complicated by tobacco use, or you take a medicine that is affected by tobacco:</p> <p>\$0 copay.</p> <p><u>Out-of-Network</u></p> <p>20% coinsurance.</p>
<p>Other Services</p>	
<p>Services to treat kidney disease and conditions*</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3) • Inpatient dialysis treatments (if you are admitted as an inpatient 	<p>Authorization rules may apply.</p> <p>For Medicare-covered services:</p> <p><u>In-Network</u></p> <p>\$0 copay for kidney disease education services.</p> <p>\$0 copay for renal dialysis.</p> <p><u>Out-of-Network</u></p>

Services that are covered for you	What you must pay when you get these services
<p>to a hospital for special care)</p> <ul style="list-style-type: none"> • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) <p>Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section below, “Medicare Part B prescription drugs.”</p>	<p>20% coinsurance.</p>
<p>Medicare Part B prescription drugs*</p> <p>These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include:</p> <ul style="list-style-type: none"> • Drugs that usually aren’t self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Drugs you take using durable medical equipment (such as nebulizers) that was authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary 	<p>In-Network 20% of our contracted cost for Part B drugs</p> <p>Out-of-Network 20% of the Medicare allowable cost for Part B drugs out-of-network.</p>

Services that are covered for you	What you must pay when you get these services
<p>immune deficiency diseases</p> <p>Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is listed in Chapter 6.</p>	
<p>Additional Benefits</p>	
<p>Hearing services</p> <ul style="list-style-type: none"> – Diagnostic hearing exams – Routine hearing exam 	<p>In-Network \$0 copay for Medicare-covered diagnostic hearing exams</p> <p>\$0 copay for up to one routine hearing test ever year.</p> <p>Out-of-Network 20% of the Medicare allowable cost for hearing exams</p>
<p>Hearing aids</p> <ul style="list-style-type: none"> – Inner ear – Outer ear – Over the ear 	<p>You are covered up to \$500 for hearing aids every three years.</p>
<p>Health and wellness education programs</p> <p>Programs designed to enrich the health and lifestyles of members including:</p> <ul style="list-style-type: none"> – Medicare-covered smoking cessation counseling sessions – Written health education materials, including Newsletters – Nutritional Training – Health Club Membership/Fitness Classes – Nursing Hotline 	<p>In-Network \$0 copay</p> <p>Out-of-Network \$50 copay per month on standard monthly membership fee for a licensed fitness facility.</p> <p>20% of the Medicare allowable cost for all</p>

Services that are covered for you	What you must pay when you get these services
other services.	

SECTION 3 What benefits are not covered by the plan?

Section 3.1 Benefits we do *not* cover (exclusions)

This section tells you what kinds of benefits are “excluded.” Excluded means that the plan doesn’t cover these benefits.

The list below describes some services and items that aren’t covered under any conditions and some that are excluded only under specific conditions.

If you get benefits that are excluded, you must pay for them yourself. We won’t pay for the excluded medical benefits listed in this section (or elsewhere in this booklet), and neither will Original Medicare. The only exception: If a benefit on the exclusion list is found upon appeal to be a medical benefit that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 5.3 in this booklet.)

In addition to any exclusions or limitations described in the Benefits Chart, or anywhere else in this *Evidence of Coverage*, **the following items and services aren’t covered under Original Medicare or by our plan:**

- Services considered not reasonable and necessary, according to the standards of Original Medicare, unless these services are listed by our plan as covered services.
- Experimental medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under a Medicare-approved clinical research study. (See Chapter 3, Section 5 for more information on clinical research studies.) Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when it is considered medically necessary and covered under Original Medicare.
- Private room in a hospital, except when it is considered medically necessary.
- Private duty nurses.
- Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.

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- Full-time nursing care in your home.
 - Custodial care, unless it is provided with covered skilled nursing care and/or skilled rehabilitation services. Custodial care, or non-skilled care, is care that helps you with activities of daily living, such as bathing or dressing.
 - Homemaker services include basic household assistance, including light housekeeping or light meal preparation.
 - Fees charged by your immediate relatives or members of your household.
 - Meals delivered to your home.
 - Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
 - Cosmetic surgery or procedures, unless because of an accidental injury or to improve a malformed part of the body. However, all stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
 - Routine dental care, such as cleanings, fillings or dentures. However, non-routine dental care required to treat illness or injury may be covered as inpatient or outpatient care.
 - Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.
 - Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace or the shoes are for a person with diabetic foot disease.
 - Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
 - Eyeglasses and routine eye examinations, except for those services covered by the plan and described in the Medical Benefits Chart in Section 2.1 of this chapter; radial keratotomy, LASIK surgery, vision therapy and other low vision aids. However, eyeglasses are covered for people after cataract surgery.
 - Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies.
 - Acupuncture.
 - Naturopath services (uses natural or alternative treatments).
 - Services provided to veterans in Veterans Affairs (VA) facilities. However, when emergency services are received at VA hospital and the VA cost sharing is more than the cost sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.

The plan will not cover the excluded services listed above. Even if you receive the services at an emergency facility, the excluded services are still not covered.

Chapter 5. Using the plan's coverage for your Part D prescription drugs

SECTION 1	Introduction	79
Section 1.1	This chapter describes your coverage for Part D drugs	79
Section 1.2	Basic rules for the plan's Part D drug coverage	80
SECTION 2	Fill your prescription at a network pharmacy or through the plan's mail-order service	80
Section 2.1	To have your prescription covered, use a network pharmacy	80
Section 2.2	Finding network pharmacies	80
Section 2.3	Using the plan's mail-order services	81
Section 2.4	How can you get a long-term supply of drugs?	82
Section 2.5	When can you use a pharmacy that is not in the plan's network?	82
SECTION 3	Your drugs need to be on the plan's "Drug List"	84
Section 3.1	The "Drug List" tells which Part D drugs are covered	84
Section 3.2	There are four (4) "cost-sharing tiers" for drugs on the Drug List	85
Section 3.3	How can you find out if a specific drug is on the Drug List?	85
SECTION 4	There are restrictions on coverage for some drugs	85
Section 4.1	Why do some drugs have restrictions?	85
Section 4.2	What kinds of restrictions?	86
Section 4.3	Do any of these restrictions apply to your drugs?	87
SECTION 5	What if one of your drugs is not covered in the way you'd like it to be covered?	87
Section 5.1	There are things you can do if your drug is not covered in the way you'd like it to be covered	87

Section 5.2	What can you do if your drug is not on the Drug List or if the drug is restricted in some way?.....	88
Section 5.3	What can you do if your drug is in a cost-sharing tier you think is too high?.....	90
SECTION 6	What if your coverage changes for one of your drugs?	91
Section 6.1	The Drug List can change during the year	91
Section 6.2	What happens if coverage changes for a drug you are taking?.....	91
SECTION 7	What types of drugs are <i>not</i> covered by the plan?	92
Section 7.1	Types of drugs we do not cover	92
SECTION 8	Show your plan membership card when you fill a prescription	94
Section 8.1	Show your membership card	94
Section 8.2	What if you don't have your membership card with you?.....	94
SECTION 9	Part D drug coverage in special situations.....	94
Section 9.1	What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?.....	94
Section 9.2	What if you're a resident in a long-term care facility?	94
Section 9.3	What if you're also getting drug coverage from an employer or retiree group plan?.....	95
SECTION 10	Programs on drug safety and managing medications.....	96
Section 10.1	Programs to help members use drugs safely.....	96
Section 10.2	Programs to help members manage their medications	96



Did you know there are programs to help people pay for their drugs?

There are programs to help people with limited resources pay for their drugs. These include “Extra Help” and State Pharmaceutical Assistance Programs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this Evidence of Coverage about the costs for Part D prescription drugs may not apply to you.** We send you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider), which tells you about your drug coverage. If you don’t have this insert, please call Customer Service and ask for the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider). Phone numbers for Customer Service are on the back cover of this booklet.

SECTION 1 Introduction

Section 1.1 This chapter describes your coverage for Part D drugs
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This chapter explains rules for using your coverage for Part D drugs. The next chapter tells what you pay for Part D drugs (Chapter 6, *What you pay for your Part D prescription drugs*).

In addition to your coverage for Part D drugs, State of KS Advantra Freedom PPO also covers some drugs under the plan’s medical benefits:

- The plan covers drugs you are given during covered stays in the hospital or in a skilled nursing facility. Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*) tells about the benefits and costs for drugs during a covered hospital or skilled nursing facility stay.
- Medicare Part B also provides benefits for some drugs. Part B drugs include certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility. Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*) tells about your benefits and costs for Part B drugs.

The two examples of drugs described above are covered by the plan’s medical benefits. The rest of your prescription drugs are covered under the plan’s Part D benefits. **This chapter explains**

rules for using your coverage for Part D drugs. The next chapter tells what you pay for Part D drugs (Chapter 6, *What you pay for your Part D prescription drugs*).

Section 1.2	Basic rules for the plan's Part D drug coverage
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The plan will generally cover your drugs as long as you follow these basic rules:

- You must have a provider (a doctor or other prescriber) write your prescription.
- You must use a network pharmacy to fill your prescription. (See Section 2, *Fill your prescriptions at a network pharmacy or through the plan's mail-order service*.)
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Drug List" for short). (See Section 3, *Your drugs need to be on the plan's "Drug List."*)
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

SECTION 2	Fill your prescription at a network pharmacy or through the plan's mail-order service
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Section 2.1	To have your prescription covered, use a network pharmacy
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In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies. (See Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term "covered drugs" means all of the Part D prescription drugs that are covered on the plan's Drug List.

Section 2.2	Finding network pharmacies
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How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *State of KS Advantra Freedom PPO Provider/Pharmacy Directory*, visit our website (<http://PharmacyLocator.coventry-medicare.com>), or call Customer Service (phone numbers are on the back cover of this booklet). Choose whatever is easiest for you.

You may go to any of our network pharmacies. If you switch from one network pharmacy to another, and you need a refill of a drug you have been taking, you can ask either to have a new

prescription written by a provider or to have your prescription transferred to your new network pharmacy.

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can get help from Customer Service (phone numbers are on the back cover of this booklet) or use the *State of KS Advantra Freedom PPO Provider/Pharmacy Directory*. You can also find information on our website at <http://PharmacyLocator.coventry-medicare.com>.

What if you need a specialized pharmacy?

Sometimes prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care facility. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. Residents may get prescription drugs through the facility's pharmacy as long as it is part of our network. If your long-term care pharmacy is not in our network, please contact Customer Service.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *State of KS Advantra Freedom PPO Provider/Pharmacy Directory* or call Customer Service.

Section 2.3	Using the plan's mail-order services
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For certain kinds of drugs, you can use the plan's network mail-order services. Generally, the drugs available through mail order are drugs that you take on a regular basis, for a chronic or long-term medical condition.

Our plan's mail-order service allows you to order **up to a 90-day supply**.

To get order forms and information about filling your prescriptions by mail, you can either call Customer Service at the telephone number provided on the back cover of this booklet or visit our website at <http://KSDrugForms.coventry-medicare.com>. If you use a mail-order pharmacy not in the plan's network, your prescription will not be covered.

Usually a mail-order pharmacy order will get to you in no more than 15 days. If your mail-order is delayed, please call Customer Service at the phone number on the back cover of this booklet and let them know you have not received your mail-order. They will work with you to ensure you have enough medication until your mail order arrives.

Section 2.4	How can you get a long-term supply of drugs?
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When you get a long-term supply of drugs, your cost sharing may be lower. The plan offers two ways to get a long-term supply of “mail-order” drugs on our plan’s Drug List. (Mail-order drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

1. **Some retail pharmacies** in our network allow you to get a long-term supply of mail-order drugs. Your *State of KS Advantra Freedom PPO Provider/Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of mail-order drugs. You can also call Customer Service for more information.
2. You can use the plan’s network **mail-order services**. Our plan’s mail-order service allows you to order up to a 90-day supply. See Section 2.3 for more information about using our mail-order services.

Section 2.5	When can you use a pharmacy that is not in the plan’s network?
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Your prescription may be covered in certain situations

We have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

MEDICAL EMERGENCIES OR URGENTLY NEEDED CARE

We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care, are included in our Formulary without restrictions, and are not excluded from Medicare Part D coverage.

In these situations, you will have to pay the full cost (rather than paying just your copayment or coinsurance) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a paper claim form within three (3) months of the purchase of the drug. You will be responsible for paying the difference between what we would pay for a prescription filled at an in-network pharmacy and what the out-of-network pharmacy charged for your prescription. (Chapter 7, Section 2.1 explains how to ask the plan to pay you back.)

We cannot pay for any prescriptions that are filled by pharmacies outside of the United States and territories, even for a medical emergency or urgently needed care.

SPECIAL CIRCUMSTANCES AS LISTED BELOW

- If you are unable to get a covered drug in a timely manner because there is no network pharmacy within a reasonable driving distance providing 24-hour service.
- If you are trying to fill a covered prescription drug that is not regularly stocked at a network retail or mail-order pharmacy (these drugs include orphan drugs or other specialty pharmaceuticals).
- If you get a covered prescription drug from an institutional-based pharmacy while a patient in an emergency room, provider-based clinic, outpatient surgery clinic, or other outpatient setting.
- If you become evacuated due to a state or federal emergency disaster declaration or other public health emergency declaration and cannot readily find an in-network pharmacy.

In these situations, please check first with Customer Service to see if there is a network pharmacy nearby. If there is no network pharmacy nearby and you purchase your prescription drugs at a non-network pharmacy, you will have to pay the full cost (rather than paying just your copayment or coinsurance) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a paper claim form within three (3) months of the purchase of the drug. You will be responsible for paying the difference between what we would pay for a prescription filled at an in-network pharmacy and what the out-of-network pharmacy charged for your prescription. (Chapter 7, Section 2.1 explains how to ask the plan to pay you back.)

PRESCRIPTION DRUGS WHILE TRAVELING WITHIN THE UNITED STATES

We are pleased to offer a large national network of pharmacies. That way when you are traveling within the United States and become ill or run out of your prescription drugs, you have access to network pharmacies. You simply show your membership ID card to the pharmacist and receive your prescription drug benefits right then and there. You may be able to purchase up to a 90-day supply of your prescription drug ahead of time through our mail-order service or through a retail network pharmacy that offers an extended supply.

If you are traveling for longer than three (3) months within the United States and you know the area you will be traveling to, we encourage you to make arrangements to have your prescription transferred from your current network pharmacy to a network pharmacy in the area you will be visiting, or you can simply use our mail-order program and have your prescriptions mailed to you. We will not provide you with more than a 90-day supply of your medication prior to leaving the service area.

In these situations, **please check first with Customer Service** to see if there is a network pharmacy nearby.

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal share of the cost) when you fill your prescription. You can ask us to reimburse

you for our share of the cost. (Chapter 7, Section 2.1 explains how to ask the plan to pay you back.)

SECTION 3 Your drugs need to be on the plan's "Drug List"

Section 3.1 The "Drug List" tells which Part D drugs are covered
--

The plan has a "*List of Covered Drugs (Formulary)*." In this *Evidence of Coverage*, we call it the "**Drug List**" for short.

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the plan's Drug List.

The drugs on the Drug List are only those covered under Medicare Part D (earlier in this chapter, Section 1.1 explains about Part D drugs).

We will generally cover a drug on the plan's Drug List as long as you follow the other coverage rules explained in this chapter and the use of the drug is a medically accepted indication. A "medically accepted indication" is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- -- *or* -- supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor.)

The Drug List includes both brand name and generic drugs

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Generally, it works just as well as the brand name drug and usually costs less. There are generic drug substitutes available for many brand name drugs.

What is *not* on the Drug List?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on our Drug List.

Section 3.2	There are four (4) “cost-sharing tiers” for drugs on the Drug List
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Every drug on the plan's Drug List is in one of four (4) cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug:

- Tier 1 contains all of the Plan's Preferred Generic Drugs for the lowest copayment.
- Tier 2 contains all of the Plan's Preferred Brand Drugs for a copayment higher than Tier 1.
- Tier 3 contains all of the Plan's Non-Preferred Brand Drugs and some non-preferred generics for a copayment that is higher than Tiers 1 and 2.
- Tier 4 contains all of the Plan's Specialty Tier Drugs for a coinsurance that is higher than Tiers 1, 2 and 3.

To find out which cost-sharing tier your drug is in, look it up in the plan's Drug List.

The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6 (*What you pay for your Part D prescription drugs*).

Section 3.3	How can you find out if a specific drug is on the Drug List?
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You have three ways to find out:

1. Check the most recent Drug List we sent you in the mail.
2. Visit the plan's website (<http://KSFormulary.coventry-medicare.com>). The Drug List on the website is always the most current.
3. Call Customer Service to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list. Phone numbers for Customer Service are on the back cover of this booklet.

SECTION 4 **There are restrictions on coverage for some drugs**

Section 4.1	Why do some drugs have restrictions?
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For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. Whenever a safe, lower-cost drug will work medically just as well as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost

option. We also need to comply with Medicare's rules and regulations for drug coverage and cost sharing.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If you want us to waive the restriction for you, you will need to use the formal appeals process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 6.2 for information about asking for exceptions.)

Section 4.2 What kinds of restrictions?

Our plan uses different types of restrictions to help our members use drugs in the most effective ways. The sections below tell you more about the types of restrictions we use for certain drugs.

Restricting brand name drugs when a generic version is available

Generally, a "generic" drug works the same as a brand name drug and usually costs less. **When a generic version of a brand name drug is available, our network pharmacies will provide you the generic version.** We usually will not cover the brand name drug when a generic version is available. However, if your provider has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug. (Your share of the cost may be greater for the brand name drug than for the generic drug.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called "**prior authorization.**" Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

This requirement encourages you to try less costly but just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called "**step therapy.**"

Quantity limits

For certain drugs, we limit the amount of the drug that you can have. For example, the plan might limit how many refills you can get, or how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

Section 4.3	Do any of these restrictions apply to your drugs?
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The plan's Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Customer Service (phone numbers are on the back cover of this booklet) or check our website (<http://KSFormulary.coventry-medicare.com>).

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If there is a restriction on the drug you want to take, you should contact Customer Service to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the formal appeals process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 6.2 for information about asking for exceptions.)

SECTION 5	What if one of your drugs is not covered in the way you'd like it to be covered?
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Section 5.1	There are things you can do if your drug is not covered in the way you'd like it to be covered
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Suppose there is a prescription drug you are currently taking, or one that you and your provider think you should be taking. We hope that your drug coverage will work well for you, but it's possible that you might have a problem. For example:

- **What if the drug you want to take is not covered by the plan?** For example, the drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.
- **What if the drug is covered, but there are extra rules or restrictions on coverage for that drug?** As explained in Section 4, some of the drugs covered by the plan have extra rules to restrict their use. For example, you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. Or there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period. In some cases, you may want us to waive the restriction for you. For example, you might want us to cover a certain drug for you without having to try other drugs first. Or you may want us to cover more of a drug (number of pills, etc.) than we normally will cover.
- **What if the drug is covered, but it is in a cost-sharing tier that makes your cost sharing more expensive than you think it should be?** The plan puts each covered drug into one of four (4) different cost-sharing tiers. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

There are things you can do if your drug is not covered in the way that you'd like it to be covered. Your options depend on what type of problem you have:

- If your drug is not on the Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.
- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.

Section 5.2	What can you do if your drug is not on the Drug List or if the drug is restricted in some way?
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If your drug is not on the Drug List or is restricted, here are things you can do:

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply). This will give you and your provider time to change to another drug or to file a request to have the drug covered.
- You can change to another drug.
- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, the plan can offer a temporary supply of a drug to you when your drug is not on the Drug List or when it is restricted in some way. Doing this gives you time to talk with your provider about the change in coverage and figure out what to do.

To be eligible for a temporary supply, you must meet the two requirements below:

1. The change to your drug coverage must be one of the following types of changes:

- The drug you have been taking is **no longer on the plan's Drug List**.
- -- or -- the drug you have been taking is **now restricted in some way** (Section 4 in this chapter tells about restrictions).

2. You must be in one of the situations described below:

- **For those members who were in the plan last year and aren't in a long-term care facility:**

We will cover a temporary supply of your drug **one time only during the first 90 days of the calendar year**. This temporary supply will be for a maximum of a 30-day supply, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.

- **For those members who are new to the plan and aren't in a long-term care facility:**

We will cover a temporary supply of your drug **one time only during the first 90 days of your membership** in the plan. This temporary supply will be for a maximum of a 30-day supply, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.

- **For those members who are new to the plan and reside in a long-term care facility:**

We will cover a temporary supply of your drug **during the first 90 days of your membership** in the plan. The first supply will be for a maximum of a 31-day supply, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in the plan.

- **For those members who have been in the plan for more than 90 days and reside in a long-term care facility and need a supply right away:**

We will cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the above long-term care transition supply.

- **For those members who are changing from one treatment setting to another, for example entering a long-term care facility from a hospital or being discharged from a hospital to home:**

You will need to utilize our exception process as defined below if your drug is not on our formulary for 2012. You will be given a one time emergency supply of a 31-day supply for medications if you have not already received a temporary supply.

To ask for a temporary supply, call Customer Service (phone numbers are on the back cover of this booklet).

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug. The sections below tell you more about these options.

You can change to another drug

Start by talking with your provider. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

You can ask for an exception

You and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule. For example, you can ask the plan to cover a drug even though it is not on the plan's Drug List. Or you can ask the plan to make an exception and cover the drug without restrictions.

If you are a current member and a drug you are taking will be removed from the formulary or restricted in some way for next year, we will allow you to request a formulary exception in advance for next year. We will tell you about any change in the coverage for your drug for the following year. You can then ask us to make an exception and cover the drug in the way you would like it to be covered for the following year. We will give you an answer to your request for an exception before the change takes effect.

If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Section 5.3	What can you do if your drug is in a cost-sharing tier you think is too high?
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If your drug is in a cost-sharing tier you think is too high, here are things you can do:

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, start by talking with your provider. Perhaps there is a different drug in a lower cost-sharing tier that might work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

You can ask for an exception

For drugs in Tier 3 – Non-Preferred Brand Drugs, you and your provider can ask the plan to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule.

If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Drugs in some of our cost-sharing tiers are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in Tier 4 – Specialty Tier Drugs.

SECTION 6 What if your coverage changes for one of your drugs?

Section 6.1 The Drug List can change during the year
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Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the plan might make many kinds of changes to the Drug List. For example, the plan might:

- **Add or remove drugs from the Drug List.** New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.
- **Move a drug to a higher or lower cost-sharing tier.**
- **Add or remove a restriction on coverage for a drug** (for more information about restrictions to coverage, see Section 4 in this chapter).
- **Replace a brand name drug with a generic drug.**

In almost all cases, we must get approval from Medicare for changes we make to the plan's Drug List.

Section 6.2 What happens if coverage changes for a drug you are taking?

How will you find out if your drug's coverage has been changed?

If there is a change to coverage *for a drug you are taking*, the plan will send you a notice to tell you. Normally, **we will let you know at least 60 days ahead of time.**

Once in a while, a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons. If this happens, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away. Your provider will also know about this change, and can work with you to find another drug for your condition.

Do changes to your drug coverage affect you right away?

If any of the following types of changes affect a drug you are taking, the change will not affect you until January 1 of the next year if you stay in the plan:

- If we move your drug into a higher cost-sharing tier.
- If we put a new restriction on your use of the drug.
- If we remove your drug from the Drug List, but not because of a sudden recall or because a new generic drug has replaced it.

If any of these changes happens for a drug you are taking, then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restriction to your use of the drug. However, on January 1 of the next year, the changes will affect you.

In some cases, you will be affected by the coverage change before January 1:

- If a **brand name drug you are taking is replaced by a new generic drug**, the plan must give you at least 60 days' notice or give you a 60-day refill of your brand name drug at a network pharmacy.
 - During this 60-day period, you should be working with your provider to switch to the generic or to a different drug that we cover.
 - Or you and your provider can ask the plan to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).
- Again, if a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away.
 - Your provider will also know about this change, and can work with you to find another drug for your condition.

SECTION 7 What types of drugs are *not* covered by the plan?

Section 7.1 Types of drugs we do not cover
--

This section tells you what kinds of prescription drugs are “excluded.” This means Medicare does not pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself. We won't pay for the drugs that are listed in this section. The only exception: If the requested drug is found upon appeal to be a drug that is not excluded under Part D and we should have paid for or covered it because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to Chapter 9, Section 6.5 in this booklet.)

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- Our plan usually cannot cover off-label use. “Off-label use” is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.

- Generally, coverage for “off-label use” is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor. If the use is not supported by any of these reference books, then our plan cannot cover its “off-label use.”

Also, by law, these categories of drugs are not covered by Medicare drug plans:

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra, and Caverject
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Barbiturates and Benzodiazepines

We offer additional coverage of some prescription drugs not normally covered in a Medicare prescription drug plan (enhanced drug coverage). Although we don't cover the above medications, we do cover specific over-the-counter medications when written with a prescription, as part of step-therapy. This over-the-counter medication benefit is further discussed in Chapter 6, Section 8 of this booklet. The amount you pay when you fill a prescription for these drugs does not count towards qualifying you for the Catastrophic Coverage Stage. (The Catastrophic Coverage Stage is described in Chapter 6, Section 7 of this booklet.)

In addition, if you are **receiving Extra Help from Medicare** to pay for your prescriptions, the Extra Help program will not pay for the drugs not normally covered. (Please refer to your formulary or call Customer Service for more information.) However, if you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

SECTION 8 Show your plan membership card when you fill a prescription

Section 8.1 Show your membership card

To fill your prescription, show your plan membership card at the network pharmacy you choose. When you show your plan membership card, the network pharmacy will automatically bill the plan for *our* share of your covered prescription drug cost. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription.

Section 8.2 What if you don't have your membership card with you?

If you don't have your plan membership card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information.

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up.** (You can then **ask us to reimburse you** for our share. See Chapter 7, Section 2.1 for information about how to ask the plan for reimbursement.)

SECTION 9 Part D drug coverage in special situations

Section 9.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?
--

If you are admitted to a hospital or to a skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, the plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this section that tell about the rules for getting drug coverage. Chapter 6 (*What you pay for your Part D prescription drugs*) gives more information about drug coverage and what you pay.

Please Note: When you enter, live in, or leave a skilled nursing facility, you are entitled to a special enrollment period. During this time period, you can switch plans or change your coverage at any time. (Chapter 10, *Ending your membership in the plan*, tells when you can leave our plan and join a different Medicare plan.)

Section 9.2 What if you're a resident in a long-term care facility?

Usually, a long-term care facility (such as a nursing home) has its own pharmacy, or a pharmacy that supplies drugs for all of its residents. If you are a resident of a long-term care facility, you may get your prescription drugs through the facility's pharmacy as long as it is part of our network.

Check your *State of KS Advantra Freedom PPO Provider/Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Customer Service.

What if you're a resident in a long-term care facility and become a new member of the plan?

If you need a drug that is not on our Drug List or is restricted in some way, the plan will cover a **temporary supply** of your drug during the first 90 days of your membership. The first supply will be for a maximum of a 31-day supply, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in the plan.

If you have been a member of the plan for more than 90 days and need a drug that is not on our Drug List or if the plan has any restriction on the drug's coverage, we will cover one 31-day supply, or less if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells what to do.

Section 9.3	What if you're also getting drug coverage from an employer or retiree group plan?
--------------------	--

Do you currently have other prescription drug coverage through your (or your spouse's) employer or retiree group? If so, please contact **that group's benefits administrator**. He or she can help you determine how your current prescription drug coverage will work with our plan.

In general, if you are currently employed, the prescription drug coverage you get from us will be *secondary* to your employer or retiree group coverage. That means your group coverage would pay first.

Special note about 'creditable coverage':

Each year your employer or retiree group should send you a notice that tells if your prescription drug coverage for the next calendar year is "creditable" and the choices you have for drug coverage.

If the coverage from the group plan is "**creditable**," it means that the plan has drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.

Keep these notices about creditable coverage, because you may need them later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn't get a notice about creditable coverage from your employer or retiree group plan, you can get a copy from the employer or retiree group's benefits administrator or the employer or union.

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely
--

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one provider who prescribes their drugs.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

- Possible medication errors
- Drugs that may not be necessary because you are taking another drug to treat the same medical condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions written for drugs that have ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you are taking.

If we see a possible problem in your use of medications, we will work with your provider to correct the problem.

Section 10.2 Programs to help members manage their medications
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We have programs that can help our members with special situations. For example, some members have several complex medical conditions or they may need to take many drugs at the same time, or they could have very high drug costs.

These programs are voluntary and free to members. A team of pharmacists and doctors developed the programs for us. The programs can help make sure that our members are using the drugs that work best to treat their medical conditions and help us identify possible medication errors.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw

you from the program. If you have any questions about these programs, please contact Customer Service (phone numbers are on the back cover of this booklet).

Chapter 6. What you pay for your Part D prescription drugs

SECTION 1	Introduction	100
Section 1.1	Use this chapter together with other materials that explain your drug coverage	100
SECTION 2	What you pay for a drug depends on which “drug payment stage” you are in when you get the drug.....	101
Section 2.1	What are the (3) drug payment stages for State of KS Advantra Freedom PPO members?.....	101
SECTION 3	We send you reports that explain payments for your drugs and which payment stage you are in.....	102
Section 3.1	We send you a monthly report called the “Explanation of Benefits” (the “EOB”)	102
Section 3.2	Help us keep our information about your drug payments up to date.....	102
SECTION 4	There is no deductible for State of KS Advantra Freedom PPO	103
Section 4.1	You do not pay a deductible for your Part D drugs	103
SECTION 5	During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share.....	103
Section 5.1	What you pay for a drug depends on the drug and where you fill your prescription	103
Section 5.2	A table that shows your costs for a <i>one-month</i> supply of a drug.....	104
Section 5.3	A table that shows your costs for a <i>long-term</i> (up to a 90-day) supply of a drug	105
Section 5.4	You stay in the Initial Coverage Stage until your total drug costs for the year reach \$4,700	106
SECTION 6	During the Coverage Gap Stage, the plan provides coverage for tier 1 Preferred Generic Drugs. For all other Part D drugs you receive a discount on brand name drugs and only pay 86% on the costs of generic drugs.....	108

Section 6.1	You stay in the Coverage Gap Stage until your out-of-pocket costs reach \$4,700.....	108
Section 6.2	How Medicare calculates your out-of-pocket costs for prescription drugs.....	108
SECTION 7	During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs	111
Section 7.1	Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year.....	111
SECTION 8	Additional benefits information	111
Section 8.1	Our plan offers additional benefits	111
SECTION 9	What you pay for vaccinations covered by Part D depends on how and where you get them.....	112
Section 9.1	Our plan has separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccination shot.....	112
Section 9.2	You may want to call us at Customer Service before you get a vaccination	114
SECTION 10	Do you have to pay the Part D “late enrollment penalty”?.....	114
Section 10.1	What is the Part D “late enrollment penalty”?.....	114
Section 10.2	How much is the Part D late enrollment penalty?	115
Section 10.3	In some situations, you can enroll late and not have to pay the penalty.....	115
Section 10.4	What can you do if you disagree about your late enrollment penalty?.....	116
SECTION 11	Do you have to pay an extra Part D amount because of your income?	116
Section 11.1	Who pays an extra Part D amount because of income?.....	116
Section 11.2	How much is the extra Part D amount?	117
Section 11.3	What can you do if you disagree about paying an extra Part D amount?	118



Did you know there are programs to help people pay for their drugs?

There are programs to help people with limited resources pay for their drugs. These include “Extra Help” and State Pharmaceutical Assistance Programs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** We send you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider), which tells you about your drug coverage. If you don’t have this insert, please call Customer Service and ask for the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider). Phone numbers for Customer Service are on the back cover of this booklet.

SECTION 1 Introduction

Section 1.1	Use this chapter together with other materials that explain your drug coverage
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This chapter focuses on what you pay for your Part D prescription drugs. To keep things simple, we use “drug” in this chapter to mean a Part D prescription drug. As explained in Chapter 5, not all drugs are Part D drugs – some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law.

To understand the payment information we give you in this chapter, you need to know the basics of what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Here are materials that explain these basics:

- **The plan’s *List of Covered Drugs (Formulary)*.** To keep things simple, we call this the “Drug List.”
 - This Drug List tells which drugs are covered for you.
 - It also tells which of the four (4) “cost-sharing tiers” the drug is in and whether there are any restrictions on your coverage for the drug.
 - If you need a copy of the Drug List, call Customer Service (phone numbers are on the back cover of this booklet). You can also find the Drug List on our website at

<http://KSFormulary.coventry-medicare.com>. The Drug List on the website is always the most current.

- **Chapter 5 of this booklet.** Chapter 5 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 5 also tells which types of prescription drugs are not covered by our plan.
- **The plan’s *State of KS Advantra Freedom PPO Provider/Pharmacy Directory*.** In most situations you must use a network pharmacy to get your covered drugs (see Chapter 5 for the details). The *State of KS Advantra Freedom PPO Provider/Pharmacy Directory* has a list of pharmacies in the plan’s network. It also explains how you can get a long-term supply of a drug (such as filling a prescription for a three-month’s supply).

SECTION 2 What you pay for a drug depends on which “drug payment stage” you are in when you get the drug

Section 2.1	What are the (3) drug payment stages for State of KS Advantra Freedom PPO members?
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As shown in the table below, there are (3) “drug payment stages” for your prescription drug coverage under State of KS Advantra Freedom PPO. How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled.

Stage 1 <i>Initial Coverage Stage</i>	Stage 2 <i>Coverage Gap Stage</i>	Stage 3 <i>Catastrophic Coverage Stage</i>
The plan pays its share of the cost of your drugs and you pay your share of the cost. You stay in this stage until your payments for the year plus the plan’s payments total \$2,930. (Details are in Section 4 of this chapter).	The plan provides limited Part D drug coverage during the coverage gap stage. For Part D drugs not covered by the plan during the coverage gap stage, you receive a discount on brand name drugs and you pay only 86% of the costs of generic drugs. You stay in this stage until your “out-of-pocket costs” reach a total of \$4,700. This amount and rules for counting costs toward this amount have been set by Medicare. (Details are in Section 5 of this chapter.)	Once you have paid enough for your drugs to move on to this last payment stage, the plan will pay most of the cost of your drugs for the rest of the year. (Details are in Section 6 of this chapter.)

SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in

Section 3.1	We send you a monthly report called the “Explanation of Benefits” (the “EOB”)
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Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your **“out-of-pocket”** cost.
- We keep track of your **“total drug costs.”** This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.

Our plan will prepare a written report called the *Explanation of Benefits* (it is sometimes called the “EOB”) when you have had one or more prescriptions filled through the plan during the previous month. It includes:

- **Information for that month.** This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called “year-to-date” information. It shows you the total drug costs and total payments for your drugs since the year began.

Section 3.2	Help us keep our information about your drug payments up to date
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To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2 of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
 - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan’s benefit.

- When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
- Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program, the Indian Health Service, and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive an *Explanation of Benefits* (an EOB) in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call us at Customer Service (phone numbers are on the back cover of this booklet). Be sure to keep these reports. They are an important record of your drug expenses.

SECTION 4 There is no deductible for State of KS Advantra Freedom PPO

Section 4.1 You do not pay a deductible for your Part D drugs

There is no deductible for State of KS Advantra Freedom PPO. You begin in the Initial Coverage Stage when you fill your first prescription of the year. See Section 5 for information about your coverage in the Initial Coverage Stage.

SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription
--

During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share (your copayment or coinsurance amount). Your share of the cost will vary depending on the drug and where you fill your prescription.

The plan has four (4) cost-sharing tiers

Every drug on the plan's Drug List is in one of four (4) cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

- Tier 1 contains all of the Plan's Preferred Generic Drugs for the lowest copayment.

- Tier 2 contains all of the Plan’s Preferred Brand Drugs for a copayment higher than Tier 1.
- Tier 3 contains all of the Plan’s Non-Preferred Brand Drugs and some non-preferred generics for a copayment that is higher than Tiers 1 and 2.
- Tier 4 contains all of the Plan’s Specialty Tier Drugs for a coinsurance that is higher than Tiers 1, 2 and 3.

To find out which cost-sharing tier your drug is in, look it up in the plan’s Drug List.

Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- A retail pharmacy that is in our plan’s network
- A pharmacy that is not in the plan’s network
- The plan’s mail-order pharmacy

For more information about these pharmacy choices and filling your prescriptions, see Chapter 5 in this booklet and the plan’s *State of KS Advantra Freedom PPO Provider/Pharmacy Directory*.

Section 5.2 A table that shows your costs for a *one-month* supply of a drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

- **“Copayment”** means that you pay a fixed amount each time you fill a prescription.
- **“Coinsurance”** means that you pay a percent of the total cost of the drug each time you fill a prescription.

As shown in the table below, the amount of the copayment or coinsurance depends on which cost-sharing tier your drug is in. Please note:

- If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower*.
- We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5 for information about when we will cover a prescription filled at an out-of-network pharmacy.

Your share of the cost when you get a *one-month* supply (or less) of a covered Part D prescription drug from:

	Network pharmacy (up to a 30-day supply)	The plan's mail-order service (up to a 30-day supply)	Network long-term care pharmacy (up to a 31-day supply)	Out-of-network pharmacy (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 30-day supply)
Cost-Sharing Tier 1 (Preferred Generic Drugs)	\$5 copay	\$5 copay	\$5 copay	\$5 copay
Cost-Sharing Tier 2 (Preferred Brand Drugs)	\$30 copay	\$30 copay	\$30 copay	\$30 copay
Cost-Sharing Tier 3 (Non-Preferred Brand Drugs)	\$60 copay	\$60 copay	\$60 copay	\$60 copay
Cost-Sharing Tier 4 (Specialty Tier Drugs)	33% coinsurance	Mail order is not available for drugs in Tier 4-Specialty Tier Drugs.	33% coinsurance	33% coinsurance

Section 5.3 A table that shows your costs for a *long-term* (up to a 90-day) supply of a drug

For some drugs, you can get a long-term supply (also called an “extended supply”) when you fill your prescription. A long-term supply is up to a 90-day supply. (For details on where and how to get a long-term supply of a drug, see Chapter 5.)

The table below shows what you pay when you get a long-term (up to a 90-day) supply of a drug.

- Please note: If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower*.

Your share of the cost when you get a *long-term* supply of a covered Part D prescription drug from:

	Network pharmacy (up to a 90-day supply)	The plan's mail-order service (up to a 90-day supply)
Cost-Sharing Tier 1 (Preferred Generic Drugs)	\$10 copay	\$10 copay
Cost-Sharing Tier 2 (Preferred Brand Drugs)	\$60 copay	\$60 copay
Cost-Sharing Tier 3 (Non-Preferred Brand Drugs)	\$120 copay	\$120 copay
Cost-Sharing Tier 4 (Specialty Tier Drugs)	A long-term supply is not available for drugs in Tier 4-Specialty Tier Drugs	A long-term supply is not available for drugs in Tier 4-Specialty Tier Drugs

Section 5.4	You stay in the Initial Coverage Stage until your total drug costs for the year reach \$4,700
--------------------	--

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled and refilled reaches the **\$4,700 limit for the Initial Coverage Stage**.

Your total drug cost is based on adding together what you have paid and what any Part D plan has paid:

- **What you have paid** for all the covered drugs you have gotten since you started with your first drug purchase of the year. (See Section 6.2 for more information about how Medicare calculates your out-of-pocket costs.) This includes:
 - The total you paid as your share of the cost for your drugs during the Initial Coverage Stage.
- **What the plan has paid** as its share of the cost for your drugs during the Initial Coverage Stage. (If you were enrolled in a different Part D plan at any time during 2012, the amount that plan paid during the Initial Coverage Stage also counts toward your total drug costs.)

We offer additional coverage on some prescription drugs that are not normally covered in a Medicare Prescription Drug Plan. Payments made for these drugs will not count toward your initial coverage limit or total out-of-pocket costs. We also provide some over-the-counter medications exclusively for your use. These over-the-counter drugs are provided at no cost to you. To find out which drugs our plan covers, refer to your formulary.

The *Explanation of Benefits* (EOB) that we send to you will help you keep track of how much you and the plan have spent for your drugs during the year. Many people do not reach the \$2,930 limit in a year.

We will let you know if you reach this \$2,930 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage.

SECTION 6 **During the Coverage Gap Stage, the plan provides coverage for tier 1 Preferred Generic Drugs. For all other Part D drugs you receive a discount on brand name drugs and only pay 86% on the costs of generic drugs.**

Section 6.1	You stay in the Coverage Gap Stage until your out-of-pocket costs reach \$4,700
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When you are in the Coverage Gap Stage, you pay your copay for Tier 1 Preferred Generic drugs. For all other Part D drugs, you will pay a discounted price for brand name drugs and you will pay 86% of the costs of generic drugs. You continue paying the copay for Tier 1 drugs, the discounted price for brand name drugs, and 86% of the costs of generic drugs, until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. In 2011, that amount is \$ 4,700.

Medicare has rules about what counts and what does *not* count as your out-of-pocket costs. When you reach an out-of-pocket limit of \$4,700, you leave the Coverage Gap Stage and move on to the Catastrophic Coverage Stage.

Section 6.2	How Medicare calculates your out-of-pocket costs for prescription drugs
--------------------	--

Here are Medicare's rules that we must follow when we keep track of your out-of-pocket costs for your drugs.

*These payments **are included** in
your out-of-pocket costs*

*When you add up your out-of-pocket costs, **you can include** the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 5 of this booklet):*

- The amount you pay for drugs when you are in any of the following drug payment stages:
 - The Initial Coverage Stage.
 - The Coverage Gap Stage.
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

It matters who pays:

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are *also included* if they are made on your behalf by **certain other individuals or organizations**. This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, by a State Pharmaceutical Assistance Program that is qualified by Medicare, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of \$4,700 in out-of-pocket costs within the calendar year, you will move from the Coverage Gap Stage to the Catastrophic Coverage Stage.

*These payments are **not included** in your out-of-pocket costs*

When you add up your out-of-pocket costs, you are **not allowed to include** any of these types of payments for prescription drugs:

- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from Part D coverage by Medicare.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments made by the plan for your generic drugs while in the Coverage Gap.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veteran's Administration.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Worker's Compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan. Call Customer Service to let us know (phone numbers are on the back cover of this booklet).

How can you keep track of your out-of-pocket total?

- **We will help you.** The *Explanation of Benefits* (EOB) report we send to you includes the current amount of your out-of-pocket costs (Section 3 in this chapter tells about this report). When you reach a total of \$4,700 in out-of-pocket costs for the year, this report will tell you that you have left the Initial Coverage Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

SECTION 7 During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs

Section 7.1 Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the \$4,700 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

During this stage, the plan will pay most of the cost for your drugs.

- **Your share** of the cost for a covered drug will be either coinsurance or a copayment, whichever is the *larger* amount:
 - *–either* – coinsurance of 5% of the cost of the drug
 - *–or* – \$2.60 copayment for a generic drug or a drug that is treated like a generic. Or a \$6.50 copayment for all other drugs.
- **Our plan pays the rest** of the cost.

SECTION 8 Additional benefits information

Section 8.1 Our plan offers additional benefits

OVER-THE-COUNTER MEDICATIONS (OTCs) AS STEP THERAPY

The Over-the-Counter medications we cover as part of Step Therapy are listed below. These over-the-counter medications will require a prescription from your doctor in order to have them filled at a network pharmacy and covered under your prescription drug benefit. Quantity limits may apply. Please refer to your Comprehensive Formulary for more information. We provide a 31-day (one-month) supply for members in long-term care. Your copayment is \$0 for these covered over-the-counter medications regardless of where you are in the various stages of your prescription drug benefit.

Drug Name	Type	Strength
Loratadine	Tablets	10mg
Loratadine	Dissolve Tablets	10mg
Loratadine	Syrup	5mg/5 ml
Loratadine and Pseudoephedrine Sulfate	12 Hour Tablets	5mg/120mg
Loratadine and Pseudoephedrine Sulfate	24 Hour Tablets	10mg/240mg
Cetirizine	Tablets	5mg

Drug Name	Type	Strength
Cetirizine	Tablets	10 mg
Cetirizine	Chewable Tablets	5mg
Cetirizine	Chewable Tablets	10 mg
Cetirizine	Syrup	1 mg/ml
Cetirizine HCL and Pseudoephedrine Hydrochloride	12 Hour Tablets	5 mg/120 mg

SECTION 9 What you pay for vaccinations covered by Part D depends on how and where you get them

Section 9.1	Our plan has separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccination shot
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Our plan provides coverage of a number of Part D vaccines. We also cover vaccines that are considered medical benefits. You can find out about coverage of these vaccines by going to the Medical Benefits Chart in Chapter 4, Section 2.1.

There are two parts to our coverage of Part D vaccinations:

- The first part of coverage is the cost of **the vaccine medication itself**. The vaccine is a prescription medication.
- The second part of coverage is for the cost of **giving you the vaccination shot**. (This is sometimes called the “administration” of the vaccine.)

What do you pay for a Part D vaccination?

What you pay for a Part D vaccination depends on three things:

- 1. The type of vaccine** (what you are being vaccinated for).
 - Some vaccines are considered medical benefits. You can find out about your coverage of these vaccines by going to Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*.
 - Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan’s *List of Covered Drugs (Formulary)*.
- 2. Where you get the vaccine medication.**
- 3. Who gives you the vaccination shot.**

What you pay at the time you get the Part D vaccination can vary depending on the circumstances. For example:

- Sometimes when you get your vaccination shot, you will have to pay the entire cost for both the vaccine medication and for getting the vaccination shot. You can ask our plan to pay you back for our share of the cost.
- Other times, when you get the vaccine medication or the vaccination shot, you will pay only your share of the cost.

To show how this works, here are three common ways you might get a Part D vaccination shot. Remember you are responsible for all of the costs associated with vaccines (including their administration) during the Coverage Gap Stage of your benefit.

Situation 1: You buy the Part D vaccine at the pharmacy and you get your vaccination shot at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to administer a vaccination.)

- You will have to pay the pharmacy the amount of your copayment for the vaccine itself.
- Our plan will pay for the cost of giving you the vaccination shot.

Situation 2: You get the Part D vaccination at your doctor's office.

- When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 7 of this booklet (*Asking us to pay our share of a bill you have received for covered medical services or drugs*).
- You will be reimbursed the amount you paid less your normal copayment for the vaccine (including administration) less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help, we will reimburse you for this difference.)

Situation 3: You buy the Part D vaccine at your pharmacy, and then take it to your doctor's office where they give you the vaccination shot.

- You will have to pay the pharmacy the amount of your copayment for the vaccine itself.
- When your doctor gives you the vaccination shot, you will pay the entire cost for this service. You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7 of this booklet.
- You will be reimbursed the amount charged by the doctor for administering the vaccine less any difference between the amount the

doctor charges and what we normally pay. (If you get Extra Help, we will reimburse you for this difference.)

Section 9.2	You may want to call us at Customer Service before you get a vaccination
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The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call us first at Customer Service whenever you are planning to get a vaccination (phone numbers are on the back cover of this booklet).

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
- We can tell you how to keep your own cost down by using providers and pharmacies in our network.
- If you are not able to use a network provider and pharmacy, we can tell you what you need to do to get payment from us for our share of the cost.

SECTION 10 Do you have to pay the Part D “late enrollment penalty”?

Section 10.1	What is the Part D “late enrollment penalty”?
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Note: If you receive “Extra Help” from Medicare to pay for your prescription drugs, the late enrollment penalty rules do not apply to you. You will not pay a late enrollment penalty, even if you go without “creditable” prescription drug coverage.

You may pay a financial penalty if you did not enroll in a plan offering Medicare Part D drug coverage when you first became eligible for this drug coverage or you experienced a continuous period of 63 days or more when you didn’t have creditable prescription drug coverage. (“Creditable prescription drug coverage” is coverage that meets Medicare’s minimum standards since it is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.) The amount of the penalty depends on how long you waited to enroll in a creditable prescription drug coverage plan any time after the end of your initial enrollment period or how many full calendar months you went without creditable prescription drug coverage.

When you first enroll in State of KS Advantra Freedom PPO, we let you know the amount of the penalty. Your late enrollment penalty is considered your plan premium.

Section 10.2 How much is the Part D late enrollment penalty?

Medicare determines the amount of the penalty. Here is how it works:

- First count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months in which you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn't have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2011, this average premium amount was \$32.34. This amount may change for 2012.
- To get your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here it would be 14% times \$32.34, which equals \$4.53. This rounds to \$4.50. This amount would be added to the **monthly premium for someone with a late enrollment penalty**.

There are three important things to note about this monthly premium penalty:

- First, **the penalty may change each year**, because the average monthly premium can change each year. If the national average premium (as determined by Medicare) increases, your penalty will increase.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits.
- Third, if you are under 65 and currently receiving Medicare benefits, the late enrollment penalty will reset when you turn 65. After age 65, your late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

Section 10.3 In some situations, you can enroll late and not have to pay the penalty

Even if you have delayed enrolling in a plan offering Medicare Part D coverage when you were first eligible, sometimes you do not have to pay the late enrollment penalty.

You will not have to pay a premium penalty for late enrollment if you are in any of these situations:

- If you already have prescription drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Medicare calls this "**creditable drug coverage**." Please note:

- Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.
 - Please note: If you receive a “certificate of creditable coverage” when your health coverage ends, it may not mean your prescription drug coverage was creditable. The notice must state that you had “creditable” prescription drug coverage that expected to pay as much as Medicare’s standard prescription drug plan pays.
- The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.
- For additional information about creditable coverage, please look in your *Medicare & You* 2012 Handbook or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
- If you were without creditable coverage, but you were without it for less than 63 days in a row.
- If you are receiving “Extra Help” from Medicare.

Section 10.4	What can you do if you disagree about your late enrollment penalty?
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If you disagree about your late enrollment penalty, you or your representative can ask for a review of the decision about your late enrollment penalty. Generally, you must request this review **within 60 days** from the date on the letter you receive stating you have to pay a late enrollment penalty. Call Customer Service at the number on the back cover of this booklet to find out more about how to do this.

SECTION 11 Do you have to pay an extra Part D amount because of your income?

Section 11.1	Who pays an extra Part D amount because of income?
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Most people pay a standard monthly Part D premium. However, some people pay an extra amount because of their yearly income. If your income is \$85,000 or above for an individual (or married individuals filing separately) or \$170,000 or above for married couples, you must pay an extra amount for your Medicare Part D coverage.

If you have to pay an extra amount, the Social Security Administration, not your Medicare plan, will send you a letter telling you what that extra amount will be and how to pay it. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. The extra amount must be paid separately and cannot be paid with your monthly plan premium.

Section 11.2 How much is the extra Part D amount?

If your modified adjusted gross income as reported on your IRS tax return is above a certain amount, you will pay an extra amount in addition to your monthly plan premium.

The chart below shows the extra amount based on your income.

If you filed an individual tax return and your income in 2010 was:	If you were married but filed a separate tax return and your income in 2010 was:	If you filed a joint tax return and your income in 2010 was:	This is the monthly cost of your extra Part D amount (to be paid in addition to your plan premium)
Equal to or less than \$85,000	Equal to or less than \$85,000	Equal to or less than \$170,000	\$0.00
Greater than \$85,000 and less than or equal to \$107,000		Greater than \$170,000 and less than or equal to \$214,000	\$11.60
Greater than \$107,000 and less than or equal to \$160,000		Greater than \$214,000 and less than or equal to \$320,000	\$29.90
Greater than \$160,000 and less than or equal to \$214,000	Greater than \$85,000 and less than or equal to \$129,000	Greater than \$320,000 and less than or equal to \$428,000	\$48.10
Greater than \$214,000	Greater than \$129,000	Greater than \$428,000	\$66.40

Section 11.3	What can you do if you disagree about paying an extra Part D amount?
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If you disagree about paying an extra amount because of your income, you can ask the Social Security Administration to review the decision. To find out more about how to do this, contact the Social Security Administration at 1-800-772-1213 (TTY 1-800-325-0778).

Chapter 7. Asking us to pay our share of a bill you have received for covered medical services or drugs

SECTION 1	Situations in which you should ask us to pay our share of the cost of your covered services or drugs	120
Section 1.1	If you pay our plan’s share of the cost of your covered services or drugs, or if you receive a bill, you can ask us for payment	120
SECTION 2	How to ask us to pay you back or to pay a bill you have received	122
Section 2.1	How and where to send us your request for payment.....	122
SECTION 3	We will consider your request for payment and say yes or no.....	123
Section 3.1	We check to see whether we should cover the service or drug and how much we owe	123
Section 3.2	If we tell you that we will not pay for all or part of the medical care or drug, you can make an appeal.....	123
SECTION 4	Other situations in which you should save your receipts and send copies to us.....	124
Section 4.1	In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs	124

SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered services or drugs

Section 1.1	If you pay our plan's share of the cost of your covered services or drugs, or if you receive a bill, you can ask us for payment
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Sometimes when you get medical care or a prescription drug, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our plan to pay you back (paying you back is often called “reimbursing” you). It is your right to be paid back by our plan whenever you’ve paid more than your share of the cost for medical services or drugs that are covered by our plan.

There may also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

Here are examples of situations in which you may need to ask our plan to pay you back or to pay a bill you have received:

1. When you’ve received medical care from a provider who is not in our plan’s network

When you received care from a provider who is not part of our network, you are only responsible for paying your share of the cost, not for the entire cost. (Your share of the cost may be higher for an out-of-network provider than for a network provider.) You should ask the provider to bill the plan for our share of the cost.

- If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
- At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
 - If the provider is owed anything, we will pay the provider directly.
 - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.
- **Please note:** While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. We cannot pay a provider who is not eligible to participate in Medicare. If the provider is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive.

2. When a network provider sends you a bill you think you should not pay

Network providers should always bill the plan directly, and ask you only for your share of the cost. But sometimes they make mistakes, and ask you to pay more than your share.

- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

3. If you are retroactively enrolled in our plan.

Sometimes a person's enrollment in the plan is retroactive. (Retroactive means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered services or drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork for us to handle the reimbursement.

- Please call Customer Service for additional information about how to ask us to pay you back and deadlines for making your request.

4. When you use an out-of-network pharmacy to get a prescription filled

If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. (We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to Chapter 5, Sec. 2.5 to learn more.)

- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

5. When you pay the full cost for a prescription because you don't have your plan membership card with you

If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

6. When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on the plan's *List of Covered Drugs (Formulary)*; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 9 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has information about how to make an appeal.

SECTION 2 How to ask us to pay you back or to pay a bill you have received

Section 2.1 How and where to send us your request for payment
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Send us your request for payment, along with your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website (<http://KSForms.coventry-medicare.com>) or call Customer Service and ask for the form. The phone numbers for Customer Service are on the back cover of this booklet.

For medical claims: Mail your request for payment together with any bills or receipts to us at this address:

State of KS Advantra Freedom PPO
PO Box 7370
London, KY 40742

For prescription drug claims: Mail your request for payment together with any bills or receipts to us at this address:

Medco Health Solutions, Inc.
PO Box 14724
Lexington, KY 40512

You must submit your claim to us within 365 calendar days for medical claims, or three months for prescription drug claims, of the date you received the service, item, or drug.

Please be sure to contact Customer Service if you have any questions. If you don't know what you should have paid, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

SECTION 3 We will consider your request for payment and say yes or no

Section 3.1 We check to see whether we should cover the service or drug and how much we owe

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the medical care or drug is covered and you followed all the rules for getting the care or drug, we will pay for our share of the cost. If you have already paid for the service or drug, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services covered. Chapter 5 explains the rules you need to follow for getting your Part D prescription drugs covered.)
- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

Section 3.2 If we tell you that we will not pay for all or part of the medical care or drug, you can make an appeal

If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details on how to make this appeal, go to Chapter 9 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*). The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 9. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as “appeal.” Then after you have read Section 4, you can go to the section in Chapter 9 that tells what to do for your situation:

- If you want to make an appeal about getting paid back for a medical service, go to Section 5.3 in Chapter 9.
- If you want to make an appeal about getting paid back for a drug, go to Section 6.5 of Chapter 9.

SECTION 4 Other situations in which you should save your receipts and send copies to us

Section 4.1 In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs

There are some situations when you should let us know about payments you have made for your drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your out-of-pocket costs correctly. This may help you to qualify for the Catastrophic Coverage Stage more quickly.

Here are two situations when you should send us copies of receipts to let us know about payments you have made for your drugs:

1. When you buy the drug for a price that is lower than our price

Sometimes when you are in the Coverage Gap Stage you can buy your drug **at a network pharmacy** for a price that is lower than our price.

- For example, a pharmacy might offer a special price on the drug. Or you may have a discount card that is outside our benefit that offers a lower price.
- Unless special conditions apply, you must use a network pharmacy in these situations and your drug must be on our Drug List.
- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** If you are in the Coverage Gap Stage, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

2. When you get a drug through a patient assistance program offered by a drug manufacturer

Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside the plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.

- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** Because you are getting your drug through the patient assistance program and not through the plan's benefits, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

Since you are not asking for payment in the two cases described above, these situations are not considered coverage decisions. Therefore, you cannot make an appeal if you disagree with our decision.

Chapter 8. Your rights and responsibilities

SECTION 1	Our plan must honor your rights as a member of the plan	127
Section 1.1	We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or other alternate formats, etc.).....	127
Section 1.2	We must treat you with fairness and respect at all times	127
Section 1.3	We must ensure that you get timely access to your covered services and drugs	127
Section 1.4	We must protect the privacy of your personal health information	128
Section 1.5	We must give you information about the plan, its network of providers, and your covered services	133
Section 1.6	We must support your right to make decisions about your care.....	134
Section 1.7	You have the right to make complaints and to ask us to reconsider decisions we have made.....	136
Section 1.8	What can you do if you think you are being treated unfairly or your rights are not being respected?.....	137
Section 1.9	How to get more information about your rights	137
SECTION 2	You have some responsibilities as a member of the plan.....	138
Section 2.1	What are your responsibilities?.....	138

SECTION 1 Our plan must honor your rights as a member of the plan

Section 1.1	We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or other alternate formats, etc.)
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To get information from us in a way that works for you, please call Customer Service (phone numbers are on the back cover of this booklet).

Our plan has people and free language interpreter services available to answer questions from non-English speaking members. We can also give you information in Braille, in large print, or other alternate formats if you need it. If you are eligible for Medicare because of a disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you.

If you have any trouble getting information from our plan because of problems related to language or a disability, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and tell them that you want to file a complaint. TTY users call 1-877-486-2048.

Section 1.2	We must treat you with fairness and respect at all times
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Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Customer Service (phone numbers are on the back cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

Section 1.3	We must ensure that you get timely access to your covered services and drugs
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You have the right to choose a provider in the plan's network. Call Customer Service to learn which doctors are accepting new patients (phone numbers are on the back cover of this booklet). You also have the right to go to a women's health specialist (such as a gynecologist) without a referral and still pay the in-network cost-sharing amount.

As a plan member, you have the right to get appointments and covered services from your providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9, Section 10 of this booklet tells what you can do. (If we have denied coverage for your medical care or drugs and you don't agree with our decision, Chapter 9, Section 4 tells what you can do.)

Section 1.4	We must protect the privacy of your personal health information
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Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your “personal health information” includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a “Notice of Privacy Practice,” that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you first*. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
 - For example, we are required to release health information to government agencies that are checking on quality of care.
 - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Customer Service (phone numbers are on the back cover of this booklet).

Your Privacy Matters

In compliance with the Health Insurance Portability and Accountability Act (HIPAA), Coventry Health Careⁱ is providing you important information about how your medical and personal information may be used and about how you can access this information. Please review the Notice of Privacy Practices carefully. If you have any questions, please call the Customer Service number on the back of your membership identification card.

Notice of Privacy Practices

Effective: 4/14/2003 (Revised 1/1/2011)

THIS NOTICE DESCRIBES HOW MEDICAL AND PERSONAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A. Our Commitment to Your Privacy

We understand the importance of keeping your personal and health informationⁱⁱ secure and private. We are required by law to provide you with this notice. This notice informs you of your rights about the privacy of your personal information and how we may use and share your personal information. We will make sure that your personal information is only used and shared in the manner described. We may, at times, update this notice. Changes to this notice will apply to the information that we already have about you as well as any information that we may receive or create in the future. Our current notice is posted at www.cvty.com. You may request a copy at any time. Throughout this notice, examples are provided. Please note that all of these examples may not apply to the services Coventry provides to your particular health benefit plan.

B. What Types of Personal Information Do We Collect?

To best service your benefits, we need information about you. This information may come from you, your employer, or other payors or health benefits plan sponsors, and our affiliates. Examples include your name, address, phone number, Social Security number, date of birth, marital status, employment information, or medical history. We also receive information from health care providers and others about you. Examples include the health care services you

receive. This information may be in the form of health care claims and encounters, medical information, or a service request. We may receive your information in writing, by telephone, or electronically.

C. How Do We Protect the Privacy of Your Personal Information?

Keeping your information safe is one of our most important duties. We limit access to your personal information to those who need it. We maintain appropriate safeguards to protect it. For example, we protect access to our buildings and computer systems. Our Privacy Office also assures the training of our staff on our privacy and security policies.

D. How Do We Use and Share Your Information for Treatment, Payment, and Health Care Operations?

To properly service your benefits, we may use and share your personal information for “treatment,” “payment,” and “health care operations.” Below we provide examples of each. We may limit the amount of information we share about you as required by law. For example, HIV/AIDS, substance abuse, and genetic information may be further protected by law. Our privacy policies will always reflect the most protective laws that apply.

- **Treatment:** We may use and share your personal information with health care providers for coordination and management of your care. Providers include physicians, hospitals, and other caregivers who provide services to you.
- **Payment:** We may use and share your personal information to determine your eligibility, coordinate care, review medical necessity, pay claims, obtain external review, and respond to complaints. For example, we may use information from your health care provider to help process your claims. We may also use and share your personal information to obtain payment from others that may be responsible for such costs.
- **Health care operations:** We may use and share your personal information as part of our operations in servicing your benefits. Operations include credentialing of providers; quality improvement activities; accreditation by independent organizations; responses to your questions, or grievance or external review programs; and disease management, case management, and care coordination. We may also use and share information for our general administrative activities such as pharmacy benefits administration; detection and investigation of fraud; auditing; underwriting and rate-making; securing and servicing reinsurance policies; or in the sale, transfer, or merger of all or a part of a Coventry company with another entity. For example, we may use or share your personal information in order to evaluate the quality of health care delivered, to remind you about preventive care, or to inform you about a disease management program.

We may also share your personal information with providers and other health plans for their treatment, payment, and certain health care operation purposes. For example, we may share personal information with other health plans identified by you or your plan sponsor when those plans may be responsible to pay for certain health care benefits.

E. What Other Ways Do We Use or Share Your Information?

We may also use or share your personal information for the following:

- **Medical home / accountable care organizations:** Coventry may work with your primary care physician, hospitals and other health care providers to help coordinate your treatment and care. Your information may be shared with your health care providers to assist in a team-based approach to your health.
- **Health care oversight and law enforcement:** To comply with federal or state oversight agencies. These may include, but are not limited to, your state department of insurance or the U.S. Department of Labor.
- **Legal proceedings:** To comply with a court order or other lawful process.
- **Treatment options:** To inform you about treatment options or health-related benefits or services.
- **Plan sponsors:** To permit the sponsor of your health benefit plan to service the benefit plan and your benefits. Please see your employer's plan documents for more information.
- **Research:** To researchers so long as all procedures required by law have been taken to protect the privacy of the data.
- **Others involved in your health care:** We may share certain personal information with a relative, such as your spouse, close personal friend, or others you have identified as being involved in your care or payment for that care. For example, to those individuals with knowledge of a specific claim, we may confirm certain information about it. Also, we may mail an explanation of benefits to the subscriber. Your family may also have access to such information on our Web site. If you do not want this information to be shared, please tell us in writing.
- **Personal representatives:** We may share personal information with those having a relationship that gives them the right to act on your behalf. Examples include parents of an unemancipated minor or those having a Power of Attorney.
- **Business associates:** To persons providing services to us and who assure us that they will protect the information. Examples may include those companies providing your pharmacy or behavioral health benefits.
- **Other situations:** We also may share personal information in certain public interest situations. Examples include protecting victims of abuse or neglect; preventing a serious threat to health or safety; tracking diseases or medical devices; or informing military or veteran authorities if you are an armed forces member. We may also share your information with coroners; for workers' compensation; for national security; and as required by law.

F. What About Other Sharing of Information and What Happens If You Are No Longer Enrolled?

We will obtain your written permission to use or share your health information for reasons not identified by this notice and not otherwise permitted or required by law. If you withdraw your permission, we will no longer use or share your health information for those reasons.

We do not destroy your information when your coverage ends. It is necessary to use and share your information, for many of the purposes described above, even after your coverage ends. However, we will continue to protect your information regardless of your coverage status.

G. Rights Established by Law

- **Requesting restrictions:** You can request a restriction on the use or sharing of your health information for treatment, payment, or health care operations. However, we may not agree to a requested restriction.
- **Confidential communications:** You can request that we communicate with you about your health and related issues in a certain way, or at a certain location. For example, you may ask that we contact you by mail, rather than by telephone, or at work, rather than at home. We will accommodate reasonable requests.
- **Access and copies:** You can inspect and obtain a copy of certain health information. We may charge a fee for the costs of copying, mailing, labor, and supplies related to your request. We may deny your request to inspect or copy in some situations. In some cases denials allow for a review of our decision. We will notify you of any costs pertaining to these requests, and you may withdraw your request before you incur any costs. You may also request your health information electronically and it will be provided to you in a secure format.
- **Amendment:** You may ask us to amend your health information if you believe it is incorrect or incomplete. You must provide us with a reason that supports your request. We may deny your request if the information is accurate, or as otherwise allowed by law. You may send a statement of disagreement.
- **Accounting of disclosures:** You may request a report of certain times we have shared your information. Examples include sharing your information in response to court orders or with government agencies that license us. All requests for an accounting of disclosures must state a time period that may not include a date earlier than six years prior to the date of the request and may not include dates before April 14, 2003. We will notify you of any costs pertaining to these requests, and you may withdraw your request before you incur any costs.

H. To Receive More Information or File a Complaint

Please contact Customer Service to find out how to exercise any of your rights listed in this notice, or if you have any questions about this notice. The telephone number or address is listed in your benefit documents or on your membership card. If you believe we have not followed the terms of this notice, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with the Secretary, write to 200 Independence Avenue, S.W. Washington, D.C. 20201 or call 1-877-696-6775. You will not be penalized for filing a complaint. To contact us, please follow the complaint, grievance, or appeal process in your benefit documents.

i

For purposes of this notice, the pronouns "we", "us" and "our" and the name "Coventry" refers to Coventry Health Care, Inc. and its licensed affiliated companies, including, but not limited to, Altius Health Plans, Inc.; Cambridge Life Insurance Company; Carelink Health Plans, Inc.; Coventry Health Care of Delaware, Inc.; Coventry Health Care of Florida, Inc.; Coventry Health Plan of Florida, Inc.; Coventry Health Care of Georgia, Inc.; Coventry Health Care of Iowa, Inc.;

Coventry Health Care of Nebraska, Inc.; Coventry Health Care of Pennsylvania, Inc.; Coventry Health Care of Louisiana, Inc.; Coventry Health and Life Insurance Company; Coventry Health Care of Kansas, Inc.; Coventry Health Care National Accounts, Inc.; Coventry Summit Health Plan, Inc.; First Health Life & Health Insurance Company; First Health Services Corp.; Group Dental Services, Inc.; Group Health Plan, Inc.; HealthAmerica Pennsylvania, Inc.; HealthAssurance Pennsylvania, Inc.; HealthCare USA of Missouri, L.L.C.; Kansas Health Plan, Inc.; Mercy Health Plans; MHP, Inc.; MHNet Specialty Services, LLC.; MHNet of Florida, Inc.; MHNet Life and Health Insurance Company; Mental Health Associates, Inc.; Mental Health Network of New York IPA, Inc.; OmniCare Health Plan, Inc.; PersonalCare Insurance of Illinois, Inc.; Preferred Benefits Administrator, Inc.; Preferred Health Care, Inc.; Preferred Health Systems, Inc.; Preferred Health Systems Insurance Company; Preferred Plus of Kansas, Inc.; Southern Health Services, Inc.; and WellPath Select, Inc. These entities abide by the privacy practices described in this Notice.

ii

Under various laws, different requirements can apply to different types of information. Therefore we use the term "health information" to mean information concerning the provision of, or payment for, health care that is individually identifiable. We use the term "personal information" to include both health information and other nonpublic identifiable information that we obtain in providing benefits to you.

Section 1.5	We must give you information about the plan, its network of providers, and your covered services
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As a member of our plan, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

If you want any of the following kinds of information, please call Customer Service (phone numbers are on the back cover of this booklet):

- **Information about our plan.** This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **Information about our network providers including our network pharmacies.**
 - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
 - For a list of the providers and pharmacies in the plan's network, see the *State of KS Advantra Freedom PPO Provider/Pharmacy Directory*.
 - For more detailed information about our providers or pharmacies, you can call Customer Service (phone numbers are on the back cover of this booklet) or visit

our websites at <http://ProviderDirectory.coventry-medicare.com> and <http://PharmacyLocator.coventry-medicare.com>.

- **Information about your coverage and rules you must follow in using your coverage.**
 - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
 - To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 of this booklet plus the plan's *List of Covered Drugs (Formulary)*. These chapters, together with the *List of Covered Drugs (Formulary)*, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
 - If you have questions about the rules or restrictions, please call Customer Service (phone numbers are on the back cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
 - If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.
 - If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 9 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 9 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
 - If you want to ask our plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 7 of this booklet.

Section 1.6	We must support your right to make decisions about your care
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You have the right to know your treatment options and participate in decisions about your health care

You have the right to get full information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices *in a way that you can understand*.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say “no.”** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 9 of this booklet tells how to ask the plan for a coverage decision.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called “**advance directives**.” There are different types of advance directives and different names for them. Documents called “**living will**” and “**power of attorney for health care**” are examples of advance directives.

If you want to use an “advance directive” to give your instructions, here is what to do:

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.

- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital.**

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with the State Department of Health.

Section 1.7	You have the right to make complaints and to ask us to reconsider decisions we have made
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If you have any problems or concerns about your covered services or care, Chapter 9 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints.

As explained in Chapter 9, what you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Customer Service (phone numbers are on the back cover of this booklet).

Section 1.8	What can you do if you think you are being treated unfairly or your rights are not being respected?
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If it is about discrimination, call the Office for Civil Rights

If you think you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?

If you think you have been treated unfairly or your rights have not been respected, *and it's not* about discrimination, you can get help dealing with the problem you are having:

- You can **call Customer Service** (phone numbers are on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 1.9	How to get more information about your rights
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There are several places where you can get more information about your rights:

- You can **call Customer Service** (phone numbers are on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare**.
 - You can visit the Medicare website to read or download the publication "Your Medicare Rights & Protections." (The publication is available at: <http://www.medicare.gov/Publications/Pubs/pdf/10112.pdf>.)
 - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 2 You have some responsibilities as a member of the plan

Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Service (phone numbers are on the back cover of this booklet). We're here to help.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** *Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered services.*
 - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
 - Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** *Please call Customer Service to let us know.*
 - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called “**coordination of benefits**” because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We'll help you with it. (For more information about coordination of benefits, go to Chapter 1, Section 7.)
- **Tell your doctor and other health care providers that you are enrolled in our plan.** *Show your plan membership card whenever you get your medical care or Part D prescription drugs.*
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
 - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
 - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
 - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.

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- **Be considerate.** *We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.*
 - **Pay what you owe.** *As a plan member, you are responsible for these payments:*
 - In order to be eligible for our plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B. For that reason, some plan members must pay a premium for Medicare Part A and most plan members must pay a premium for Medicare Part B to remain a member of the plan.
 - For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your medical services. Chapter 6 tells what you must pay for your Part D prescription drugs.
 - If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
 - If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see Chapter 9 of this booklet for information about how to make an appeal.
 - If you are required to pay a late enrollment penalty, you must pay the penalty to remain a member of the plan.
 - **Tell us if you move.** *If you are going to move, it's important to tell us right away. Call Customer Service (phone numbers are on the back cover of this booklet).*
 - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, we can let you know if we have a plan in your new area.
 - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
 - **Call Customer Service for help if you have questions or concerns.** *We also welcome any suggestions you may have for improving our plan.*
 - Phone numbers and calling hours for Customer Service are on the back cover of this booklet.
 - For more information on how to reach us, including our mailing address, please see Chapter 2.

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1	Introduction	143
Section 1.1	What to do if you have a problem or concern.....	143
Section 1.2	What about the legal terms?.....	143
SECTION 2	You can get help from government organizations that are not connected with us.....	144
Section 2.1	Where to get more information and personalized assistance.....	144
SECTION 3	To deal with your problem, which process should you use?	144
Section 3.1	Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?.....	144
SECTION 4	A guide to the basics of coverage decisions and appeals.....	146
Section 4.1	Asking for coverage decisions and making appeals: the big picture	146
Section 4.2	How to get help when you are asking for a coverage decision or making an appeal	147
Section 4.3	Which section of this chapter gives the details for <u>your</u> situation?	148
SECTION 5	Your medical care: How to ask for a coverage decision or make an appeal	148
Section 5.1	This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care	148
Section 5.2	Step-by-step: How to ask for a coverage decision (how to ask our plan to authorize or provide the medical care coverage you want)	150
Section 5.3	Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan)	153
Section 5.4	Step-by-step: How to make a Level 2 Appeal	156

Section 5.5	What if you are asking us to pay you for our share of a bill you have received for medical care?	158
SECTION 6	Your Part D prescription drugs: How to ask for a coverage decision or make an appeal	159
Section 6.1	This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug	159
Section 6.2	What is an exception?	161
Section 6.3	Important things to know about asking for exceptions.....	163
Section 6.4	Step-by-step: How to ask for a coverage decision, including an exception	163
Section 6.5	Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan)	166
Section 6.6	Step-by-step: How to make a Level 2 Appeal	168
SECTION 7	How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon	170
Section 7.1	During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights	171
Section 7.2	Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date.....	172
Section 7.3	Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date.....	174
Section 7.4	What if you miss the deadline for making your Level 1 Appeal?	176
SECTION 8	How to ask us to keep covering certain medical services if you think your coverage is ending too soon.....	178
Section 8.1	<i>This section is about three services <u>only</u>:</i> Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services	178
Section 8.2	We will tell you in advance when your coverage will be ending	179

Section 8.3	Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time.....	180
Section 8.4	Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time.....	182
Section 8.5	What if you miss the deadline for making your Level 1 Appeal?	183
SECTION 9	Taking your appeal to Level 3 and beyond	186
Section 9.1	Levels of Appeal 3, 4, and 5 for Medical Service Appeals	186
Section 9.2	Levels of Appeal 3, 4, and 5 for Part D Drug Appeals.....	187
SECTION 10	How to make a complaint about quality of care, waiting times, customer service, or other concerns	189
Section 10.1	What kinds of problems are handled by the complaint process?.....	189
Section 10.2	The formal name for “making a complaint” is “filing a grievance”	191
Section 10.3	Step-by-step: Making a complaint	192
Section 10.4	You can also make complaints about quality of care to the Quality Improvement Organization	193

BACKGROUND

SECTION 1 Introduction

Section 1.1	What to do if you have a problem or concern
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This chapter explains two types of processes for handling problems and concerns:

- For some types of problems, you need to use the **process for coverage decisions and making appeals**.
- For other types of problems, you need to use the **process for making complaints**.

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Which one do you use? That depends on the type of problem you are having. The guide in Section 3 will help you identify the right process to use.

Section 1.2	What about the legal terms?
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There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says “making a complaint” rather than “filing a grievance,” “coverage decision” rather than “organization determination” or “coverage determination,” and “Independent Review Organization” instead of “Independent Review Entity.” It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 You can get help from government organizations that are not connected with us

Section 2.1 Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers in Chapter 2, Section 3 of this booklet.

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can visit the Medicare website (<http://www.medicare.gov>).

SECTION 3 To deal with your problem, which process should you use?

Section 3.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

To figure out which part of this chapter will help with your specific problem or concern,
START HERE

Is your problem or concern about your benefits or coverage?

(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)

Yes.

My problem is about benefits or coverage.

Go on to the next section of this chapter, **Section 4, “A guide to the basics of coverage decisions and making appeals.”**

No.

My problem is not about benefits or coverage.

Skip ahead to **Section 10** at the end of this chapter: **“How to make a complaint about quality of care, waiting times, customer service or other concerns.”**

COVERAGE DECISIONS AND APPEALS

SECTION 4 A guide to the basics of coverage decisions and appeals

Section 4.1	Asking for coverage decisions and making appeals: the big picture
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The process for coverage decisions and making appeals deals with problems related to your benefits and coverage for medical services and prescription drugs, including problems related to payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases we might decide a service or drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision and you are not satisfied with this decision, you can “appeal” the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you make an appeal, we review the coverage decision we have made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review, we give you our decision.

If we say no to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to us. (In some situations, your case will be automatically sent to the independent organization for a Level 2

Appeal. If this happens, we will let you know. In other situations, you will need to ask for a Level 2 Appeal.) If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through several more levels of appeal.

Section 4.2	How to get help when you are asking for a coverage decision or making an appeal
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Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- **You can call us at Customer Service** (phone numbers are on the back cover of this booklet).
- To **get free help from an independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter).
- **Your doctor or other provider can make a request for you.** Your doctor or other provider can request a coverage decision or a Level 1 Appeal on your behalf. To request any appeal after Level 1, your doctor or other provider must be appointed as your representative.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your “representative” to ask for a coverage decision or make an appeal.
 - There may be someone who is already legally authorized to act as your representative under State law.
 - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Customer Service and ask for the “Appointment of Representative” form. (The form is also available on Medicare’s website at <http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf> or on our website at <http://KSForms.coventry-medicare.com>.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.3	Which section of this chapter gives the details for <u>your</u> situation?
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There are four different types of situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 5** of this chapter: “Your medical care: How to ask for a coverage decision or make an appeal”
- **Section 6** of this chapter: “Your Part D prescription drugs: How to ask for a coverage decision or make an appeal”
- **Section 7** of this chapter: “How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon”
- **Section 8** of this chapter: “How to ask us to keep covering certain medical services if you think your coverage is ending too soon” (*Applies to these services only*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you’re not sure which section you should be using, please call Customer Service (phone numbers are on the back cover of this booklet). You can also get help or information from government organizations such as your State Health Insurance Assistance Program (Chapter 2, Section 3, of this booklet has the phone numbers for this program).

SECTION 5 Your medical care: How to ask for a coverage decision or make an appeal



Have you read Section 4 of this chapter (*A guide to “the basics” of coverage decisions and appeals*)?

If not, you may want to read it before you start this section.

Section 5.1	This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care
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This section is about your benefits for medical care and services (but does not cover Part D drugs, please see Section 6 for Part D drug appeals). These benefits are described in Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*. To keep things simple, we generally refer to “medical care coverage” or “medical care” in the rest of this section, instead of repeating “medical care or treatment or services” every time.

This section tells what you can do if you are in any of the five following situations:

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.
2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan.
3. You have received medical care or services that you believe should be covered by the plan, but we have said we will not pay for this care.
4. You have received and paid for medical care or services that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care.
5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.
 - **NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services**, you need to read a separate section of this chapter because special rules apply to these types of care. Here's what to read in those situations:
 - Chapter 9, Section 7: *How to ask us for a longer hospital stay if you think you are being asked to leave the hospital too soon.*
 - Chapter 9, Section 8: *How to ask us to keep covering certain medical services if you think your coverage is ending too soon.* This section is about three services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.
 - For *all other* situations that involve being told that medical care you have been getting will be stopped, use this section (Section 5) as your guide for what to do.

Which of these situations are you in?	
If you are in this situation:	This is what you can do:
Do you want to find out whether we will cover the medical care or services you want?	You can ask us to make a coverage decision for you. Go to the next section of this chapter, Section 5.2.
Have we already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for?	You can make an appeal . (This means you are asking us to reconsider.) Skip ahead to Section 5.3 of this chapter.
Do you want to ask us to pay you back for medical care or services you have already received and paid for?	You can send us the bill. Skip ahead to Section 5.5 of this chapter.

Section 5.2	Step-by-step: How to ask for a coverage decision (how to ask our plan to authorize or provide the medical care coverage you want)
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Legal Terms	When a coverage decision involves your medical care, it is called an “ organization determination. ”
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Step 1: You ask our plan to make a coverage decision on the medical care you are requesting. If your health requires a quick response, you should ask us to make a “**fast decision.**”

Legal Terms	A “fast decision” is called an “ expedited determination. ”
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How to request coverage for the medical care you want

- Start by calling, writing, or faxing our plan to make your request for us to provide coverage for the medical care you want. You, your doctor, or your representative can do this.

- For the details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision about your medical care.*

Generally we use the standard deadlines for giving you our decision

When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. **A standard decision means we will give you an answer within 14 days** after we receive your request.

- **However, we can take up to 14 more calendar days** if you ask for more time, or if we need information (such as medical records) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing.
- If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

If your health requires it, ask us to give you a “fast decision”

- **A fast decision means we will answer within 72 hours.**
 - **However, we can take up to 14 more calendar days** if we find that some information that may benefit you is missing, or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing.
 - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.) We will call you as soon as we make the decision.
- **To get a fast decision, you must meet two requirements:**
 - You can get a fast decision *only* if you are asking for coverage for medical care *you have not yet received.* (You cannot get a fast decision if your request is about payment for medical care you have already received.)
 - You can get a fast decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor tells us that your health requires a “fast decision,” we will automatically agree to give you a fast decision.**
- If you ask for a fast decision on your own, without your doctor’s support, we will decide whether your health requires that we give you a fast decision.

- If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead).
- This letter will tell you that if your doctor asks for the fast decision, we will automatically give a fast decision.
- The letter will also tell how you can file a “fast complaint” about our decision to give you a standard decision instead of the fast decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

Step 2: We consider your request for medical care coverage and give you our answer.

Deadlines for a “fast” coverage decision

- Generally, for a fast decision, we will give you our answer **within 72 hours**.
 - As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the decision, we will tell you in writing.
 - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)
 - If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our decision, we will provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Deadlines for a “standard” coverage decision

- Generally, for a standard decision, we will give you our answer **within 14 days of receiving your request**.
 - We can take up to 14 more calendar days (“an extended time period”) under certain circumstances. If we decide to take extra days to make the decision, we will tell you in writing.
 - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will

give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

- If we do not give you our answer within 14 days (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 14 days after we received your request. If we extended the time needed to make our decision, we will provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Step 3: If we say no to your request for coverage for medical care, you decide if you want to make an appeal.

- If we say no, you have the right to ask us to reconsider – and perhaps change – this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see Section 5.3 below).

Section 5.3 Step-by-step: How to make a Level 1 Appeal
(how to ask for a review of a medical care coverage decision made by our plan)

Legal Terms An appeal to the plan about a medical care coverage decision is called a plan **“reconsideration.”**

Step 1: You contact us and make your appeal. If your health requires a quick response, you must ask for a **“fast appeal.”**

What to do

- **To start your appeal, you, your doctor, or your representative, must contact us.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 look for section called, *How to contact us when you are making an appeal about your medical care.*
- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a signed request.**
 - If you have someone appealing our decision for you other than your doctor, your appeal must include an Appointment of Representative form authorizing

this person to represent you. (To get the form, call Customer Service and ask for the “Appointment of Representative” form. It is also available on Medicare’s website at

<http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf> or on our website at <http://KSForms.coventry-medicare.com>.) While we can accept an appeal request without the form, we cannot complete our review until we receive it. If we do not receive the form within 44 days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be sent to the Independent Review Organization for dismissal.

- **If you are asking for a fast appeal, make your appeal in writing or call us** at the phone number shown in Chapter 2, Section 1 (*How to contact us when you are making an appeal about your medical care*).
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision and add more information to support your appeal.**
 - You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
 - If you wish, you and your doctor may give us additional information to support your appeal.

If your health requires it, ask for a “fast appeal” (you can make a request by calling us)

Legal Terms	A “fast appeal” is also called an “expedited reconsideration.”
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- If you are appealing a decision we made about coverage for care you have not yet received, you and/or your doctor will need to decide if you need a “fast appeal.”
- The requirements and procedures for getting a “fast appeal” are the same as those for getting a “fast decision.” To ask for a fast appeal, follow the instructions for asking for a fast decision. (These instructions are given earlier in this section.)
- If your doctor tells us that your health requires a “fast appeal,” we will give you a fast appeal.

Step 2: We consider your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if we need it. We may contact you or your doctor to get more information.

Deadlines for a “fast” appeal

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to do so.
 - However, if you ask for more time, or if we need to gather more information that may benefit you, we **can take up to 14 more calendar days**. If we decide to take extra days to make the decision, we will tell you in writing.
 - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

Deadlines for a “standard” appeal

- If we are using the standard deadlines, we must give you our answer **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. We will give you our decision sooner if your health condition requires us to.
 - However, if you ask for more time, or if we need to gather more information that may benefit you, **we can take up to 14 more calendar days**.
 - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

- If we do not give you an answer by the deadline above (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 30 days after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

Step 3: If our plan says no to part or all of your appeal, your case will automatically be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your appeal, **we are required to send your appeal to the “Independent Review Organization.”** When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

Section 5.4	Step-by-step: How to make a Level 2 Appeal
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If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms	The formal name for the “Independent Review Organization” is the “ Independent Review Entity. ” It is sometimes called the “ IRE. ”
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Step 1: The Independent Review Organization reviews your appeal.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- We will send the information about your appeal to this organization. This information is called your “case file.” **You have the right to ask us for a copy of your case file.** We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the Independent Review Organization additional information to support your appeal.

- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

If you had a “fast” appeal at Level 1, you will also have a “fast” appeal at Level 2

- If you had a fast appeal to our plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal within 72 hours of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**.

If you had a “standard” appeal at Level 1, you will also have a “standard” appeal at Level 2

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**.

Step 2: The Independent Review Organization gives you their answer.

The Independent Review Organization will tell you its decision in writing and explain the reasons for it.

- **If the review organization says yes to part or all of what you requested**, we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization.
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called “upholding the decision.” It is also called “turning down your appeal.”)
 - The written notice you get from the Independent Review Organization will tell you the dollar amount that must be in dispute to continue with the appeals process. For example, to continue and make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).

- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you got after your Level 2 Appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 5.5	What if you are asking us to pay you for our share of a bill you have received for medical care?
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If you want to ask us for payment for medical care, start by reading Chapter 7 of this booklet: *Asking us to pay our share of a bill you have received for covered medical services or drugs*. Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 4.1 of this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service (see Chapter 4: *Medical Benefits Chart (what is covered and what you pay)*). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: *Using the plan's coverage for your medical services*).

We will say yes or no to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care within 60 calendar days after we receive your request. Or, if you haven't paid for the services, we will send the payment directly to the provider. When we send the payment, it's the same as saying *yes* to your request for a coverage decision.)
- If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why. (When we turn down your request for payment, it's the same as saying *no* to your request for a coverage decision.)

What if you ask for payment and we say that we will not pay?

If you do not agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in part 5.3 of this section. Go to this part for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)
- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

SECTION 6 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal



Have you read Section 4 of this chapter (*A guide to “the basics” of coverage decisions and appeals*)?

If not, you may want to read it before you start this section.

Section 6.1	This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug
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Your benefits as a member of our plan include coverage for many outpatient prescription drugs. Medicare calls these outpatient prescription drugs “Part D drugs.” You can get these drugs as long as they are included in our plan’s *List of Covered Drugs (Formulary)* and the use of the drug is a medically accepted indication. (A “medically accepted indication” is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3 for more information about a medically accepted indication.)

- **This section is about your Part D drugs only.** To keep things simple, we generally say “drug” in the rest of this section, instead of repeating “covered outpatient prescription drug” or “Part D drug” every time.
- For details about what we mean by Part D drugs, the *List of Covered Drugs (Formulary)*, rules and restrictions on coverage, and cost information, see Chapter 5 (*Using our plan’s coverage for your Part D prescription drugs*) and Chapter 6 (*What you pay for your Part D prescription drugs*).

Part D coverage decisions and appeals

As discussed in Section 4 of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

Legal Terms	An initial coverage decision about your Part D drugs is called a “coverage determination.”
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Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including:
 - Asking us to cover a Part D drug that is not on the plan’s *List of Covered Drugs (Formulary)*
 - Asking us to waive a restriction on the plan’s coverage for a drug (such as limits on the amount of the drug you can get)
 - Asking to pay a lower cost-sharing amount for a covered non-preferred drug
- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on the plan’s *List of Covered Drugs (Formulary)* but we require you to get approval from us before we will cover it for you.)
 - *Please note:* If your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal. Use the chart below to help you determine which part has information for your situation:

Which of these situations are you in?			
<p>Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover?</p> <p>You can ask us to make an exception. (This is a type of coverage decision.)</p> <p>Start with Section 6.2 of this chapter.</p>	<p>Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?</p> <p>You can ask us for a coverage decision.</p> <p>Skip ahead to Section 6.4 of this chapter.</p>	<p>Do you want to ask us to pay you back for a drug you have already received and paid for?</p> <p>You can ask us to pay you back. (This is a type of coverage decision.)</p> <p>Skip ahead to Section 6.4 of this chapter.</p>	<p>Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?</p> <p>You can make an appeal. (This means you are asking us to reconsider.)</p> <p>Skip ahead to Section 6.5 of this chapter.</p>

Section 6.2 What is an exception?

If a drug is not covered in the way you would like it to be covered, you can ask us to make an “exception.” An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

- Covering a Part D drug for you that is not on our *List of Covered Drugs (Formulary)*.**
 (We call it the “Drug List” for short.)

Legal Terms	Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a “formulary exception.”
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- If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in Tier 3 – Non Preferred Brand Drugs. You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.
- You cannot ask for coverage of any “excluded drugs” or other non-Part D drugs which Medicare does not cover. (For more information about excluded drugs, see Chapter 5.)

2. Removing a restriction on our coverage for a covered drug. There are extra rules or restrictions that apply to certain drugs on our *List of Covered Drugs (Formulary)* (for more information, go to Chapter 5 and look for Section 4).

Legal Terms	Asking for removal of a restriction on coverage for a drug is sometimes called asking for a “formulary exception.”
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- The extra rules and restrictions on coverage for certain drugs include:
 - *Being required to use the generic version* of a drug instead of the brand name drug.
 - *Getting plan approval in advance* before we will agree to cover the drug for you. (This is sometimes called “prior authorization.”)
 - *Being required to try a different drug first* before we will agree to cover the drug you are asking for. (This is sometimes called “step therapy.”)
 - *Quantity limits.* For some drugs, there are restrictions on the amount of the drug you can have.
- If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

3. Changing coverage of a drug to a lower cost-sharing tier. Every drug on our Drug List is in one of four (4) cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

Legal Terms	Asking to pay a lower preferred price for a covered non-preferred drug is sometimes called asking for a “tiering exception.”
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- If your drug is in Tier 3 – Non-Preferred Brand Drugs you can ask us to cover it at the cost-sharing amount that applies to drugs in Tier 2 – Preferred Brand Drugs. This would lower your share of the cost for the drug.
- You cannot ask us to change the cost-sharing tier for any drug in Tier 4 – Specialty Tier Drugs.

Section 6.3	Important things to know about asking for exceptions
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Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called “alternative” drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. Section 6.5 tells how to make an appeal if we say no.

The next section tells you how to ask for a coverage decision, including an exception.

Section 6.4	Step-by-step: How to ask for a coverage decision, including an exception
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Step 1: You ask us to make a coverage decision about the drug(s) or payment you need. If your health requires a quick response, you must ask us to make a “**fast decision.**” **You cannot ask for a fast decision if you are asking us to pay you back for a drug you already bought.**

What to do

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. For the details, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision about your Part D prescription drugs.* Or if you are asking us to pay you back for a drug, go to the section called, *Where to send a request that asks us to pay for our share of the cost for medical care or a drug you have received.*
- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. Section 4 of this chapter tells how you can give written

permission to someone else to act as your representative. You can also have a lawyer act on your behalf.

- **If you want to ask us to pay you back for a drug**, start by reading Chapter 7 of this booklet: *Asking us to pay our share of a bill you have received for covered medical services or drugs*. Chapter 7 describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- **If you are requesting an exception, provide the “doctor’s statement.”** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the “doctor’s statement.”) Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See Sections 6.2 and 6.3 for more information about exception requests.

If your health requires it, ask us to give you a “fast decision”

Legal Terms A “fast decision” is called an **“expedited coverage determination.”**

- When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. A standard decision means we will give you an answer within 72 hours after we receive your doctor’s statement. A fast decision means we will answer within 24 hours.
- **To get a fast decision, you must meet two requirements:**
 - You can get a fast decision *only* if you are asking for a *drug you have not yet received*. (You cannot get a fast decision if you are asking us to pay you back for a drug you already bought.)
 - You can get a fast decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor or other prescriber tells us that your health requires a “fast decision,” we will automatically agree to give you a fast decision.**
- If you ask for a fast decision on your own (without your doctor’s or other prescriber’s support), we will decide whether your health requires that we give you a fast decision.
 - If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead).
 - This letter will tell you that if your doctor or other prescriber asks for the fast decision, we will automatically give a fast decision.
 - The letter will also tell how you can file a complaint about our decision to give you a standard decision instead of the fast decision you requested. It tells how to file a “fast” complaint, which means you would get our answer to your complaint within 24 hours. (The process for making a complaint is different

from the process for coverage decisions and appeals. For more information about the process for making complaints, see Section 10 of this chapter.)

Step 2: We consider your request and we give you our answer.

Deadlines for a “fast” coverage decision

- If we are using the fast deadlines, we must give you our answer **within 24 hours**.
 - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor’s statement supporting your request. We will give you our answer sooner if your health requires us to.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor’s statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Deadlines for a “standard” coverage decision about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer **within 72 hours**.
 - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor’s statement supporting your request. We will give you our answer sooner if your health requires us to.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested –**
 - If we approve your request for coverage, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor’s statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Deadlines for a “standard” coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 30 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Step 3: If we say no to your coverage request, you decide if you want to make an appeal.

- If we say no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made.

Section 6.5	Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan)
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Legal Terms	An appeal to the plan about a Part D drug coverage decision is called a plan “redetermination.”
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Step 1: You contact us and make your Level 1 Appeal. If your health requires a quick response, you must ask for a “fast appeal.”

What to do

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact us.**
 - For details on how to reach us by phone, fax, or mail for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called, *How to contact us when you are making an appeal about your Part D prescription drugs*.
- **If you are asking for a standard appeal, make your appeal by submitting a written request.**
- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown in Chapter 2, Section 1** (*How to contact us when you are making an appeal about your part D prescription drugs*).

- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.**
 - You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
 - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a “fast appeal”

Legal Terms	A “fast appeal” is also called an “ expedited redetermination. ”
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- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a “fast appeal.”
- The requirements for getting a “fast appeal” are the same as those for getting a “fast decision” in Section 6.4 of this chapter.

Step 2: Our plan considers your appeal and we give you our answer.

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a “fast” appeal

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal.** We will give you our answer sooner if your health requires it.
 - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.

- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

Deadlines for a “standard” appeal

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for “fast” appeal.
 - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested** –
 - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we receive your appeal.
 - If we approve a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive your appeal request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

Step 3: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal.
- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

Section 6.6	Step-by-step: How to make a Level 2 Appeal
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If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms	The formal name for the “Independent Review Organization” is the “ Independent Review Entity. ” It is sometimes called the “ IRE. ”
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Step 1: To make a Level 2 Appeal, you must contact the Independent Review Organization and ask for a review of your case.

- If we say no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.
- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your “case file.” **You have the right to ask us for a copy of your case file.** We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the Independent Review Organization additional information to support your appeal.

Step 2: The Independent Review Organization does a review of your appeal and gives you an answer.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with us.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

Deadlines for “fast” appeal at Level 2

- If your health requires it, ask the Independent Review Organization for a “fast appeal.”
- If the review organization agrees to give you a “fast appeal,” the review organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.
- **If the Independent Review Organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

Deadlines for “standard” appeal at Level 2

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal.
- **If the Independent Review Organization says yes to part or all of what you requested –**

- If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
- If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. (This is called “upholding the decision.” It is also called “turning down your appeal.”)

To continue and make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

Step 3: If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about our coverage for your hospital care, including any limitations on this coverage, see Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*.

During your hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for care you may need after you leave.

- The day you leave the hospital is called your “**discharge date.**” Our plan’s coverage of your hospital stay ends on this date.
- When your discharge date has been decided, your doctor or the hospital staff will let you know.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This section tells you how to ask.

Section 7.1	During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights
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During your hospital stay, you will be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call Customer Service. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

- 1. Read this notice carefully and ask questions if you don’t understand it.** It tells you about your rights as a hospital patient, including:
 - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
 - Your right to be involved in any decisions about your hospital stay, and know who will pay for it.
 - Where to report any concerns you have about quality of your hospital care.
 - Your right to appeal your discharge decision if you think you are being discharged from the hospital too soon.

Legal Terms	The written notice from Medicare tells you how you can “ request an immediate review. ” Requesting an immediate review is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time. (Section 7.2 below tells you how you can request an immediate review.)
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- 2. You must sign the written notice to show that you received it and understand your rights.**
 - You or someone who is acting on your behalf must sign the notice. (Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.)

- Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice **does not mean** you are agreeing on a discharge date.
3. **Keep your copy** of the signed notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.
- If you sign the notice more than 2 days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
 - To look at a copy of this notice in advance, you can call Customer Service or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see it online at http://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp.

Section 7.2	Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date
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If you want to ask for your hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Service (phone numbers are on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

Step 1: Contact the Quality Improvement Organization in your state and ask for a “fast review” of your hospital discharge. You must act quickly.

Legal Terms	A “fast review” is also called an “ immediate review. ”
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What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care professionals who are paid by the Federal government. These experts are not part of our plan. This organization is paid by Medicare to check on and help improve the quality of care for

people with Medicare. This includes reviewing hospital discharge dates for people with Medicare.

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than your planned discharge date**. (Your “planned discharge date” is the date that has been set for you to leave the hospital.)
 - If you meet this deadline, you are allowed to stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision on your appeal from the Quality Improvement Organization.
 - If you do *not* meet this deadline, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 7.4.

Ask for a “fast review”:

- You must ask the Quality Improvement Organization for a **“fast review”** of your discharge. Asking for a “fast review” means you are asking for the organization to use the “fast” deadlines for an appeal instead of using the standard deadlines.

Legal Terms	A “fast review” is also called an “ immediate review ” or an “ expedited review .”
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Step 2: The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them “the reviewers” for short) will ask you (or your representative) why you believe coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.

- By noon of the day after the reviewers informed our plan of your appeal, you will also get a written notice that gives your planned discharge date and explains the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Legal Terms	This written explanation is called the “ Detailed Notice of Discharge. ” You can get a sample of this notice by calling Customer Service or 1-800-MEDICARE (1-800-633-4227, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.) Or you can see a sample notice online at http://www.cms.hhs.gov/BNI/
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Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the review organization says *yes* to your appeal, **we must keep providing your covered hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See Chapter 4 of this booklet).

What happens if the answer is no?

- If the review organization says *no* to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the review organization says *no* to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to “Level 2” of the appeals process.

Section 7.3	Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date
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If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level

2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If we turn down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day when the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 calendar days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your hospital care for as long as it is medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

- It means they agree with the decision they made on your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.

- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7.4 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 7.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. (“Quickly” means before you leave the hospital and no later than your planned discharge date). If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Legal Terms	A “fast” review (or “fast appeal”) is also called an “ expedited appeal ”.
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Step 1: Contact us and ask for a “fast review.”

- For details on how to contact our plan, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are making an appeal about your medical care.*
- **Be sure to ask for a “fast review.”** This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines.

Step 2: We do a “fast” review of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- In this situation, we will use the “fast” deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: We give you our decision within 72 hours after you ask for a “fast review” (“fast appeal”).

- **If we say yes to your fast appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your

covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)

- **If we say no to your fast appeal**, we are saying that your planned discharge date was medically appropriate. Our coverage for your hospital services ends as of the day we said coverage would end.
 - If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

Step 4: If we say *no* to your fast appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the “Independent Review Organization.”** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: How to make a Level 2 *Alternate Appeal*

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your “fast appeal.” This organization decides whether the decision we made should be changed.

Legal Terms	The formal name for the “Independent Review Organization” is the “ Independent Review Entity. ” It is sometimes called the “ IRE. ”
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Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 10 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a

government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.

- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says *yes* to your appeal**, then we must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan's coverage of your hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal**, it means they agree with us that your planned hospital discharge date was medically appropriate.
 - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 8.1	<i>This section is about three services <u>only</u>: Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services</i>
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This section is about the following types of care *only*:

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a “skilled nursing facility,” see Chapter 12, *Definitions of important words*.)
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are

getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 12, *Definitions of important words.*)

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay).*

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *we will stop paying our share of the cost for your care.*

If you think we are ending the coverage of your care too soon, **you can appeal our decision.** This section tells you how to ask for an appeal.

Section 8.2	We will tell you in advance when your coverage will be ending
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- 1. You receive a notice in writing.** At least two days before our plan is going to stop covering your care, the agency or facility that is providing your care will give you a letter or notice.
 - The written notice tells you the date when we will stop covering the care for you.
 - The written notice also tells what you can do if you want to ask our plan to change this decision about when to end your care, and keep covering it for a longer period of time.

Legal Terms	In telling you what you can do, the written notice is telling how you can request a “fast-track appeal.” Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. (Section 8.5 below tells how you can request a fast-track appeal.)
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Legal Terms	The written notice is called the “Notice of Medicare Non-Coverage.” To get a sample copy, call Customer Service or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or see a copy online at http://www.cms.hhs.gov/BNI/
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- 2. You must sign the written notice to show that you received it.**

- You or someone who is acting on your behalf must sign the notice. (Section 4 tells how you can give written permission to someone else to act as your representative.)
- Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with the plan that it's time to stop getting the care.

Section 8.3	Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time
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If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 10 of this chapter tells you how to file a complaint.)
- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Service (phone numbers are on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.

Step 1: Make your Level 1 Appeal: contact the Quality Improvement Organization in your state and ask for a review. You must act quickly.

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care experts who are paid by the Federal government. These experts are not part of our plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of medical care.

How can you contact this organization?

- The written notice you received tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

What should you ask for?

- Ask this organization to do an independent review of whether it is medically appropriate for us to end coverage for your medical services.

Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal *no later than noon of the day after you receive the written notice telling you when we will stop covering your care.*
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see Section 8.5.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them “the reviewers” for short) will ask you (or your representative) why you believe coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers informed us of your appeal, and you will also get a written notice from us that gives our reasons for ending our coverage for your services.

Legal Terms	This notice explanation is called the “ Detailed Explanation of Non-Coverage. ”
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Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.

What happens if the reviewers say yes to your appeal?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see Chapter 4 of this booklet).

What happens if the reviewers say no to your appeal?

- If the reviewers say *no* to your appeal, then **your coverage will end on the date we have told you.** We will stop paying our share of the costs of this care.

- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- This first appeal you make is “Level 1” of the appeals process. If reviewers say *no* to your Level 1 Appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make another appeal.
- Making another appeal means you are going on to “Level 2” of the appeals process.

Section 8.4	Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time
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If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If we turn down your Level 2 Appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes to your appeal?

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision we made to your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 8.5	What if you miss the deadline for making your Level 1 Appeal?
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You can appeal to us instead

As explained above in Section 8.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 Alternate Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Here are the steps for a Level 1 Alternate Appeal:

Legal Terms	A “fast” review (or “fast appeal”) is also called an “ expedited appeal ”.
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Step 1: Contact our plan and ask for a “fast review.”

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are making an appeal about your medical care*.
- **Be sure to ask for a “fast review.”** This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines.

Step 2: We do a “fast” review of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan’s coverage for services you were receiving.
- We will use the “fast” deadlines rather than the standard deadlines for giving you the answer to this review. (Usually, if you make an appeal to our plan and ask for a “fast review,” we are allowed to decide whether to agree to your request and give you a “fast review.” But in this situation, the rules require us to give you a fast response if you ask for it.)

Step 3: We give you our decision within 72 hours after you ask for a “fast review” (“fast appeal”).

- **If we say yes to your fast appeal**, it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal**, then your coverage will end on the date we have told you and we will not pay after this date. We will stop paying our share of the costs of this care.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end, then **you will have to pay the full cost** of this care yourself.

Step 4: If we say no to your fast appeal, your case will automatically go on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the “Independent Review Organization.”** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: How to make a Level 2 *Alternate Appeal*

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your “fast appeal.” This organization decides whether the decision we made should be changed.

Legal Terms	The formal name for the “Independent Review Organization” is the “ Independent Review Entity. ” It is sometimes called the “ IRE. ”
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Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 10 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- **If this organization says *yes* to your appeal,** then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
 - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 Taking your appeal to Level 3 and beyond

Section 9.1	Levels of Appeal 3, 4, and 5 for Medical Service Appeals
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This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

<p>Level 3 Appeal A judge who works for the Federal government will review your appeal and give you an answer. This judge is called an “Administrative Law Judge.”</p>

- **If the Administrative Law Judge says yes to your appeal, the appeals process *may* or *may not* be over** - We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
 - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the judge’s decision.
 - If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- **If the Administrative Law Judge says no to your appeal, the appeals process *may* or *may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal The **Medicare Appeals Council** will review your appeal and give you an answer. The Medicare Appeals Council works for the Federal government.

- **If the answer is yes, or if the Medicare Appeals Council denies our request to review a favorable Level 3 Appeal decision, the appeals process *may* or *may not* be over -** We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you.
 - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the Medicare Appeals Council's decision.
 - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Medicare Appeals Council denies the review request, the appeals process *may* or *may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Medicare Appeals Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal A judge at the **Federal District Court** will review your appeal.

- This is the last step of the administrative appeals process.

Section 9.2 Levels of Appeal 3, 4, and 5 for Part D Drug Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the drug you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal A judge who works for the Federal government will review your appeal and give you an answer. This judge is called an “Administrative Law Judge.”

- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal The Medicare Appeals Council will review your appeal and give you an answer. The Medicare Appeals Council works for the Federal government.

- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Medicare Appeals Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Medicare Appeals Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal A judge at the Federal District Court will review your appeal.

- This is the last step of the appeals process.

MAKING COMPLAINTS

SECTION 10 **How to make a complaint about quality of care, waiting times, customer service, or other concerns**



If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.

Section 10.1 What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only*. This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

**If you have any of these kinds of problems,
you can “make a complaint”****Quality of your medical care**

- Are you unhappy with the quality of the care you have received (including care in the hospital)?

Respecting your privacy

- Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?

Disrespect, poor customer service, or other negative behaviors

- Has someone been rude or disrespectful to you?
- Are you unhappy with how our Customer Service has treated you?
- Do you feel you are being encouraged to leave the plan?

Waiting times

- Are you having trouble getting an appointment, or waiting too long to get it?
- Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Customer Service or other staff at the plan?
 - Examples include waiting too long on the phone, in the waiting room, when getting a prescription, or in the exam room.

Cleanliness

- Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor’s office?

Information you get from us

- Do you believe we have not given you a notice that we are required to give?
- Do you think written information we have given you is hard to understand?

*The next page has more examples of
possible reasons for making a complaint*

Possible complaints
(continued)**These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals**

The process of asking for a coverage decision and making appeals is explained in Sections 4-9 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked us to give you a “fast response” for a coverage decision or appeal, and we have said we will not, you can make a complaint.
- If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.
- When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services or drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.
- When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 10.2 The formal name for “making a complaint” is “filing a grievance”**Legal Terms**

- What this section calls a “**complaint**” is also called a “**grievance.**”
- Another term for “**making a complaint**” is “**filing a grievance.**”
- Another way to say “**using the process for complaints**” is “**using the process for filing a grievance.**”

Section 10.3	Step-by-step: Making a complaint
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Step 1: Contact us promptly – either by phone or in writing.

- **Usually, calling Customer Service is the first step.** If there is anything else you need to do, Customer Service will let you know. 1-800-727-9712 (TTY/TDD: 711 Telecommunications Relay Service), 8:00 am to 8:00 pm, Central Time, 7 days a week.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- To use our grievance process, you should call us or send your written complaint to the address listed in *Chapter 2: Important Phone Numbers and Resources (How to contact us when you are making a complaint about your Part D prescription drugs or How to contact us when you are making a complaint about your medical care)*.

Please be sure you provide all pertinent information, including any supporting documents you believe are appropriate. Your grievance must be received by us within 60 days of the event or incident.

Your issue will be investigated by an Appeals and Grievance Coordinator who did not have any previous involvement with your case. If you submit your grievance verbally, we will verbally inform you the result of our review and our decision, unless you request a written response. If you send us a written grievance, we will send you a written response, stating the result of our review. Our notice will include a description of our understanding of your grievance, and our decision in clear terms.

We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 calendar days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest.

You also have the right to ask for a fast “expedited” grievance. A fast “expedited” grievance is a type of complaint that must be resolved within 24 hours from the time you contact us. You have the right to request a fast “expedited” grievance if you disagree with:

- Our plan to take a 14-day extension on an organization/coverage determination or reconsideration/redetermination; or
- Our denial of your request to expedite an organization/coverage determination or reconsideration for health services; or
- Our denial of your request to expedite a coverage determination or redetermination for a prescription drug.

The fast “expedited” grievance process is as follows:

- You or an authorized representative can call, fax, or mail your complaint and mention that you want the fast “expedited” grievance process. Call the phone number, fax, or write your complaint and send it to the address listed in *Chapter 2: Important Phone Numbers and Resources (How to contact us when you are making a complaint about your Part D prescription drugs or How to contact us when you are making a complaint about your medical care)*. When we receive your complaint, we will promptly investigate the issue you have identified. If we agree with your complaint, we will cancel the 14-day extension, or expedite the determination or appeal as you originally requested. Regardless of whether we agree or not, we will investigate your complaint and notify you of our decision within 24 hours.
- **Whether you call or write, you should contact Customer Service right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a “fast response” to a coverage decision or appeal, we will automatically give you a “fast” complaint.** If you have a “fast” complaint, it means we will give you **an answer within 24 hours.**

Legal Terms What this section calls a “fast complaint” is also called an “expedited grievance.”

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint.
- **If we do not agree** with some or all of your complaint or don’t take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 10.4 You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received to us by using the step-by-step process outlined above.

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).
 - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.
 - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

Chapter 10. Ending your membership in the plan

SECTION 1	Introduction	196
Section 1.1	This chapter focuses on ending your membership in our plan	196
SECTION 2	When can you end your membership in our plan?	196
Section 2.1	You can end your membership during the Annual Enrollment Period.....	196
Section 2.2	You can end your membership during the annual Medicare Advantage Disenrollment Period, but your choices are more limited	197
Section 2.3	In certain situations, you can end your membership during a Special Enrollment Period	198
Section 2.4	Where can you get more information about when you can end your membership?	199
SECTION 3	How do you end your membership in our plan?	199
Section 3.1	Usually, you end your membership by enrolling in another plan.....	199
SECTION 4	Until your membership ends, you must keep getting your medical services and drugs through our plan	201
Section 4.1	Until your membership ends, you are still a member of our plan.....	201
SECTION 5	State of KS Advantra Freedom PPO must end your membership in the plan in certain situations	201
Section 5.1	When must we end your membership in the plan?	201
Section 5.2	We <u>cannot</u> ask you to leave our plan for any reason related to your health.....	202
Section 5.3	You have the right to make a complaint if we end your membership in our plan	202

SECTION 1 Introduction

Section 1.1	This chapter focuses on ending your membership in our plan
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Ending your membership in State of KS Advantra Freedom PPO may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave.
 - There are only certain times during the year, or certain situations, when you may voluntarily end your membership in the plan. Section 2 tells you *when* you can end your membership in the plan.
 - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your medical care and prescription drugs through our plan until your membership ends.

NOTE: If you are part of an employer group, you may have restrictions regarding when you may disenroll from this plan, or may prohibit you from re-enrolling at a later date if you terminate your coverage. Contact your employer group for disenrollment information.

SECTION 2 When can you end your membership in our plan?

You may end your membership in our plan only during certain times of the year, known as enrollment periods. All members have the opportunity to leave the plan during the Annual Enrollment Period and during the annual Medicare Advantage Disenrollment Period. In certain situations, you may also be eligible to leave the plan at other times of the year.

Section 2.1	You can end your membership during the Annual Enrollment Period
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You can end your membership during the **Annual Enrollment Period** (also known as the “Annual Coordinated Election Period”). This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

- **When is the Annual Enrollment Period?** This happens from October 15 to December 7 in 2011.

- **What type of plan can you switch to during the Annual Enrollment Period?**
During this time, you can review your health coverage and your prescription drug coverage. You can choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:
 - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
 - Original Medicare *with* a separate Medicare prescription drug plan.
 - – *or* – Original Medicare *without* a separate Medicare prescription drug plan.
 - **If you receive Extra Help from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. (“Creditable” coverage means the coverage is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.) See Chapter 6, Section 10 for more information about the late enrollment penalty.

- **When will your membership end?** Your membership will end when your new plan’s coverage begins on January 1.

Section 2.2 You can end your membership during the annual Medicare Advantage Disenrollment Period, but your choices are more limited

You have the opportunity to make *one* change to your health coverage during the annual **Medicare Advantage Disenrollment Period**.

- **When is the annual Medicare Advantage Disenrollment Period?** This happens every year from January 1 to February 14.
- **What type of plan can you switch to during the annual Medicare Advantage Disenrollment Period?** During this time, you can cancel your Medicare Advantage Plan enrollment and switch to Original Medicare. If you choose to switch to Original Medicare during this period, you have until February 14 to join a separate Medicare prescription drug plan to add drug coverage.
- **When will your membership end?** Your membership will end on the first day of the month after we get your request to switch to Original Medicare. If you also choose to

enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

Section 2.3	In certain situations, you can end your membership during a Special Enrollment Period
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In certain situations, members of State of KS Advantra Freedom PPO may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you are eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (<http://www.medicare.gov>):
 - Usually, when you have moved.
 - If you have Medicaid.
 - If you are eligible for Extra Help with paying for your Medicare prescriptions.
 - If we violate our contract with you.
 - If you are getting care in an institution, such as a nursing home or long-term care hospital.
 - If you enroll in the Program of All-inclusive Care for the Elderly (PACE).
- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.
- **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
 - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
 - Original Medicare *with* a separate Medicare prescription drug plan.
 - – *or* – Original Medicare *without* a separate Medicare prescription drug plan.
 - **If you receive Extra Help from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment

penalty if you join a Medicare drug plan later. (“Creditable” coverage means the coverage is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.) See Chapter 6, Section 10 for more information about the late enrollment penalty.

- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plan.

Section 2.4	Where can you get more information about when you can end your membership?
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If you have any questions or would like more information on when you can end your membership:

- You can **call Customer Service** (phone numbers are on the back cover of this booklet).
- You can find the information in the *Medicare & You 2012* Handbook.
 - Everyone with Medicare receives a copy of *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.
 - You can also download a copy from the Medicare website (<http://www.medicare.gov>). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 3 **How do you end your membership in our plan?**

Section 3.1	Usually, you end your membership by enrolling in another plan
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Usually, to end your membership in our plan, you simply enroll in another Medicare plan during one of the enrollment periods (see Section 2 for information about the enrollment periods). However, if you want to switch from our plan to Original Medicare *without* a Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. (Contact Customer Service if you need more information on how to do this.)
- --or-- You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if

you join a Medicare drug plan later. (“Creditable” coverage means the coverage is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.) See Chapter 6, Section 10 for more information about the late enrollment penalty.

The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	This is what you should do:
<ul style="list-style-type: none"> • Another Medicare health plan. 	<ul style="list-style-type: none"> • Enroll in the new Medicare health plan. <p>You will automatically be disenrolled from State of KS Advantra Freedom PPO when your new plan’s coverage begins.</p>
<ul style="list-style-type: none"> • Original Medicare <i>with</i> a separate Medicare prescription drug plan. 	<ul style="list-style-type: none"> • Enroll in the new Medicare prescription drug plan. <p>You will automatically be disenrolled from State of KS Advantra Freedom PPO when your new plan’s coverage begins.</p>
<ul style="list-style-type: none"> • Original Medicare <i>without</i> a separate Medicare prescription drug plan. <ul style="list-style-type: none"> ○ Note: If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. See Chapter 6, Section 10 for more information about the late enrollment penalty. 	<ul style="list-style-type: none"> • Send us a written request to disenroll. Contact Customer Service if you need more information on how to do this (phone numbers are on the back cover of this booklet). • You can also contact Medicare, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from State of KS Advantra Freedom PPO when your coverage in Original Medicare begins.

SECTION 4 Until your membership ends, you must keep getting your medical services and drugs through our plan

Section 4.1 Until your membership ends, you are still a member of our plan
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If you leave State of KS Advantra Freedom PPO, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care and prescription drugs through our plan.

- **You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy including through our mail-order pharmacy services.
- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 State of KS Advantra Freedom PPO must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

State of KS Advantra Freedom PPO must end your membership in the plan if any of the following happen:

- If you do not stay continuously enrolled in Medicare Part A and Part B.
- If you move out of our service area for more than six months.
 - If you move or take a long trip, you need to call Customer Service to find out if the place you are moving or traveling to is in our plan's area.
 - If you have been a member of our plan continuously since before January 1999 *and* you were living outside of our service area before January 1999, you may continue your membership. However, if you move and your move is to another location that is outside of our service area, you will be disenrolled from our plan.
- If you become incarcerated (go to prison).

- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
 - We cannot make you leave our plan for this reason unless we get permission from Medicare first.
- If you let someone else use your membership card to get medical care.
 - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you are no longer an eligible retiree or dependent of a retiree of the Plan Sponsor.

Where can you get more information?

If you have questions or would like more information on when we can end your membership:

- You can call **Customer Service** for more information (phone numbers are on the back cover of this booklet).

Section 5.2 We cannot ask you to leave our plan for any reason related to your health

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can make a complaint about our decision to end your membership. You can also look in Chapter 9, Section 10 for information about how to make a complaint.

Chapter 11. Legal notices

SECTION 1 Notice about governing law 204
SECTION 2 Notice about nondiscrimination 204

SECTION 1 Notice about governing law

Many laws apply to this *Evidence of Coverage* and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage Plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

Chapter 12. Definitions of important words

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Annual Enrollment Period – A set time each fall when members can change their health or drugs plans or switch to Original Medicare. The Annual Enrollment Period is from October 15 until December 7, 2011.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for a drug, item, or service you think you should be able to receive. Chapter 9 explains appeals, including the process involved in making an appeal.

Balance Billing – A situation in which a provider (such as a doctor or hospital) bills a patient more than the plan's cost-sharing amount for services. As a member of State of KS Advantra Freedom PPO, you only have to pay the plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" you. See Chapter 4, Section 1.3 for more information about balance billing.

Benefit Period – The way that Original Medicare measures your use of hospital services and the way both our plan and Original Medicare measure your use of skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent \$4,700 in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

Coinsurance – An amount you may be required to pay as your share of the cost for services or prescription drugs. Coinsurance is usually a percentage (for example, 20%).

Combined Maximum Out-of-Pocket Amount – This is the most you will pay in a year for all services from both network (preferred) providers and out-of-network (non-preferred) providers. See Chapter 4, Section 1.2 for information about your combined maximum out-of-pocket amount.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor’s visit, hospital outpatient visit, or a prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay \$10 or \$20 for a doctor’s visit or prescription drug.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services or drugs are received. Cost sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed “copayment” amount that a plan requires when a specific service or drug is received; or (3) any “coinsurance” amount, a percentage of the total amount paid for a service or drug, that a plan requires when a specific service or drug is received.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of four (4) cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn’t covered under your plan, that isn’t a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called “coverage decisions” in this booklet. Chapter 9 explains how to ask us for a coverage decision.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

Covered Services – The general term we use in this EOC to mean all of the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care that can be provided by people who don’t have professional skills or training, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also

include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Customer Service – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Customer Service.

Deductible – The amount you must pay for health care or prescriptions before our plan begins to pay.

Disenroll or Disenrollment – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs such as the pharmacist's time to prepare and package the prescription.

Durable Medical Equipment – Certain medical equipment that is ordered by your doctor for use at home. Examples are walkers, wheelchairs, or hospital beds.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care – Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor's formulary (a formulary exception), or get a non-preferred drug at the preferred cost-sharing level (a tiering exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a “generic” drug works the same as a brand name drug and usually costs less.

Grievance - A type of complaint you make about us or one of our network providers or pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Home Health Aide – A home health aide provides services that don’t need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Initial Coverage Limit – The maximum limit of coverage under the Initial Coverage Stage.

Initial Coverage Stage – This is the stage before your total drug expenses have reached \$2,930, including amounts you’ve paid and what our plan has paid on your behalf.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part B. For example, if you’re eligible for Part B when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

In-Network Maximum Out-of-Pocket Amount – The most you will pay for covered services received from network (preferred) providers. After you have reached this limit, you will not have to pay anything when you get covered services from network providers for the rest of the contract year. However, until you reach your combined out-of-pocket amount, you must continue to pay your share of the costs when you seek care from an out-of-network (non-preferred) provider. See Chapter 4, Section 1.2 for information about your in-network maximum out-of-pocket amount.

Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive Extra Help from Medicare to pay your prescription drug plan costs, the late enrollment penalty rules do not apply to you. If you receive Extra Help, you do not pay a penalty, even if you go without “creditable” prescription drug coverage.

List of Covered Drugs (Formulary or “Drug List”) – A list of prescription drugs covered by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand name and generic drugs.

Low Income Subsidy – See “Extra Help.”

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3 for more information about a medically accepted indication.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, a Medicare Cost Plan, a PACE plan, or a Medicare Advantage Plan.

Medicare Advantage Disenrollment Period – A set time each year when members in a Medicare Advantage plan can cancel their plan enrollment and switch to Original Medicare. The Medicare Advantage Disenrollment Period is from January 1 until February 14, 2012.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare Cost Plan – A Medicare Cost Plan is a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand name drugs to Part D enrollees who have reached the Coverage Gap Stage and who are not already receiving “Extra Help.” Discounts are based on agreements between the Federal government and certain drug manufacturers. For this reason, most, but not all, brand name drugs are discounted.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the

plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

“Medigap” (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill “gaps” in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or “Plan Member”) – A person with Medicare who is eligible to get covered services, who has enrolled in our plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Network Pharmacy – A network pharmacy is a pharmacy where members of our plan can get their prescription drug benefits. We call them “network pharmacies” because they contract with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider – “Provider” is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them “**network providers**” when they have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Our plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as “plan providers.”

Organization Determination - The Medicare Advantage organization has made an organization determination when it, or one of its providers, makes a decision about whether services are covered or how much you have to pay for covered services. Organization determinations are called “coverage decisions” in this booklet. Chapter 9 explains how to ask us for a coverage decision.

Original Medicare (“Traditional Medicare” or “Fee-for-service” Medicare) – Original Medicare is offered by the government, and not a private health plan such as Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Orphan Drug – Any drug that is approved by the Food & Drug Administration (FDA) to treat a rare disease or condition. The FDA is responsible for determining what qualifies as a rare disease or condition.

Out-of-Network Pharmacy – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. As explained in this Evidence of Coverage, most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

Out-of-Pocket Costs – See the definition for “cost sharing” above. A member's cost-sharing requirement to pay for a portion of services drugs received is also referred to as the member's “out-of-pocket” cost requirement.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

Part C – see “Medicare Advantage (MA) Plan.”

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Primary Care Physician (PCP) – Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care

and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider. See Chapter 3, Section 2.1 for information about Primary Care Physicians.

Prior Authorization – Approval in advance to get services or certain drugs that may or may not be on our formulary. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other network provider gets “prior authorization” from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4. Some drugs are covered only if your doctor or other network provider gets “prior authorization” from us. Covered drugs that need prior authorization are marked in the formulary.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Service Area – A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it’s also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you move out of the plan’s service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drugs plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting “Extra Help” with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by the Social Security Administration to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Care – Urgently needed care is care provided to treat a non-emergency, unforeseen medical illness, injury, or condition, that requires immediate medical care, but the plan's network of providers is temporarily unavailable or inaccessible.

State of KS Advantra Freedom PPO Customer Service

CALL	1-800-727-9712 Calls to this number are free. 8:00 am to 8:00 pm, Central Time, 7 days a week. After hours, our automated system will allow you to check the status of a claim, check the status of an authorization request, or request a replacement member ID Card. Customer Service also has free language interpreter services available for non-English speakers.
TTY/TDD	711 Telecommunications Relay Service This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8:00 am to 8:00 pm, Central Time, 7 days a week.
FAX	1-866-759-4415
WRITE	Advantra Customer Service PO Box 7370 London, KY 40742
WEBSITE	http://member.coventry-medicare.com

State Health Insurance Assistance Program

The State Health Insurance Assistance Program is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

For information on how to contact the State Health Insurance Assistance Program, see Chapter 2, Section 3 of this booklet.

**Advantra Freedom (PPO)
Advantra Advantage (HMO)
Employer Group
(Tier 1 Gap Coverage)**

2012 Formulary

(List of Covered Drugs)

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

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

Beneficiaries must use network pharmacies to access their prescription drug benefit. Benefits, formulary, pharmacy network, premium and/or copayments/coinsurance may change on January 1, 2013.

A Coordinated Care Plan with a Medicare Advantage contract.

This document may be available for free in other alternative formats. Please call 1-866-294-9803-PPO or 1-866-505-6162- HMO (TTY/TDD users only: 711 Telecommunications Relay Services), 24 hours a day, 7 days a week if you need plan information in another format.



What is the Advantra Freedom (PPO) and Advantra Advantage (HMO) Formulary?

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

Can the Formulary change?

Generally, if you are taking a drug on our 2012 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2012 coverage year except when a new, less expensive generic drug becomes available or when new adverse information about the safety or effectiveness of a drug is released. Other types of formulary changes, such as removing a drug from our formulary, will not affect members who are currently taking the drug. It will remain available at the same cost-sharing for those members taking it for the remainder of the coverage year. We feel it is important that you have continued access for the remainder of the coverage year to the formulary drugs that were available when you chose our plan, except for cases in which you can save additional money or we can ensure your safety.

If we remove drugs from our formulary, or add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 60 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 60-day supply of the drug. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug. The enclosed formulary is current as of 08/10/2011. To get updated information about the drugs covered by Advantra Freedom (PPO) and Advantra Advantage (HMO), please call Customer Service at:

Advantra Freedom (PPO) 1-866-294-9803

Advantra Advantage (HMO) 1-866-505-6162

24 hours a day, 7 days a week. TTY/TDD users should call 711 Telecommunications Relay Services.

In the event of a mid-year non-maintenance formulary change such as changing a preferred or non-preferred formulary drug, adding an additional requirement or limit to a drug, removing a dosage form, or exchanging therapeutic alternatives by adding or deleting a drug or changing a tier as a result of a therapeutic alternative, we will notify you by providing you with a written notice of the non-maintenance formulary change. In addition, we will also update our online searchable formulary.

How do I use the Formulary?

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

Medical Condition

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

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page i1. The Index provides an alphabetical list of all of the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

Advantra Freedom (PPO) and Advantra Advantage (HMO) covers both brand name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand name drug. Generally, generic drugs cost less than brand name drugs.

Are there any restrictions on my coverage?

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

Prior Authorization: Advantra Freedom (PPO) and Advantra Advantage (HMO) requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from Advantra Freedom (PPO) and Advantra Advantage (HMO) before you fill your prescriptions. If you don't get approval, Advantra Freedom (PPO) and Advantra Advantage (HMO) may not cover the drug.

Quantity Limits: For certain drugs, Advantra Freedom (PPO) and Advantra Advantage (HMO) limits the amount of the drug that Advantra Freedom (PPO) and Advantra Advantage (HMO) will cover. For example, Advantra Freedom (PPO) and Advantra Advantage (HMO) provides not more than 2 inhalers per prescription for ProAir HFA per 30 days. This may be in addition to a standard one month or three month supply.

Step Therapy: In some cases, Advantra Freedom (PPO) and Advantra Advantage (HMO) requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, Advantra Freedom (PPO) and Advantra Advantage (HMO) may not cover Drug B unless you try Drug A first. If Drug A does not work for you, Advantra Freedom (PPO) and Advantra Advantage (HMO) will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 1.

You can ask Advantra Freedom (PPO) and Advantra Advantage (HMO) to make an exception to these restrictions or limits. See the section, "How do I request an exception to the Advantra Freedom (PPO) and Advantra Advantage (HMO) formulary?" on page iv for information about how to request an exception.

What are over-the counter (OTC) drugs?

OTC drugs are non-prescription drugs that are not normally covered by a Medicare Prescription Drug Plan. Advantra Freedom (PPO) and Advantra Advantage (HMO) pays for certain OTC drugs. In addition, all have quantity limits:

Drug Name	Type	Strength
Loratadine	Tablets	10mg
Loratadine	Dissolve Tablets	10mg
Loratadine	Syrup	5mg/5 ml
Loratadine and Pseudoephedrine Sulfate	12 Hour Tablets	5mg/120mg
Loratadine and Pseudoephedrine Sulfate	24 Hour Tablets	10mg/240mg
Cetirizine	Tablets	5mg
Cetirizine	Tablets	10 mg
Cetirizine	Chewable Tablets	5mg
Cetirizine	Chewable Tablets	10 mg
Cetirizine	Syrup	1 mg/ml
Cetirizine HCL and Pseudoephedrine Hydrochloride	12 Hour Tablets	5 mg/120 mg

Advantra Freedom (PPO) and Advantra Advantage (HMO) will provide these OTC drugs at no cost to you. The cost to Advantra Freedom (PPO) and Advantra Advantage (HMO) of these OTC drugs will not count toward your total drug costs.

What if my drug is not on the Formulary?

If your drug is not included in this formulary, you should first contact Customer Service and confirm that your drug is not covered. If you learn that Advantra Freedom (PPO) and Advantra Advantage (HMO) does not cover your drug, you have two options:

- You can ask Customer Service for a list of similar drugs that are covered by Advantra Freedom (PPO) and Advantra Advantage (HMO). When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by Advantra Freedom (PPO) and Advantra Advantage (HMO).
- You can ask Advantra Freedom (PPO) and Advantra Advantage (HMO) to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the Advantra Freedom (PPO) and Advantra Advantage (HMO)'s Formulary?

You can ask Advantra Freedom (PPO) and Advantra Advantage (HMO) to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover your drug even if it is not on our formulary.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, Advantra Freedom (PPO) and Advantra Advantage (HMO) limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.
- You can ask us to provide a higher level of coverage for your drug. If your drug is contained in our Non-Preferred Brand Drugs Tier, the highest tier subject to the tiering exceptions process tier, you can ask us to cover it at the cost-sharing amount that applies to drugs in the Preferred Brand Tier, the lowest tier

subject to the tiering exceptions process instead. This would lower the amount you must pay for your drug. Please note, if we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug. Also, you may not ask us to provide a higher level of coverage for drugs that are in the tier designated as the high-cost/unique drug tier.

Generally, Advantra Freedom (PPO) and Advantra Advantage (HMO) will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower-tiered drug or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

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

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

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

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

If you are a resident of a long-term care facility, we will allow you to refill your prescription until we have provided you with a 91-day transition supply, consistent with the dispensing increment, (unless you have a prescription written for fewer days). We will cover more than one refill of these drugs for the first 90 days you are a member of our plan. If you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug (unless you have a prescription for fewer days) while you pursue a formulary exception.

For current members who are changing from one treatment setting to another, for example entering a long-term care facility from a hospital or being discharged from a hospital to home, the member and provider will need to utilize our exception and appeals process should the drugs not be on our formulary. Members entering or being discharged from a long-term care facility will be allowed a one time emergency supply of a 31-day supply for medications which the member has not already received a transition supply. In addition, the dispensing pharmacist will be able to override early refill edits, where appropriate, for members entering or being discharged from a long-term care facility where beneficiaries are not allowed to take their previously filled medications with them to their new location.

For more information

For more detailed information about your Advantra Freedom (PPO) and Advantra Advantage (HMO) prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about Advantra Freedom (PPO) and Advantra Advantage (HMO), please call Customer Service at

Advantra Freedom (PPO) 1-866-294-9803

Advantra Advantage (HMO) 1-866-505-6162

24 hours a day, 7 days a week. TTY/TDD users should call 711 Telecommunications Relay Services.

Or visit

Advantra Freedom (PPO) and Advantra Advantage (HMO) - <http://chcadvantra.com>

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

Advantra Freedom (PPO) and Advantra Advantage (HMO)'s Formulary

The formulary that begins on page 1 provides coverage information about some of the drugs covered by Advantra Freedom (PPO) and Advantra Advantage (HMO) (“the plan”). If you have trouble finding your drug in the list, turn to the Index that begins on page i1.

How to Read the Drug List

The formulary drug list that begins on page 1 is set up like a table to make it easy to read. The column headers look as follows:

A Drug Name	B Drug Notes	C Plan Name Appears Here	
		D Tier	E Plan Notes

A. The first column of the chart is the “Drug Name”. This column will list out the names of drugs. Brand name drugs are capitalized (e.g., COUMADIN) and generic drugs are listed in lower-case italics (e.g., *warfarin*).

B. The second column is called “Drug Notes”. This column will list the requirements that apply to that drug in all cases where the drug is covered on the plan’s formulary.

C. The remaining columns are specific to the plan you are enrolled in. The name of the plan will appear on top of the “Tier” and “Plan Notes” columns.

D. The “Tier” column defines the type of drug and the copayment and/or coinsurance level. Please refer to “Explanation of Cost-Sharing Tiers” on page viii for an explanation of the cost-share tiers and the levels of coverage. In addition, please refer to your Summary of Benefits for the exact amounts you pay for the drugs in each cost-sharing tier.

E. The “Plan Notes” column defines the special requirements that apply to the drug on your plan’s formulary where the note is listed. The requirements under “Plan Notes” are in addition to those listed under “Drug Notes”.

DRUG NOTES

The following list contains an explanation of the abbreviations you will see in the “Drug Notes” column. These are the special requirements that apply to the drug in all cases where the drug is covered on the formulary.

Medicare Part B v. Medicare Part D | B v D

This drug requires a prior authorization to determine if this drug may be covered under Medicare Part B or Part D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

90-day Long-Term Supply | 90D

The plan provides a long-term (extended day) supply up to 90 days of these drugs.

High Risk Medications | HRM

The plan recognizes that there are certain medications that are considered high risk medications. We encourage you to speak with your doctor if you are prescribed one of these medications to see if there may be other alternatives available to you.

Limited Distribution | LD

This prescription may be available only at certain pharmacies. For more information call Customer Service at the telephone numbers provided on the cover of this formulary.

Quantity Limits | QL

The plan will only cover a certain amount of these drugs for one copay/coinsurance or over a defined number of days. These limits may be in place to ensure safe and efficient use of a drug. If your doctor prescribes more than this amount or thinks the limit is not right for your situation, you or your doctor can ask the plan to cover the additional quantity.

PLAN NOTES

The following list contains an explanation of the abbreviations you will see in the “Plan Notes” column. These are the special requirements that apply to the drug on your plan’s formulary where the note is listed

Prior Authorization | PA

You or your doctor must provide additional information to the plan before the plan will cover this drug. The plan uses this information to help ensure the drug is covered appropriately for Medicare-eligible health conditions. In some cases you may be asked to try another drug on the formulary before the plan covers the drug you are requesting. If you do not get approval, your drug may not be covered by the plan, and you would be responsible for the full cost.

Step Therapy | ST

There are effective, clinically proven lower-cost alternatives to this drug that treat the same health condition. The plan may require that you try an alternative drug for your health condition before the plan will cover the drug you are requesting. If you have already tried other drugs or your doctor thinks other drugs are not right for your situation, you or your doctor can ask the plan to cover these drugs.

Non-Formulary | NF

This drug is a non-formulary drug. The plan does not include this drug on its formulary. You or your doctor may request an exception. Your doctor will need to provide a supporting statement for an exception.

Drugs Covered in the GAP Phase | G

We provide additional coverage of this prescription drug in the coverage gap. Please refer to your Summary of Benefits and Evidence of Coverage for more information about this coverage.

Explanation of Cost-Sharing Tiers

Every drug on the formulary is in one of 4 cost-sharing tiers. When you review the drug list that appears on page 1, the column called “Tier” will show whether the drug is on Tier 1, 2, 3, or 4. In general, the higher the cost-sharing tier, the higher your cost for the drug. Here is how the plan defines its cost-sharing tiers:

Four Tier Plans – Advantra Freedom (PPO) and Advantra Advantage (HMO)

Tier 1 – “Preferred Generic Drugs”

For the lowest out-of-pocket cost, you and your doctor should decide if Tier 1 medications are right for your treatment.

Tier 2 - “Preferred Brand Drugs”

Some Tier 2 drugs have lower-cost Tier 1 options that you may consider with your doctor.

Tier 3 - “Non-Preferred Brand Drugs”

Drugs in Tier 3, which include brand and some generic drugs, usually have lower-cost treatment options in Tier 1 or Tier 2. If you along with your prescribing physician request a formulary exception for a non-formulary drug (a drug that is not on our drug list) and your request is approved, the non-formulary drug will be treated as a Tier 3 drug and you will be responsible for the cost-share of a Tier 3 drug.

Tier 4 – “Specialty Tier Drugs”

Includes very high-cost/unique drugs. Tier 4 includes both brand and generic drugs.

Where Can I Find the Actual Costs Associated With The Cost-Share Tiers?

Please refer to your Summary of Benefits for the exact amounts you pay for the drugs in each cost-sharing tier.

If you are in a program that helps pay for your drugs, we mail an insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider), that tells you about your drug coverage. This Rider also lists the amount you pay for drugs in each cost-sharing tier. You can also contact Customer Service at the telephone numbers on the cover of this formulary to find out what your costs are in this situation.

Network Pharmacies

We have over 60,000 pharmacies in our network across the United States and the District of Columbia. That means you can have your covered prescription drugs filled at any network pharmacy in the area even

if you are traveling for business or leisure. A listing of all our network pharmacies is provided in our Pharmacy Directory and on our website at <http://PharmacyLocator.coventry-medicare.com>.

Limited Distribution of Some Drugs

Some drugs may be subject to limited distribution or restricted access. This means that a drug may only be available at certain pharmacies. These pharmacies dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

The drug list provided identifies those drugs that will need to be purchased at specific specialty pharmacies within the network. If you have questions, please contact Customer Service at the telephone numbers provided on the cover of this formulary.

Mail Order

We are pleased to also offer Mail-Order services to all of our members. Our mail-order service, in general, is designed for those medications that members may take on an ongoing basis. It is a great way to purchase and receive your medications. You can obtain up to a 90-day supply of your prescription medications through mail order.

Please note that the actual quantity and/or days' supply may vary for each prescription. Your doctor's instructions on how to take the medication, state and federal dispensing guidelines, or how the medication is packaged may impact the quantity and/or days' supply you can receive.

What is the timeframe for Mail-Order

First-time orders will usually be delivered within 8 to 11 days after your order is received.

- Refills usually arrive in less time. Refills ordered online are usually delivered within 5 to 8 days after your order is received.
- New and renewal prescriptions faxed from your doctor will usually be delivered in 5 to 8 days.

How are medications shipped?

Most medications are shipped via the U.S. Postal Service at no cost to you. Medications containing certain controlled substances are shipped United Parcel Service (UPS). If necessary, you can request express shipping for an additional fee.

What if I need to speak with a pharmacist?

Our registered pharmacists are available 24 hours a day, seven days a week to answer any questions about your medications. Please call Customer Service at the telephone numbers listed on the cover.

How Much Do I Pay For Mail Order?

The amount you pay for covered drugs through our Medco-By-Mail service may be lower than if you purchase them at a network pharmacy. Please refer to Chapter 6, "What you pay for your Part D prescription drugs" in your Evidence of Coverage for your cost-shares for drugs purchased through Mail Order.

Cancelling your order

If you fill your prescription through our mail order service, please be advised that we do not notify you in advance to let you know when your order will be shipped to you. Should you change your mind about having your prescription filled through our mail order service, you must call us immediately at the Customer Service telephone number on the back of your member ID card and request that we cancel your order. If you do not request that we cancel your order, your medication will be shipped to you and if a copayment/coinsurance is required, you will be charged when your order is shipped.

Please note: If your cancellation request is received AFTER your order has been processed, you may still be charged for your order.

For additional information about our mail order cancellation policy, please contact Customer Service at the telephone number on the back of your member ID card.

Can I return my medication for a refund or credit?

Once an order has been properly dispensed and shipped, which means there was no error on the part of the plan, we will not accept the return of your medication for a refund or credit. This policy is based in part on certain federal and state laws which are designed to ensure the integrity of prescription medications that have been properly dispensed.

We do make an exception in cases where the plan has made an error, where in those cases, we may request that you return the medication to us (we will pay for the shipping), so we can destroy it and refund or credit you for any charges incurred.

What should I do with my expired or unused medication?

Please contact Customer Service for general instructions on how to dispose of your expired or unused medication.

Working with your doctor or other prescriber

If we receive a prescription directly from your doctor or other prescriber, we will work with your doctor or other prescriber to fill your prescription. In some cases, we may contact your doctor or other prescriber if we have questions about your prescription before it is filled and shipped to you. To ensure that you are properly informed of any changes to your prescription that your doctor or other prescriber may make, we ask that you contact your doctor or other prescriber before your prescription is filled and shipped to you to learn if there were any changes to your prescription that you may not agree with.

If your medication has been shipped, we will not be able to accept it if you return it to us. We cannot accept the return of properly dispensed prescription medications for credit or refund.

Generic Substitution

If your doctor or other prescriber writes a prescription for a brand drug, we may substitute it for a generic drug where appropriate and in compliance with state law. For example, if your doctor or other prescriber writes a prescription for a brand drug (and a generic equivalent is available) but did not indicate “dispense as written,” or “brand only,” we may dispense the generic equivalent drug instead, if permitted to do so. Please also refer to Chapter 5, “Using the plan’s coverage for your Part D prescription drugs, Section 4.2, “What kinds of restriction?” in your Evidence of Coverage for additional information.

Automatic credit card charge for mail order drugs

For your convenience, we have several different methods that you can use to pay for your prescriptions that are filled through our mail order service. You may pay by personal check, electronic funds transfer, money order or credit card. If you agree to pay by credit card, we will contact you by telephone and request your approval in situations where the total order exceeds \$350.00, before we charge your credit card. Please also note that the shipment of your order will be delayed until we get your approval.

If you have given us your approval in the past on orders exceeding \$350.00, we will use this previous approval as the basis for charging your credit card for any future orders that exceed \$350.00. Therefore, we will not contact you for your approval to charge your credit card each time your order exceeds \$350.00, so long as we have your previous approval and you have not withdrawn this approval.

Handling of mail order claims that are close to the end of the year

Unless you have notified us otherwise, mail order requests received towards the end of the benefit year will be processed for the current benefit year and your TrOOP and drug spend amounts will be applied to your current benefit year.

If you would like us to process your request for the upcoming benefit year, instead of the current benefit year, you must notify us in writing of your request and we will place your prescription on hold for a future date not greater than 90 days from the date of your request.

Drugs Packaged to Provide an Extended Day Supply

Some drugs are packaged by the manufacturer to provide greater than a 30-day supply, such as medroxyprogesterone acetate injection. In these cases you may be responsible for paying multiple copayments for a single prescription when filling a packaged drug that would normally provide greater than a 30-day supply. For more information please call the toll-free Customer Service number located on the cover.

Early Refills

We have guidelines regarding refilling your prescription too early. These guidelines are designed for your safety and to minimize the excessive use, waste and stockpiling of prescription medications. In general, the plan does not cover early refills.

To avoid having a refill delayed, you may want to use these guidelines. Please note these are simply guidelines.

- For a 30-day retail prescription, order a refill when you have no more than a seven (7) -day supply left. (For a 30-day mail order prescription, you may order the refill a few days earlier, to ensure you receive the refill before the medication on hand is used.)
- For a 90-day retail or mail order prescription, request the refill when you have no more than a 14-day supply remaining.

The determination of whether your prescription is filled too early is based on a number of factors such as:

- a. The original prescription from your physician, including his/her instructions for dosage;
- b. Refills you have purchased of the same prescription drug previously; and
- c. How much of the prescription drug you still should have on-hand based on your previous refills and your physician's instructions on dosage.

If you order a refill at a network pharmacy too soon, you will be asked to wait until the allowable refill date. If you order the refill through our mail order service too soon, the mail-order service may hold the refill until the allowable date.

Vaccines

Your prescription drug benefit covers vaccines for meningitis, shingles, diphtheria, tetanus and more. Some vaccines, like those for the flu and pneumonia, are covered by Medicare Part B. The cost for vaccines depends on where you have it administered.

For the best coverage, we recommend that you get vaccines at a network pharmacy, if your state allows it. The administration fee (the service cost that the healthcare professional charges for giving the vaccine) will likely be lower, so it could save you money. Please refer to your Evidence of Coverage for description on other coverage methods for vaccines and information on how these vaccines are paid for. If you don't see the vaccine you need listed in the drug list, call Customer Service at the telephone numbers provided on the cover of this formulary. They can see if the vaccine is covered and send you a reimbursement form if you need one.

My Online Services

My Online Services is a secure web-based tool with features that allow you to view, track and store personal health information. Through *My Online Services*, you may find a pharmacy near you, track your current medications and prescription history, track your claims and authorizations, access your health benefit information, research clinical and health-related information, request an ID card, update your address and more.

To register for *My Online Services*, you must be an enrolled member and the registration process is easy. Go to <http://www.kc.chcadvantra.com> and click on *My Online Services* located at the top of the screen. You will need your member ID number (found on the back of your card), your zip code, your date of birth and your e-mail address.

Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Analgesics			
Nonsteroidal Anti-inflammatory Drugs			
PENNSAID DROPS QL-300ML 30 DAYS	QL	3	
VIMOVO TAB QL-60 QY 30 DY	90D; QL	2	
Opioid Analgesics			
ABSTRAL TAB, SUBL QL-120 QY 30 DY	QL	4	PA
<i>apap/caffeine/dihydrocodeine tab QL-150 QY 30 DY</i>	QL	3	
<i>apap/codeine elixir QL-4950 QY 30 DY</i>	QL	1	G
<i>apap/codeine tab QL-390 QY 30 DY</i>	QL	1	G
<i>ascomp/codeine cap</i>		3	
<i>butalbital/apap/caffeine/codeine cap QL-180 QY 30 DY</i>	QL	3	
<i>butorphanol tart aero</i>		3	
CAPITAL/CODEINE SUSP QL-4950 QY 30 DY	QL	2	
<i>codeine sulfate tab</i>		3	
<i>duramorph ampul</i>		1	G
EMBEDA 100MG CAP		3	
EMBEDA 20MG CAP QL-60 QY 30 DY	QL	3	
EMBEDA 30MG CAP QL-60 QY 30 DY	QL	3	
EMBEDA 50MG CAP QL-60 QY 30 DY	QL	3	
EMBEDA 60MG CAP QL-60 QY 30 DY	QL	3	
EMBEDA 80MG CAP QL-60 QY 30 DY	QL	3	
<i>endocet 325;10mg tab QL-360 QY 30 DY</i>	QL	1	G
<i>endocet 325;5mg tab QL-360 QY 30 DY</i>	QL	1	G
<i>endocet 325;7.5mg tab QL-360 QY 30 DY</i>	QL	1	G
<i>endocet 500;7.5mg tab QL-240 QY 30 DY</i>	QL	1	G
<i>endocet 650;10mg tab QL-180 QY 30 DY</i>	QL	1	G
<i>endodan tab QL-360 QY 30 DY</i>	QL	1	G
EXALGO 12MG TAB QL-150 QY 30 DY	QL	3	
EXALGO 16MG TAB QL-120 QY 30 DY	QL	3	
EXALGO 8MG TAB QL-240 QY 30 DY	QL	3	
<i>fentanyl cit oral buccal lpop QL-120 QY 30 DY</i>	QL	4	PA
<i>fentanyl patch</i>		1	G
FENTORA TAB QL-120 QY 30 DY	QL	4	PA
<i>hydrocodone bit/apap 10/750mg tab QL-150 QY 30 DY</i>	QL	1	G

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Analgesics			
Opioid Analgesics			
<i>hydrocodone/apap soln oral QL-3600 QY 30 DY</i>	QL	1	G
<i>hydrocodone/apap tab 10/325mg QL-360 QY 30 DY</i>	QL	1	G
<i>hydrocodone/apap tab 10/500mg QL-240 QY 30 DY</i>	QL	1	G
<i>hydrocodone/apap tab 10/650mg QL-180 QY 30 DY</i>	QL	1	G
<i>hydrocodone/apap tab 10/660mg QL-180 QY 30 DY</i>	QL	1	G
<i>hydrocodone/apap tab 5/325mg QL-360 QY 30 DY</i>	QL	1	G
<i>hydrocodone/apap tab 5/500mg QL-240 QY 30 DY</i>	QL	1	G
<i>hydrocodone/apap tab 7.5/325mg QL-360 QY 30 DY</i>	QL	1	G
<i>hydrocodone/apap tab 7.5/500mg QL-240 QY 30 DY</i>	QL	1	G
<i>hydrocodone/apap tab 7.5/650mg QL-180 QY 30 DY</i>	QL	1	G
<i>hydrocodone/apap tab 7.5/750mg QL-150 QY 30 DY</i>	QL	1	G
<i>hydrocodone/apap-hs tab QL-240 QY 30 DY</i>	QL	1	G
<i>hydrocodone/ibuprofen tab</i>		3	
<i>hydromorphone 10mg/ml ampule</i>		1	G
<i>hydromorphone 1mg/ml syr</i>		1	G
<i>hydromorphone 2mg/ml syr</i>		1	G
<i>hydromorphone tab</i>		1	G
KADIAN CAP,24HR		2	
<i>levorphanol tartrate tab</i>		3	
<i>margesic-h cap QL-240 QY 30 DY</i>	QL	1	G
<i>meperidine inj</i>	HRM	3	
<i>meperidine soln oral</i>	HRM	3	
<i>meperidine tab</i>	HRM	3	
<i>meperidine vial</i>	HRM	3	
<i>methadone 10mg/ml conc oral</i>		1	G
METHADONE 10MG/ML VIAL		2	
METHADONE ORAL SOLN		2	
<i>methadone tab</i>		1	G
<i>methadose tab</i>		1	G
<i>morphine sulfate er tab, sr</i>		1	G
<i>morphine sulfate soln oral</i>		1	G
<i>morphine sulfate supp rectal</i>		1	G

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Analgesics			
Opioid Analgesics			
<i>morphine sulfate tab</i>		1	G
<i>morphine sulfate vial</i>		1	G
<i>nalbuphine vial</i>		3	
ONSOLIS QL-120 QY 30 DY	QL	4	PA
OPANA ER TAB 10MG QL-60 QY 30 DY	QL	2	
OPANA ER TAB 20MG QL-60 QY 30 DY	QL	2	
OPANA ER TAB 30MG QL-60 QY 30 DY	QL	2	
OPANA ER TAB 40MG		2	
OPANA ER TAB 5MG QL-60 QY 30 DY	QL	2	
ORAMORPH SR TAB		1	G
<i>oxycodone 10mg tab</i>		1	G
<i>oxycodone 15mg tab</i>		1	G
<i>oxycodone 20mg tab</i>		1	G
<i>oxycodone 20mg/ml conc oral</i>		1	G
<i>oxycodone 30mg tab</i>		1	G
<i>oxycodone 5mg tab</i>		1	G
<i>oxycodone-apap 325;10mg tab QL-360 QY 30 DY</i>	QL	1	G
<i>oxycodone-apap 325;7.5mg tab QL-360 QY 30 DY</i>	QL	1	G
<i>oxycodone/apap 325;2.5mg tab QL-360 QY 30 DY</i>	QL	1	G
<i>oxycodone/apap 325;5mg tab QL-360 QY 30 DY</i>	QL	1	G
<i>oxycodone/apap 500;5mg cap QL-240 QY 30 DY</i>	QL	1	G
<i>oxycodone/apap 500;7.5mg tab QL-240 QY 30 DY</i>	QL	1	G
<i>oxycodone/apap 650;10mg tab QL-180 QY 30 DY</i>	QL	1	G
<i>oxycodone/aspirin tab QL-360 QY 30 DY</i>	QL	1	G
<i>oxycodone/ibuprofen tab QL-28 QY 7 DY</i>	QL	3	
OXYCONTIN 10MG TAB12 QL-60 QY 30 DY	QL	3	PA
OXYCONTIN 15MG TAB12 QL-60 QY 30 DY	QL	3	PA
OXYCONTIN 20MG TAB12 QL-60 QY 30 DY	QL	3	PA
OXYCONTIN 30MG TAB12 QL-60 QY 30 DY	QL	3	PA
OXYCONTIN 40MG TAB12 QL-60 QY 30 DY	QL	3	PA
OXYCONTIN 60MG TAB12 QL-60 QY 30 DY	QL	3	PA
OXYCONTIN 80MG TAB12		4	PA

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Analgesics			
Opioid Analgesics			
<i>pentazocine/apap tab QL-180 QY 30 DY</i>	HRM; QL	3	
<i>pentazocine/naloxone tab</i>	HRM	3	
<i>roxicet 325;5mg tab QL-360 QY 30 DY</i>	QL	1	G
<i>roxicet 325mg/5ml;5mg/5ml oral soln QL-1800 QY 30 DY</i>	QL	2	
<i>stagesic cap QL-240 QY 30 DY</i>	QL	1	G
<i>tramadol tab</i>	90D	1	G
<i>tramadol/apap tab QL-240 QY 30 DY</i>	90D; QL	3	
<i>zlor tab QL-150 QY 30 DY</i>	QL	3	
Anesthetics			
Local Anesthetics			
<i>lidocaine jelly</i>		1	G
<i>lidocaine oint</i>	90D	1	G
<i>lidocaine soln</i>		1	G
<i>lidocaine vial</i>		1	G
<i>lidocaine viscous soln</i>		1	G
<i>lidocaine/prilocaine cream</i>		1	G
LIDODERM PTCH QL-90 PTCH 30 DY	90D; QL	2	
Anti-inflammatory Agents			
Nonsteroidal Anti-inflammatory Drugs			
ARTHROTEC TAB	90D	3	ST
CELEBREX 100MG CAP QL-30 QY 30 DY	90D; QL	3	ST
CELEBREX 200MG CAP QL-60 QY 30 DY	90D; QL	3	ST
CELEBREX 400MG CAP QL-60 QY 30 DY	90D; QL	3	ST
CELEBREX 50MG CAP QL-60 QY 30 DY	90D; QL	3	ST
<i>diclofenac ec tab</i>	90D	1	G
<i>diclofenac potassium tab</i>	90D	1	G
<i>diclofenac tab</i>	90D	1	G
<i>diclofenac xr tab</i>	90D	1	G
<i>diflunisal tab</i>	90D	1	G
<i>etodolac cap</i>	90D	1	G
<i>etodolac er tab</i>	90D	3	
<i>etodolac tab</i>	90D	1	G

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Anti-inflammatory Agents			
Nonsteroidal Anti-inflammatory Drugs			
<i>fenoprofen calcium tab</i>	90D	1	G
<i>flurbiprofen tab</i>	90D	1	G
<i>ibuprofen tab</i>	90D	1	G
INDOCIN SUSPENSION	90D	2	
<i>indomethacin cap</i>	90D	1	G
<i>indomethacin er cap</i>	90D	3	
<i>ketoprofen cap</i>	90D	1	G
<i>ketoprofen er cap</i>	90D	3	
<i>ketorolac trometh 10mg tab QL-20 QY 5 DY</i>	HRM; QL	1	G
<i>ketorolac trometh vial 15mg QL-20 VIALS 5 DY</i>	HRM; QL	1	G
<i>meclofenamate cap</i>	90D	1	G
<i>meloxicam suspension</i>	90D	1	G
<i>meloxicam tab</i>	90D	1	G
<i>nabumetone tab</i>	90D	1	G
NALFON CAP	90D	3	
<i>naproxen 275mg tab</i>	90D	1	G
<i>naproxen 550mg tab</i>	90D	1	G
<i>naproxen dr tabec 375 & 500mg</i>	90D	1	G
<i>naproxen oral suspension</i>	90D	1	G
<i>naproxen tab 250 & 375mg tabs</i>	90D	1	G
<i>oxaprozin tab</i>	90D	1	G
<i>piroxicam cap</i>	90D	1	G
<i>sulindac tab</i>	90D	1	G
<i>tolmetin cap</i>	90D	3	
<i>tolmetin tab</i>	90D	3	
Antibacterials			
Aminoglycosides			
<i>amikacin sulfate vial</i>		1	G
<i>gentamicin sulfate vial</i>		1	G
<i>gentamicin/0.9% sod chl iv</i>		1	G
<i>isotonic gentamicin iv</i>		1	G
<i>neomycin sulfate tab</i>		1	G

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Antibacterials			
Aminoglycosides			
<i>tobramycin sulfate 10mg/ml vial</i>		1	G
<i>tobramycin sulfate 80mg/2ml vial</i>		1	G
TOBRAMYCIN/SODIUM CHLORIDE IV		1	G
Antibacterials, Other			
<i>baciim vial</i>		3	
BACTROBAN NASAL OINT		2	
<i>chloramphenicol succ vial</i>		1	G
CLEOCIN CAP		3	
<i>clindamycin cap</i>		1	G
<i>clindamycin pediatric granules</i>		3	
<i>clindamycin phos vial</i>		1	G
<i>colistimethate vial</i>	B v D	4	PA
CUBICIN VIAL		2	PA
<i>methenamine hippurate tab</i>	90D	1	G
<i>metronidazole cap</i>		1	G
<i>metronidazole iv</i>		1	G
<i>metronidazole tab</i>		1	G
MONUROL PACKET		3	
<i>nitrofurantoin macrocrystalline cap</i>	90D; HRM	1	G
<i>nitrofurantoin monohydrate cap</i>	90D; HRM	1	G
<i>nitrofurantoin suspension</i>	90D; HRM	3	
PRIMSOL SOLN ORAL	90D	3	
<i>trimethoprim tab</i>		1	G
TYGACIL VIAL		2	PA
VANCOGIN 125MG CAP QL-56 QY 14 DY	QL	2	PA
VANCOGIN 250MG CAP QL-40 QY 10 DY	QL	2	PA
VANCOMYCIN DEXTROSE IV	B v D	1	G; PA
<i>vancomycin dextrose iv</i>	B v D	1	G; PA
<i>vancomycin vial</i>	B v D	1	G; PA
VIBATIV VIAL		3	PA

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Antibacterials			
<i>Antibacterials, Other</i>			
XIFAXAN 200MG TAB QL-120 QY 30 DY	QL	3	
ZYVOX IV		2	PA
ZYVOX ORAL SUSR QL-900ML 14 DY	QL	2	PA
ZYVOX TAB QL-28 QY 14 DY	QL	2	PA
<i>Beta-lactam, Cephalosporins</i>			
CEDAX CAP		3	
CEDAX SUSPENSION		3	
<i>cefaclor cap</i>		1	G
<i>cefaclor er tab</i>		1	G
<i>cefadroxil cap</i>		1	G
<i>cefadroxil suspension</i>		1	G
<i>cefadroxil tab</i>		1	G
<i>cefazolin iv</i>		1	G
<i>cefazolin vial</i>		1	G
<i>cefdinir cap</i>		3	
<i>cefdinir suspension</i>		3	
<i>cefditoren pivoxil tab</i>		3	
CEFEPIME IV		3	
<i>cefepime vial</i>		3	
<i>cefotaxime vial</i>		3	
CEFOTETAN VIAL		3	
CEFOTETAN/DEXTROSE IV		3	
CEFOXITIN IV		3	
<i>cefoxitin vial</i>		3	
<i>cefpodoxime proxetil suspension</i>		3	
<i>cefpodoxime proxetil tab</i>		3	
<i>cefprozil suspension</i>		3	
<i>cefprozil tab</i>		3	
<i>ceftazidime vial</i>		3	
<i>ceftriaxone vial</i>		3	
<i>ceftriaxone/dextrose iv</i>		3	
<i>cefuroxime axetil suspension</i>		1	G

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Antibacterials			
Beta-lactam, Cephalosporins			
<i>cefuroxime axetil tab</i>		1	G
<i>cefuroxime vial</i>		3	
CEFUROXIME/DEXTROSE IV		3	
<i>cephalexin cap</i>		1	G
<i>cephalexin suspension</i>		1	G
<i>cephalexin tab</i>		1	G
SUPRAX SUSPENSION		2	
TEFLARO VIAL		3	
Beta-lactam, Other			
<i>aztreonam vial</i>		1	G
CAYSTON VIAL		4	PA
INVANZ VIAL		3	
<i>meropenem vial</i>		3	
PRIMAXIN IM VIAL		3	
PRIMAXIN IV VIAL		3	
Beta-lactam, Penicillins			
<i>amoxicillin cap</i>		1	G
<i>amoxicillin chew</i>		1	G
<i>amoxicillin suspension</i>		1	G
<i>amoxicillin tab</i>		1	G
<i>amoxicillin/clav pota chew</i>		1	G
<i>amoxicillin/clav pota er tab</i>		3	
<i>amoxicillin/clav pota susp</i>		1	G
<i>amoxicillin/clav pota tab</i>		1	G
<i>ampicillin cap</i>		1	G
<i>ampicillin suspension</i>		1	G
<i>ampicillin vial</i>		1	G
<i>ampicillin-sulbactam vial</i>		3	
<i>dicloxacillin cap</i>		1	G
MOXATAG TAB QL-10 QY 10 DY	QL	3	
<i>nafcillin vial</i>		3	
OXACILLIN IV		3	

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Antibacterials			
Beta-lactam, Penicillins			
OXACILLIN VIAL		3	
<i>penicillin g potassium vial</i>		3	
PENICILLIN G PROCAINE SYRINGE		3	
<i>penicillin g vial</i>		3	
<i>penicillin v potassium suspension</i>		1	G
<i>penicillin v potassium tab</i>		1	G
<i>pfizerpen-g vial</i>		3	
PIPERACILLIN VIAL		3	
<i>piperacillin/tazobactam vial</i>		3	
TIMENTIN IV		3	
TIMENTIN VIAL		3	
Macrolides			
<i>azithromycin suspension</i>		1	G
<i>azithromycin tab</i>		1	G
<i>azithromycin vial</i>		1	G
<i>clarithromycin er tab QL-28 QY 14 DY</i>	QL	3	
<i>clarithromycin suspension</i>		1	G
<i>clarithromycin tab</i>		1	G
<i>e.e.s. 400 tab</i>		1	G
E.E.S. GRANULES		2	
<i>ery-tab 500mg tbec</i>		2	
<i>ery-tab tab</i>		2	
ERYPED SUSPENSION		2	
ERYTHROCIN LACTOBIONATE VIAL		3	
<i>erythrocin stearate tab</i>		1	G
<i>erythromycin base tab</i>		1	G
<i>erythromycin ethylsuccinate tab</i>		1	G
<i>erythromycin/sulfisoxazole suspension</i>		1	G
KETEK TAB QL-20 QY 10 DY	QL	3	
PCE TAB		2	
Quinolones			
AVELOX ABC PACK QL-30 QY 30 DY	QL	3	

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Antibacterials			
<i>Quinolones</i>			
AVELOX IV		3	
AVELOX TAB QL-30 QY 30 DY	QL	3	
CIPRO SUSPENSION		2	
<i>ciprofloxacin er 1000mg tab QL-14 QY 30 DY</i>	QL	3	
<i>ciprofloxacin er 500mg tab QL-60 QY 30 DY</i>	QL	3	
<i>ciprofloxacin tab</i>		1	G
<i>ciprofloxacin vial</i>		1	G
FACTIVE TAB QL-7 QY 30 DY	QL	2	
<i>ofloxacin tab</i>		1	G
<i>Sulfonamides</i>			
<i>sulfadiazine tab</i>	90D	1	G
<i>sulfamethoxazole/trimethoprim ds tab</i>	90D	1	G
<i>sulfamethoxazole/trimethoprim suspension</i>	90D	1	G
<i>sulfamethoxazole/trimethoprim tab</i>	90D	1	G
<i>sulfamethoxazole/trimethoprim vial</i>		1	G
<i>Tetracyclines</i>			
<i>demeclocycline tab</i>		3	
<i>doxycycline hyclate 100mg tabs</i>		1	G
<i>doxycycline hyclate caps</i>		1	G
<i>doxycycline hyclate vial</i>		1	G
<i>doxycycline monohydrate 150mg cap</i>		3	
<i>doxycycline monohydrate tab</i>		3	
<i>minocycline cap</i>		1	G
<i>tetracycline cap</i>		1	G
VIBRAMYCIN SYRUP		3	
Anticonvulsants			
<i>Anticonvulsants, Other</i>			
BANZEL SUSP 40MG/ML QL-2400 QY 30 DY	90D; QL	3	PA
BANZEL TAB 200MG QL-240 QY 30 DY	90D; QL	3	PA
BANZEL TAB 400MG QL-240 QY 30 DY	QL	4	PA
<i>levetiracetam 1000mg tab</i>	90D	1	G
<i>levetiracetam 250mg tab QL-180 QY 30 DY</i>	90D; QL	1	G

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Anticonvulsants			
<i>Anticonvulsants, Other</i>			
<i>levetiracetam 500mg tab QL-180 QY 30 DY</i>	90D; QL	1	G
<i>levetiracetam 750mg tab</i>	90D	1	G
<i>levetiracetam soln oral</i>	90D	1	G
<i>levetiracetam vial</i>		4	
VIMPAT SOLN ORAL	90D	3	PA
VIMPAT TAB QL-60 QY 30 DY	90D; QL	3	PA
VIMPAT VIAL		3	PA
<i>Calcium Channel Modifying Agents</i>			
CELONTIN CAP	90D	2	
<i>ethosuximide cap</i>	90D	1	G
<i>ethosuximide syrup</i>	90D	1	G
LYRICA 100MG CAP QL-90 QY 30 DY	QL	3	PA
LYRICA 150MG CAP QL-90 QY 30 DY	QL	3	PA
LYRICA 200MG CAP QL-90 QY 30 DY	QL	3	PA
LYRICA 225MG CAP QL-60 QY 30 DY	QL	3	PA
LYRICA 25MG CAP QL-90 QY 30 DY	QL	3	PA
LYRICA 300MG CAP QL-60 QY 30 DY	QL	3	PA
LYRICA 50MG CAP QL-90 QY 30 DY	QL	3	PA
LYRICA 75MG CAP QL-90 QY 30 DY	QL	3	PA
<i>Gamma-aminobutyric Acid (GABA) Augmenting Agents</i>			
<i>divalproex 125mg sprink cap</i>	90D	1	G
<i>divalproex er tab24</i>	90D	1	G
<i>divalproex tabec</i>	90D	1	G
<i>gabapentin cap</i>	90D	1	G
<i>gabapentin soln oral</i>	90D	1	G
<i>gabapentin tab</i>	90D	1	G
GABITRIL 12MG TAB QL-120 QY 30 DY	90D; QL	3	
GABITRIL 16MG TAB QL-90 QY 30 DY	90D; QL	3	
GABITRIL 2MG TAB QL-30 QY 30 DY	90D; QL	3	
GABITRIL 4MG TAB QL-240 QY 30 DY	90D; QL	3	
<i>primidone tab</i>	90D	1	G
SABRIL PACKET		4	PA

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Anticonvulsants			
<i>Gamma-aminobutyric Acid (GABA) Augmenting Agents</i>			
SABRIL TAB		4	PA
<i>valproate vial</i>		1	G
<i>valproic acid cap</i>	90D	1	G
<i>valproic acid syrup</i>	90D	1	G
<i>zonisamide cap</i>	90D	1	G
<i>Glutamate Reducing Agents</i>			
FELBATOL SUSPENSION	90D	2	
FELBATOL TAB	90D	2	
<i>lamotrigine 100mg tab QL-90 QY 30 DY</i>	90D; QL	1	G
<i>lamotrigine 150mg tab</i>	90D	1	G
<i>lamotrigine 200mg tab</i>	90D	1	G
<i>lamotrigine 25mg tab</i>	90D	1	G
<i>lamotrigine chew tab</i>	90D	3	
<i>topiramate 100mg tab QL-90 QY 30 DY</i>	90D; QL	1	G
<i>topiramate 200mg tab</i>	90D	1	G
<i>topiramate 25mg tab</i>	90D	1	G
<i>topiramate 50mg tab QL-90 QY 30 DY</i>	90D; QL	1	G
<i>topiramate cap, sprinkle</i>	90D	3	
<i>Sodium Channel Inhibitors</i>			
<i>carbamazepine chew</i>	90D	1	G
<i>carbamazepine er cp12</i>	90D	3	
<i>carbamazepine er tab</i>	90D	1	G
<i>carbamazepine suspension</i>	90D	1	G
<i>carbamazepine tab</i>	90D	1	G
CARBATROL CAP	90D	3	
DILANTIN CAP	90D	2	
DILANTIN INFATAB	90D	2	
DILANTIN SUSPENSION	90D	2	
<i>epitol tab</i>	90D	1	G
<i>oxcarbazepine oral susp</i>	90D	3	ST
<i>oxcarbazepine tab</i>	90D	3	ST
PEGANONE TAB	90D	3	

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Anticonvulsants			
<i>Sodium Channel Inhibitors</i>			
PHENYTEK CAP	90D	2	
<i>phenytoin ampul</i>		1	G
<i>phenytoin er cap</i>	90D	1	G
<i>phenytoin suspension</i>	90D	1	G
TEGRETOL CHEW	90D	2	
TEGRETOL SUSPENSION	90D	2	
TEGRETOL TAB	90D	2	
TEGRETOL-XR TAB	90D	2	
Antidementia Agents			
<i>Antidementia Agents, Other</i>			
<i>ergoloid mesylates tab</i>	90D; HRM	3	
<i>Cholinesterase Inhibitors</i>			
<i>donepezil odt tab QL-30 QY 30 DY</i>	90D; QL	1	G
<i>donepezil tab QL-30 QY 30 DY</i>	90D; QL	1	G
EXELON PATCH QL-30 QY 30 DY	90D; QL	2	
EXELON SOLN ORAL QL-180ML 30 DY	90D; QL	2	
<i>galantamine cap,24hr QL-30 QY 30 DY</i>	90D; QL	3	
<i>galantamine soln oral QL-200ML 30 DY</i>	90D; QL	3	
<i>galantamine tab QL-60 QY 30 DY</i>	90D; QL	3	
<i>rivastigmine cap QL-60 QY 30 DY</i>	90D; QL	1	G
<i>Glutamate Pathway Modifiers</i>			
NAMENDA SOLN ORAL QL-360ML 30 DY	90D; QL	2	
NAMENDA TAB QL-60 QY 30 DY	90D; QL	2	
NAMENDA TITR PAK TAB QL-49 QY 28 DY	QL	2	
Antidepressants			
<i>Antidepressants, Other</i>			
<i>budeprion sr tab</i>	90D	1	G
<i>budeprion xl tab QL-30 QY 30 DY</i>	90D; QL	3	
<i>buproban tab</i>	90D	1	G
<i>bupropion sr tab</i>	90D	1	G
<i>bupropion tab</i>	90D	1	G

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Antidepressants			
<i>Antidepressants, Other</i>			
<i>mirtazapine odt tab QL-30 QY 30 DY</i>	90D; QL	3	
<i>mirtazapine tab</i>	90D	1	G
<i>nefazodone tab</i>	90D	1	G
<i>trazodone tab</i>	90D	1	G
<i>Monoamine Oxidase Inhibitors</i>			
EMSAM PATCH QL-30 PTCH 30 DY	90D; QL	3	ST
MARPLAN TAB	90D	3	
<i>phenelzine tab</i>	90D	1	G
<i>tranylcypromine sulfate tab</i>	90D	1	G
<i>Serotonin/ Norepinephrine Reuptake Inhibitors</i>			
<i>citalopram soln oral</i>	90D	1	G
<i>citalopram tab</i>	90D	1	G
CYMBALTA 20MG CAP QL-60 QY 30 DY	90D; QL	3	PA
CYMBALTA 30MG CAP QL-90 QY 30 DY	90D; QL	3	PA
CYMBALTA 60MG CAP QL-60 QY 30 DY	90D; QL	3	PA
<i>fluoxetine cap</i>	90D	1	G
<i>fluoxetine soln oral</i>	90D	1	G
<i>fluoxetine tab</i>	90D	1	G
<i>fluoxetine wkly cap QL-4 QY 28 DY</i>	90D; QL	3	ST
<i>fluvoxamine tab</i>	90D	1	G
LEXAPRO ORAL SOLN QL-600 ML 30 DY	90D; QL	2	
LEXAPRO TAB QL-45 QY 30 DY	90D; QL	2	
<i>paroxetine er 12.5mg tab QL-90 QY 30 DY</i>	90D; QL	3	ST
<i>paroxetine er 25mg tab QL-90 QY 30 DY</i>	90D; QL	3	ST
<i>paroxetine er 37.5mg tab QL-60 QY 30 DY</i>	90D; QL	3	ST
<i>paroxetine suspension</i>	90D	1	G
<i>paroxetine tab</i>	90D	1	G
PRISTIQ TAB QL-30 QY 30 DY	90D; QL	3	ST
<i>selfemra cap</i>	90D	1	G
<i>sertraline conc oral</i>	90D	1	G
<i>sertraline tab</i>	90D	1	G
SYMBYAX CAP QL-30 QY 30 DY	90D; QL	3	PA

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Antidepressants			
Serotonin/ Norepinephrine Reuptake Inhibitors			
<i>venlafaxine er 150mg cap QL-90 QY 30 DY</i>	90D; QL	1	G
<i>venlafaxine er 150MG TAB QL-90 QY 30 DY</i>	90D; QL	3	
<i>venlafaxine er 225MG TAB QL-30 QY 30 DY</i>	90D; QL	3	
<i>venlafaxine er 37.5mg cap QL-30 QY 30 DY</i>	90D; QL	1	G
<i>venlafaxine er 37.5MG TAB QL-30 QY 30 DY</i>	90D; QL	3	
<i>venlafaxine er 75mg cap QL-30 QY 30 DY</i>	90D; QL	1	G
<i>venlafaxine er 75MG TAB QL-30 QY 30 DY</i>	90D; QL	3	
<i>venlafaxine ir tab</i>	90D	1	G
VIIBRYD TAB	90D	3	ST
Tricyclics			
<i>amitriptyline tab</i>	90D	1	G
<i>amoxapine tab</i>	90D	1	G
<i>clomipramine cap</i>	90D	1	G
<i>desipramine tab</i>	90D	1	G
<i>doxepin cap</i>	90D	1	G
<i>doxepin conc oral</i>	90D	1	G
<i>imipramine tab</i>	90D	1	G
<i>maprotiline tab</i>	90D	1	G
<i>nortriptyline cap</i>	90D	1	G
<i>nortriptyline soln oral</i>	90D	1	G
<i>perphenazine/amitriptyline tab</i>	90D	1	G
<i>protriptyline tab</i>	90D	3	
SURMONTIL CAP	90D	3	
Antidotes, Deterrents, and Toxicologic Agents			
Antidotes			
CUPRIMINE CAP	90D	2	
DEPEN TITRATAS TAB	90D	2	
EXJADE TAB		4	PA
<i>fomepizole vial</i>		4	PA
<i>kionex powder</i>		1	G
<i>leucovorin calcium soln</i>		1	G
<i>leucovorin calcium tab</i>		1	G

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Antidotes, Deterrents, and Toxicologic Agents			
<i>Antidotes</i>			
RELISTOR SOLN		3	PA
<i>sodium polystyrene sulfonate powder</i>		1	G
SYPRINE CAP		3	
<i>Deterrents</i>			
ANTABUSE TAB		2	
CAMPRAL TAB QL-180 QY 30 DY	QL	3	
CHANTIX DOSE PACK QL-53 QY 30 DY	QL	3	PA
CHANTIX TAB QL-60 QY 30 DY	QL	3	PA
NICOTROL NS SPRAY QL-4 BOTTLES 30 DY	QL	2	
SUBOXONE FILM, SUBL QL-90 QY 30 DY	QL	3	PA
<i>Toxicologic Agents</i>			
<i>depade tab</i>		1	G
<i>naloxone syringe</i>		1	G
<i>naltrexone tab</i>	90D	1	G
VIVITROL SUSPENSION		4	PA
Antiemetics			
<i>Antiemetics</i>			
<i>compro suppository</i>		1	G
<i>dronabinol cap 10mg QL-60 QY 30 DY</i>	B v D; QL	4	PA
<i>dronabinol cap 2.5mg QL-60 QY 30 DY</i>	B v D; QL	3	PA
<i>dronabinol cap 5mg QL-60 QY 30 DY</i>	B v D; QL	3	PA
EMEND 125MG CAP QL-6 QY 30 DY	B v D; QL	3	PA
EMEND 40MG CAP QL-1 QY 30 DY	QL	3	
EMEND 80MG CAP QL-6 QY 30 DY	B v D; QL	3	PA
EMEND CAP TRIFLD QL-6 QY 30 DY	B v D; QL	3	PA
<i>granisetron 1mg tab QL-30 QY 30 DY</i>	B v D; QL	3	PA
<i>ondansetron 4mg/2ml vial</i>		3	PA
<i>ondansetron ir tab</i>		1	G
<i>phenadoz suppository</i>	HRM	1	G
<i>prochlorperazine edisylate vial</i>		1	G
<i>prochlorperazine supp rectal</i>		1	G
<i>prochlorperazine tab</i>		1	G

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Antiemetics			
<i>Antiemetics</i>			
<i>promethazine supp rectal</i>	HRM	1	G
<i>promethazine syringe</i>	HRM	1	G
<i>promethazine syrup</i>	90D; HRM	1	G
<i>promethazine tab</i>	90D; HRM	1	G
<i>promethazine vial</i>	HRM	1	G
<i>promethegan supp rectal</i>	HRM	1	G
SANCUSO PTCH QL-4 PTCH 28 DY	QL	3	
<i>trimethobenzamide cap</i>	90D; HRM	3	
Antifungals			
<i>Antifungals</i>			
AMPHOTERICIN B SOLN		1	G
ANCOBON CAP		4	
CANCIDAS VIAL		4	PA
<i>ciclopirox lotion</i>		3	
<i>ciclopirox nail lacquer soln</i>		3	
<i>ciclopirox olamine cream</i>		3	
<i>clotrimazole 1% topical soln</i>		1	G
<i>clotrimazole 10mg troche</i>		1	G
<i>clotrimazole/betameth diprop cream</i>		1	G
<i>clotrimazole/betameth diprop lotion</i>		1	G
<i>econazole nitrate cream</i>		1	G
ERAXIS VIAL		4	PA
EXELDERM CREAM		3	
EXELDERM SOLN NON-ORAL		3	
<i>fluconazole in dextrose iv</i>		1	G
FLUCONAZOLE IN NAACL		1	G
<i>fluconazole suspension</i>		1	G
<i>fluconazole tab</i>		1	G
GRIFULVIN V TAB		2	
GRIS-PEG TAB		3	

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Antifungals			
<i>Antifungals</i>			
<i>griseofulvin micro susp</i>		1	G
<i>itraconazole cap</i>		1	G; PA
<i>ketoconazole 200mg tab</i>		1	G
<i>ketoconazole cream</i>		1	G
<i>ketoconazole shampoo</i>		1	G
MENTAX CREAM		3	
MYCAMINE VIAL		4	PA
NAFTIN CREAM		3	
NAFTIN GEL		3	
NOXAFIL ORAL SUSP QL-630 ML 30 DY	QL	4	PA
<i>nyamyc powder</i>		1	G
<i>nystatin cream</i>		1	G
<i>nystatin oint</i>		1	G
<i>nystatin oral susp</i>		1	G
<i>nystatin powder</i>		1	G
<i>nystatin tab</i>		1	G
<i>nystatin/triamcinolone cream</i>		1	G
<i>nystatin/triamcinolone oint</i>		1	G
<i>nystop powder</i>		1	G
OXISTAT CREAM		3	
OXISTAT LOTION		3	
<i>pedi-dri powder</i>		1	G
SPORANOX SOLN ORAL		3	PA
<i>terbinafine tab QL-30 QY 30 DY</i>	QL	1	G
VFEND IV VIAL		2	PA
VFEND SUSPENSION		2	PA
<i>voriconazole tab QL-60 QY 30 DY</i>	QL	1	G; PA
Antigout Agents			
<i>Antigout Agents</i>			
<i>allopurinol tab</i>	90D	1	G
COLCRYS TAB QL-120 QY 30 DY	90D; QL	2	
<i>probenecid tab</i>	90D	1	G

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Antigout Agents			
<i>Antigout Agents</i>			
<i>probenecid/colchicine tab</i>	90D	1	G
ULORIC TABS QL-30 QY 30 DY	90D; QL	2	ST
Antimigraine Agents			
<i>Abortive</i>			
AXERT TAB QL-8 QY 30 DY	QL	3	ST
<i>dihydroergotamine mesylate ampul</i>		3	
ERGOMAR TAB, SUBL		2	
<i>ergotamine tartrate/caffeine tab</i>		1	G
FROVA TAB QL-12 QY 30 DY	QL	3	ST
MAXALT TAB QL-12 QY 30 DY	QL	2	
MAXALT-MLT TAB QL-12 QY 30 DY	QL	2	
<i>migergot supp rectal</i>		3	
MIGRANAL QL-8 VIALS 28 DY	QL	3	
<i>naratriptan tab QL-9 QY 30 DY</i>	QL	3	ST
RELPAK TAB QL-9 QY 30 DY	QL	3	ST
<i>sumatriptan inj QL-8 INJ 30 DY</i>	QL	3	
<i>sumatriptan spray QL-8 SPRAY UNITS 30 DY</i>	QL	3	
<i>sumatriptan tab QL-9 QY 30 DY</i>	QL	3	
ZOMIG NASAL SPR QL-6 SPRAY UNITS 30 DY	QL	3	ST
ZOMIG TAB QL-6 QY 30 DY	QL	3	ST
ZOMIG ZMT TAB QL-6 QY 30 DY	QL	3	ST
Antimyasthenic Agents			
<i>Parasympathomimetics</i>			
GUANIDINE TAB	90D	3	
MESTINON SYRUP	90D	2	
MESTINON TIMESPAN TAB, SR	90D	2	
MYTELASE TAB	90D	3	
<i>pyridostigmine bromide tab</i>	90D	1	G
Antimycobacterials			
<i>Antimycobacterials, Other</i>			
DAPSONE TAB		2	
MYCOBUTIN CAP		3	

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Antimycobacterials			
<i>Antituberculars</i>			
CAPASTAT SULFATE VIAL		3	
<i>ethambutol tab</i>	90D	1	G
<i>isonarif cap</i>	90D	1	G
<i>isoniazid syrup</i>	90D	1	G
<i>isoniazid tab</i>	90D	1	G
PASER PACKET	90D	3	
PRIFTIN TAB	90D	3	
<i>pyrazinamide tab</i>	90D	1	G
<i>rifampin 600mg vial</i>		3	
<i>rifampin cap</i>	90D	1	G
RIFATER TAB	90D	3	
SEROMYCIN CAP	90D	3	
TRECTOR TAB	90D	3	
Antineoplastics			
<i>Alkylating Agents</i>			
CEENU CAP		2	
<i>cisplatin inj</i>		1	G
<i>cyclophosphamide tab</i>	B v D	1	G; PA
HEXALEN CAP		4	
LEUKERAN TAB		2	
MATULANE CAP		4	
<i>thiotepa vial</i>		3	
<i>Antiangiogenic Agents</i>			
REVLIMID CAP QL-30 QY 30 DY	QL	4	PA
THALOMID CAP QL-28 QY 28 DY	QL	4	PA
VANDETANIB TAB 100MG QL-60 QY 30 DY	QL	4	PA
VANDETANIB TAB 300MG QL-30 QY 30 DY	QL	4	PA
VOTRIENT TAB QL-120 QY 30 DY	QL	4	PA
<i>Antiestrogens/Modifiers</i>			
EMCYT CAP		2	
FARESTON TAB	90D	2	
FASLODEX SYRINGE		4	PA

G: We provide additional coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage.

Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Antineoplastics			
Antiestrogens/Modifiers			
<i>tamoxifen citrate tab</i>	90D	1	G
Antimetabolites			
DACOGEN VIAL		4	PA
DROXIA CAP		2	
ELITEK VIAL		4	PA
<i>fluorouracil vial</i>		1	G
<i>gemcitabine vial</i>		4	PA
<i>hydroxyurea cap</i>		1	G
<i>mercaptopurine tab</i>	90D	1	G
TABLOID TAB		2	
VIDAZA VIAL		4	PA
Antineoplastics, Other			
ALIMTA VIAL		4	PA
<i>amifostine vial</i>		4	
AVASTIN VIAL		4	PA
<i>bleomycin sulfate vial</i>		3	PA
DOCETAXEL VIAL		4	PA
FIRMAGON 120MG VIAL QL-2 VIALS 28 DY	QL	4	PA
ISTODAX VIAL		4	PA
IXEMPRA KIT VIAL		4	PA
<i>mesna vial</i>		1	G
MESNEX TAB		3	PA
<i>mitoxantrone vial</i>		1	G
<i>paclitaxel vial</i>		3	PA
TAXOTERE VIAL		4	PA
TRISENOX AMPUL		3	PA
TYKERB TAB QL-180 QY 30 DY	QL	4	PA
VELCADE VIAL		4	PA
ZOLINZA CAP QL-120 QY 30 DY	QL	4	PA
ZYTIGA TAB QL-120.00 QY 30 DY	QL	4	PA
Aromatase Inhibitors, 3rd Generation			
<i>anastrozole tab QL-30 QY 30 DY</i>	90D; QL	1	G

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Antineoplastics			
<i>Aromatase Inhibitors, 3rd Generation</i>			
<i>exemestane tab</i>	90D	3	
<i>letrozole tab QL-30 QY 30 DY</i>	90D; QL	3	
<i>Molecular Target Inhibitors</i>			
AFINITOR TAB QL-30 QY 30 DY	QL	4	PA
GLEEVEC 100MG TAB QL-90 QY 30 DY	QL	4	PA
GLEEVEC 400MG TAB QL-60 QY 30 DY	QL	4	PA
IRESSA TAB QL-30 QY 30 DY	QL	4	
NEXAVAR TAB QL-120 QY 30 DY	QL	4	PA
SPRYCEL 100MG TAB QL-30 QY 30 DY	QL	4	PA
SPRYCEL 140MG TAB QL-30 QY 30 DY	QL	4	PA
SPRYCEL 20MG TAB QL-60 QY 30 DY	QL	4	PA
SPRYCEL 50MG TAB QL-60 QY 30 DY	QL	4	PA
SPRYCEL 70MG TAB QL-60 QY 30 DY	QL	4	PA
SPRYCEL 80MG TAB QL-60 QY 30 DY	QL	4	PA
SUTENT CAP QL-30 QY 30 DY	QL	4	PA
TARCEVA TAB QL-30 QY 30 DY	QL	4	PA
TASIGNA CAP QL-120 QY 30 DY	QL	4	PA
<i>Monoclonal Antibodies</i>			
CAMPATH VIAL	B v D	4	PA
HERCEPTIN VIAL		4	PA
RITUXAN VIAL		4	PA
<i>Retinoids</i>			
TARGRETIN CAP		4	PA
<i>tretinoin 10mg cap</i>		4	PA
Antiparasitics			
<i>Anthelmintics</i>			
ALBENZA TAB		3	
BILTRICIDE TAB		3	
<i>mebendazole chew</i>		1	G
STROMECTOL TAB		3	
<i>Antiprotozoals</i>			
ALINIA SUSPENSION		3	

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Antiparasitics			
Antiprotozoals			
ALINIA TAB		3	
<i>chloroquine tab</i>	90D	1	G
DARAPRIM TAB		2	
<i>hydroxychloroquine sulfate tab</i>	90D	1	G
<i>mefloquine tab</i>		1	G
MEPRON SUSPENSION		4	PA
NEBUPENT VIAL	B v D	2	PA
<i>paromomycin sulfate cap</i>		1	G
PRIMAQUINE PHOSPHATE TAB		2	
QUALAQUIN CAP QL-80 QY 365 DY	QL	3	PA
Pediculicides/ Scabicides			
<i>acticin cream</i>		1	G
EURAX CREAM		3	
EURAX LOTION		3	
LINDANE LOTN QL-60 ML 30 DY	QL	3	
<i>lindane shamp QL-60ML 30 DY</i>	QL	2	
<i>malathion lotion</i>		3	
<i>permethrin cream</i>		1	G
ULESFIA LOTION		3	
Antiparkinson Agents			
Antiparkinson Agents			
<i>amantadine cap</i>	90D	1	G
<i>amantadine tab</i>	90D	1	G
APOKYN CARTRIDGE		4	PA
AZILECT TAB QL-30 QY 30 DY	90D; QL	3	ST
<i>benztropine tab</i>	90D	1	G
<i>bromocriptine cap</i>	90D	1	G
<i>bromocriptine tab</i>	90D	1	G
<i>carbidopa/levodopa cr tab</i>	90D	1	G
<i>carbidopa/levodopa odt tab</i>	90D	1	G
<i>carbidopa/levodopa sr tab</i>	90D	1	G
<i>carbidopa/levodopa tab</i>	90D	1	G

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Antiparkinson Agents			
<i>Antiparkinson Agents</i>			
COMTAN TAB	90D	2	
LODOSYN TAB	90D	3	
<i>pramipexole tab QL-90 QY 30 DY</i>	90D; QL	3	
<i>ropinirole tab</i>	90D	1	G
<i>selegiline cap</i>	90D	1	G
<i>selegiline tab</i>	90D	1	G
STALEVO TAB	90D	2	
TASMAR TAB	90D	3	
<i>trihexyphenidyl elixir</i>	90D	1	G
<i>trihexyphenidyl tab</i>	90D	1	G
Antipsychotics			
<i>Atypicals</i>			
ABILIFY DISCMELT TAB QL-60 QY 30 DY	90D; QL	3	PA
ABILIFY SOLN ORAL QL-900 ML QY 30 DY	90D; QL	3	
ABILIFY TAB QL-30 QY 30 DY	90D; QL	3	
ABILIFY VIAL		3	
<i>clozapine tab 100mg</i>	90D	1	G
<i>clozapine tab 200mg</i>	90D	2	
<i>clozapine tab 25mg</i>	90D	1	G
<i>clozapine tab 50mg</i>	90D	1	G
FANAPT TAB QL-60 QY 30 DY	90D; QL	3	PA
FANAPT TITR PACK QL-1 QY 365 DY	QL	3	PA
FAZACLO ODT TAB	90D	3	
GEODON CAP QL-60 QY 30 DY	90D; QL	3	PA
GEODON VIAL QL-60ML 30 DY	QL	3	PA
INVEGA 1.5MG TAB24 QL-30 QY 30 DY	90D; QL	3	PA
INVEGA 3MG TAB24 QL-30 QY 30 DY	90D; QL	3	PA
INVEGA 6MG TAB24 QL-60 QY 30 DY	90D; QL	3	PA
INVEGA 9MG TAB24 QL-30 QY 30 DY	90D; QL	3	PA
INVEGA SUST VIAL QL-1 INJ 28 DY	QL	3	
LATUDA TAB QL-30 QY 30 DY	90D; QL	3	
RISPERDAL CONSTA QL-2 INJ 28 DY	QL	3	

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Antipsychotics			
Atypicals			
<i>risperidone 0.25mg tab QL-90 QY 30 DY</i>	90D; QL	1	G
<i>risperidone 0.5mg tab QL-90 QY 30 DY</i>	90D; QL	1	G
<i>risperidone 1mg tab QL-60 QY 30 DY</i>	90D; QL	1	G
<i>risperidone 2mg tab QL-60 QY 30 DY</i>	90D; QL	1	G
<i>risperidone 3mg tab QL-90 QY 30 DY</i>	90D; QL	1	G
<i>risperidone 4mg tab QL-120 QY 30 DY</i>	90D; QL	1	G
<i>risperidone odt 0.25mg QL-90 QY 30 DY</i>	90D; QL	3	
<i>risperidone odt 0.5mg QL-90 QY 30 DY</i>	90D; QL	3	
<i>risperidone odt 1mg QL-60 QY 30 DY</i>	90D; QL	3	
<i>risperidone odt 2mg QL-60 QY 30 DY</i>	90D; QL	3	
<i>risperidone odt 3mg QL-90 QY 30 DY</i>	90D; QL	3	
<i>risperidone odt 4mg QL-120 QY 30 DY</i>	90D; QL	3	
<i>risperidone soln oral</i>	90D	1	G
SAPHRIS SUBL QL-60 QY 30 DY	QL	3	
SEROQUEL 100MG TAB QL-90 QY 30 DY	90D; QL	3	
SEROQUEL 200MG TAB QL-90 QY 30 DY	90D; QL	3	
SEROQUEL 25MG TAB QL-90 QY 30 DY	90D; QL	3	
SEROQUEL 300MG TAB QL-90 QY 30 DY	90D; QL	3	
SEROQUEL 400MG TAB QL-60 QY 30 DY	90D; QL	3	
SEROQUEL 50MG TAB QL-90 QY 30 DY	90D; QL	3	
SEROQUEL XR 150MG TAB QL-30 QY 30 DY	90D; QL	2	
SEROQUEL XR 200MG TAB QL-30 QY 30 DY	90D; QL	2	
SEROQUEL XR 300MG TAB QL-60 QY 30 DY	90D; QL	2	
SEROQUEL XR 400MG TAB QL-60 QY 30 DY	90D; QL	2	
SEROQUEL XR 50MG TAB QL-60 QY 30 DY	90D; QL	2	
ZYPREXA 10MG TABS QL-30 QY 30 DY	90D; QL	3	PA
ZYPREXA 15MG TABS QL-60 QY 30 DY	90D; QL	3	PA
ZYPREXA 2.5MG TABS QL-30 QY 30 DY	90D; QL	3	PA
ZYPREXA 20MG TABS QL-60 QY 30 DY	90D; QL	3	PA
ZYPREXA 5MG TABS QL-30 QY 30 DY	90D; QL	3	PA
ZYPREXA 7.5MG TABS QL-30 QY 30 DY	90D; QL	3	PA
ZYPREXA RELPREVV 210MG QL-2 INJ 28 DY	QL	3	PA

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Antipsychotics			
<i>Atypicals</i>			
ZYPREXA RELPREVV 300MG QL-2 INJ 28 DY	QL	3	PA
ZYPREXA RELPREVV 405MG QL-1 INJ 28 DY	QL	3	PA
ZYPREXA VIAL		3	PA
ZYPREXA ZYDIS 10MG TBDP QL-30 QY 30 DY	90D; QL	3	PA
ZYPREXA ZYDIS 15MG TBDP QL-60 QY 30 DY	90D; QL	3	PA
ZYPREXA ZYDIS 20MG TBDP QL-60 QY 30 DY	90D; QL	3	PA
ZYPREXA ZYDIS 5MG TBDP QL-30 QY 30 DY	90D; QL	3	PA
<i>Conventional</i>			
<i>chlorpromazine ampul</i>		1	G
<i>chlorpromazine tab</i>	90D	1	G
<i>fluphenazine conc oral</i>	90D	1	G
<i>fluphenazine decanoate vial</i>		1	G
<i>fluphenazine elixir</i>	90D	1	G
<i>fluphenazine tab</i>	90D	1	G
<i>fluphenazine vial</i>		1	G
<i>haloperidol conc oral</i>		1	G
<i>haloperidol decanoate vial</i>		1	G
<i>haloperidol lactate vial</i>		1	G
<i>haloperidol tab</i>	90D	1	G
<i>loxapine succinate cap</i>	90D	1	G
NAVANE CAP	90D	3	
ORAP TAB	90D	3	
<i>perphenazine tab</i>	90D	1	G
<i>thioridazine tab</i>	90D; HRM	1	G
<i>thiothixene cap</i>	90D	1	G
<i>trifluoperazine tab</i>	90D	1	G
Antispasticity Agents			
<i>Antispasticity Agents</i>			
<i>baclofen tab</i>	90D	1	G
<i>dantrolene cap</i>	90D	1	G

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Antivirals			
<i>Anti-cytomegalovirus (CMV) Agents</i>			
<i>foscarnet inj</i>		3	PA
<i>ganciclovir cap</i>		1	G
VALCYTE TAB		4	
<i>Anti-HIV Agents, Non-nucleoside Reverse Transcriptase Inhibitors</i>			
EDURANT TAB QL-30 QY 30 DY	QL	4	
RESCRIPTOR TAB		2	
SUSTIVA CAP		3	
SUSTIVA TAB		3	
VIRAMUNE SUSPENSION		3	
VIRAMUNE TAB		3	
VIRAMUNE XR TAB		3	
<i>Anti-HIV Agents, Nucleoside and Nucleotide Reverse Transcriptase Inhibitors</i>			
ATRIPLA TAB QL-30 QY 30 DY	QL	4	
COMBIVIR TAB		4	
<i>didanosine cap</i>		1	G
EMTRIVA CAP		3	
EMTRIVA SOLN ORAL		3	
EPIVIR SOLN ORAL		3	
EPIVIR TAB		3	
EPZICOM TAB		4	
INTELENCE 100MG TAB QL-120 QY 30 DY	QL	4	
INTELENCE 200MG TAB QL-60 QY 30 DY	QL	4	
RETROVIR IV		3	
<i>stavudine cap</i>		1	G
<i>stavudine soln oral</i>		1	G
TRIZIVIR TAB		4	
TRUVADA TAB		4	
VIDEX PEDIATRIC SOLN ORAL		2	
VIREAD TAB		3	
ZIAGEN SOLN ORAL		2	
ZIAGEN TAB		2	
<i>zidovudine cap</i>		1	G

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Antivirals			
<i>Anti-HIV Agents, Nucleoside and Nucleotide Reverse Transcriptase Inhibitors</i>			
zidovudine syrup		1	G
zidovudine tab		1	G
<i>Anti-HIV Agents, Other</i>			
FUZEON KIT QL-60 VIALS 30 DY	QL	4	
ISENTRESS TAB QL-60 QY 30 DY	QL	4	
SELZENTRY 150MG TAB QL-60 QY 30 DY	QL	4	
SELZENTRY 300MG TAB QL-120 QY 30 DY	QL	4	
<i>Anti-HIV Agents, Protease Inhibitors</i>			
APTIVUS CAP		4	
APTIVUS SOLN ORAL		4	
CRIXIVAN CAP		2	
INVIRASE CAP		3	
INVIRASE TAB		3	
KALETRA 100;25MG TAB		3	
KALETRA 200;50MG TAB		4	
KALETRA ORAL SOLN		4	
LEXIVA SUSPENSION		3	
LEXIVA TAB		4	
NORVIR CAP		2	
NORVIR SOLN ORAL		2	
NORVIR TAB		2	
PREZISTA 150MG TAB		4	
PREZISTA 400MG TAB		4	
PREZISTA 600MG TAB		4	
PREZISTA 75MG TAB		3	
REYATAZ 100MG CAP		3	
REYATAZ 150MG CAP		4	
REYATAZ 200MG CAP		4	
REYATAZ 300MG CAP		4	
VIRACEPT 50MG/GM POWDER		3	
VIRACEPT TAB		4	

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Antivirals			
Anti-influenza Agents			
RELENZA DISKHALER QL-120 DOSES 365 DY	QL	3	
<i>rimantadine tab</i>		1	G
TAMIFLU CAP 30MG & 45MG		3	
TAMIFLU CAP 75MG QL-56 QY 365 DY	QL	3	
TAMIFLU SUSPENSION		3	
Antihepatitis Agents			
BARACLUDE SOLN ORAL QL-630 ML 30 DY	QL	3	
BARACLUDE TAB QL-30 QY 30 DY	QL	3	
EPIVIR HBV SOLN ORAL		2	
EPIVIR HBV TAB		2	
HEPSERA TAB QL-30 QY 30 DY	QL	2	
<i>ribasphere cap 200mg</i>		3	PA
<i>ribasphere tab 200mg</i>		3	PA
<i>ribavirin cap 200mg</i>		3	PA
<i>ribavirin tab 200mg</i>		3	PA
TYZEKA TAB QL-30 QY 30 DY	QL	3	
Antiherpetic Agents			
<i>acyclovir cap</i>		1	G
<i>acyclovir sodium</i>		1	G
<i>acyclovir susp</i>		1	G
<i>acyclovir tab</i>		1	G
DENAVIR CREAM QL-2 GM 30 DY	QL	2	
<i>famciclovir tab QL-60 QY 30 DY</i>	QL	3	
<i>valacyclovir 1000mg tab QL-30 QY 30 DY</i>	QL	3	
<i>valacyclovir 500mg tab QL-42 QY 30 DY</i>	QL	3	
ZIRGAN GEL QL-5.00 QY 30 DY	QL	3	
ZOVIRAX 5% OINT QL-30 GM 30 DY	QL	3	
Anxiolytics			
Anxiolytics, Other			
<i>bupirone tab</i>	90D	1	G
<i>chlordiazepoxide/amitriptyline tab</i>	HRM	3	
<i>meprobamate tab</i>	HRM	3	

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Bipolar Agents			
<i>Bipolar Agents</i>			
EQUETRO CAP	90D	2	
<i>lithium carbonate cap</i>	90D	1	G
<i>lithium carbonate er tab</i>	90D	1	G
<i>lithium carbonate tab</i>	90D	1	G
<i>lithium citrate soln oral</i>	90D	1	G
LITHOBID TAB, SR	90D	3	
Blood Glucose Regulators			
<i>Antidiabetic Agents</i>			
<i>acarbose tab</i>	90D	1	G
ACTOPLUS MET 500MG; 15MG TAB QL-90 QY 30 DY	90D; QL	2	ST
ACTOPLUS MET 850MG; 15MG TAB QL-90 QY 30 DY	90D; QL	2	ST
ACTOS TAB QL-30 QY 30 DY	90D; QL	2	ST
AVANDAMET TAB QL-60 QY 30 DY	90D; QL	3	ST
AVANDARYL 1;4MG TAB QL-60 QY 30 DY	90D; QL	3	ST
AVANDARYL 2;4MG TAB QL-60 QY 30 DY	90D; QL	3	ST
AVANDARYL 2;8MG TAB QL-30 QY 30 DY	90D; QL	3	ST
AVANDARYL 4;4MG TAB QL-60 QY 30 DY	90D; QL	3	ST
AVANDARYL 4;8MG TAB QL-30 QY 30 DY	90D; QL	3	ST
AVANDIA 2MG TAB QL-60 QY 30 DY	90D; QL	3	ST
AVANDIA 4MG TAB QL-60 QY 30 DY	90D; QL	3	ST
AVANDIA 8MG TAB QL-30 QY 30 DY	90D; QL	3	ST
BYETTA PEN QL-1 PEN 30 DY	90D; QL	3	PA
<i>chlorpropamide tab</i>	90D; HRM	1	G
DUETACT TAB QL-30 QY 30 DY	90D; QL	2	ST
<i>glimepiride tab</i>	90D	1	G
<i>glipizide er tab</i>	90D	1	G
<i>glipizide tab</i>	90D	1	G
<i>glipizide xl tab</i>	90D	1	G
<i>glipizide/metformin tab</i>	90D	1	G
<i>glyburide micronized tab</i>	90D	1	G
<i>glyburide tab</i>	90D	1	G

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Blood Glucose Regulators			
<i>Antidiabetic Agents</i>			
<i>glyburide/metformin tab</i>	90D	1	G
JANUMET TAB QL-60 QY 30 DY	90D; QL	2	ST
JANUVIA TAB QL-30 QY 30 DY	90D; QL	2	ST
KOMBIGLYZE XR 1000MG; 2.5MG TAB QL-60 QY 30 DY	90D; QL	2	ST
KOMBIGLYZE XR 1000MG; 5MG TAB QL-30 QY 30 DY	90D; QL	2	ST
KOMBIGLYZE XR 500MG; 5MG TAB QL-30 QY 30 DY	90D; QL	2	ST
<i>metformin er tab</i>	90D	1	G
<i>metformin tab</i>	90D	1	G
<i>nateglinide tab QL-90 QY 30 DY</i>	90D; QL	3	
ONGLYZA TAB QL-30 QY 30 DY	90D; QL	2	ST
PRANDIN TAB 0.5MG QL-120 QY 30 DY	90D; QL	3	
PRANDIN TAB 1MG QL-120 QY 30 DY	90D; QL	3	
PRANDIN TAB 2MG QL-240 QY 30 DY	90D; QL	3	
RIOMET SOLN ORAL	90D	3	
SYMLIN 600MCG/ML VIAL QL-4 VIALS 30 DY	90D; QL	3	PA
SYMLINPEN 120 1000MCG/ML QL-4 PENS 30 DY	90D; QL	3	PA
SYMLINPEN 60 1000MCG/ML QL-8 PENS 30 DY	90D; QL	3	PA
<i>tolazamide tab</i>	90D	1	G
<i>tolbutamide tab</i>	90D	1	G
<i>Glycemic Agents</i>			
GLUCAGEN HYPOKIT QL-2 INJ 1 DY	QL	2	
GLUCAGON EMERG KIT QL-1 INJ 1 DY	QL	2	
PROGLYCEM SUSPENSION	90D	3	
<i>Insulins</i>			
APIDRA SOLOSTAR	90D	3	PA
APIDRA VIAL	90D	3	
HUMALOG INSULIN PEN	90D	3	PA
HUMALOG MIX 50/50 INSULIN PEN	90D	3	PA
HUMALOG MIX 50/50 VIAL	90D	3	
HUMALOG MIX 75/25 INSULIN PEN	90D	3	PA
HUMALOG MIX 75/25 VIAL	90D	3	
HUMALOG VIAL	90D	3	

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Blood Glucose Regulators			
<i>Insulins</i>			
HUMULIN 50/50 VIAL	90D	3	
HUMULIN 70/30 INSULIN PEN	90D	3	PA
HUMULIN 70/30 VIAL	90D	3	
HUMULIN N U-100 INSULIN PEN	90D	3	PA
HUMULIN N VIAL	90D	3	
HUMULIN R U-500 (CONC) VIAL	90D	3	
HUMULIN R VIAL	90D	3	
LANTUS SOLOSTAR	90D	2	PA
LANTUS VIAL	90D	2	
LEVEMIR FLEXPEN	90D	2	PA
LEVEMIR VIAL	90D	2	
NOVOLIN 70/30 VIAL	90D	2	
NOVOLIN N VIAL	90D	2	
NOVOLIN R VIAL	90D	2	
NOVOLOG FLEXPEN	90D	2	ST
NOVOLOG MIX 70/30 FLEXPEN	90D	2	PA
NOVOLOG MIX 70/30 VIAL	90D	2	
NOVOLOG VIAL	90D	2	
Blood Products/Modifiers/ Volume Expanders			
<i>Anticoagulants</i>			
ARIXTRA 10MG SYRINGE		2	PA
ARIXTRA 2.5MG SYRINGE		2	PA
ARIXTRA 5MG SYRINGE		2	PA
ARIXTRA 7.5MG SYRINGE		2	PA
COUMADIN TAB	90D	2	
<i>enoxaparin 100mg/ml syringe</i>		1	G; PA
<i>enoxaparin 120mg/0.8ml syringe</i>		1	G; PA
<i>enoxaparin 150mg/ml syringe</i>		1	G; PA
<i>enoxaparin 30mg/0.3ml syringe</i>		1	G; PA
<i>enoxaparin 40mg/0.4ml syringe</i>		1	G; PA
<i>enoxaparin 60mg/0.6ml syringe</i>		1	G; PA
<i>enoxaparin 80mg/0.8ml syringe</i>		1	G; PA

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Blood Products/Modifiers/ Volume Expanders			
<i>Anticoagulants</i>			
FRAGMIN INJ 10000U		2	PA
FRAGMIN INJ 12500U		2	PA
FRAGMIN INJ 15000U		2	PA
FRAGMIN INJ 18000U		2	PA
FRAGMIN INJ 25000U		2	PA
FRAGMIN INJ 2500U		2	PA
FRAGMIN INJ 5000U		2	PA
FRAGMIN INJ 7500U		2	PA
<i>heparin sod vial</i>		1	G
<i>heparin/d5w iv</i>		1	G
<i>heparin/nacl iv</i>		1	G
INNOHEP VIAL		4	PA
<i>jantoven tab</i>	90D	1	G
PRADAXA CAPS QL-60 QY 30 DY	90D; QL	3	
<i>warfarin tab</i>	90D	1	G
<i>Blood Formation Products</i>			
ARANESP 100MCG SOLN QL-4ML 28 QY	QL	3	PA
ARANESP 150MCG SOLN QL-4ML 28 DY	QL	4	PA
ARANESP 200MCG SOLN QL-4ML 28 DY	QL	4	PA
ARANESP 25MCG SOLN QL-4ML 28 DY	QL	3	PA
ARANESP 300MCG SOLN QL-4ML 28 DY	QL	4	PA
ARANESP 40MCG SOLN QL-4ML 28 QY	QL	3	PA
ARANESP 500MCG SOLN QL-1ML 21 DY	QL	4	PA
ARANESP 60MCG SOLN QL-4ML 28 DY	QL	3	PA
LEUKINE VIAL		4	PA
NEULASTA SYRINGE		4	PA
NEUMEGA VIAL		2	PA
NEUPOGEN INJ		4	PA
PROCRIT VIAL 10000U QL-12ML 28 DY	QL	3	PA
PROCRIT VIAL 20000U QL-12ML 28 DY	QL	4	PA
PROCRIT VIAL 2000U QL-12ML 28 DY	QL	3	PA
PROCRIT VIAL 3000U QL-12ML 28 DY	QL	3	PA

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Blood Products/Modifiers/ Volume Expanders			
<i>Blood Formation Products</i>			
PROCRIT VIAL 40000U QL-8 ML 28 DY	QL	4	PA
PROCRIT VIAL 4000U QL-12ML 28 DY	QL	3	PA
<i>Blood Products/Modifiers/ Volume Expanders</i>			
CINRYZE VIAL QL-20 VIALS 30 DY	QL	4	PA
PROMACTA TAB QL-30 QY 30 DY	QL	4	PA
<i>Coagulants</i>			
CYKLOKAPRON AMPUL		2	
<i>Platelet Aggregation Inhibitors</i>			
AGGRENOX CAP QL-60 QY 30 DY	90D; QL	3	
<i>anagrelide cap</i>	90D	1	G
<i>cilostazol tab</i>	90D	1	G
<i>dipyridamole tab</i>	90D; HRM	1	G
EFFIENT TAB QL-30 QY 30 DY	90D; QL	3	
<i>pentoxifylline er tab, sr</i>	90D	1	G
PLAVIX 300MG TAB QL-1 QY 365 DY	QL	2	
PLAVIX 75MG TAB QL-30 QY 30 DY	90D; QL	2	
<i>ticlopidine tab</i>	90D	1	G
Cardiovascular Agents			
<i>Alpha-adrenergic Agonists</i>			
<i>clonidine patch QL-5 PTCH 30 DY</i>	90D; QL	3	ST
<i>clonidine tab</i>	90D	1	G
CLORPRES TAB	90D	2	
<i>clorpres tab</i>	90D	2	
<i>guanabenz tab</i>	90D	1	G
<i>guanfacine tab</i>	90D	1	G
<i>methyldopa tab</i>	90D	1	G
<i>methyldopa/hctz tab</i>	90D	1	G
<i>Alpha-adrenergic Blocking Agents</i>			
DIBENZYLINE CAP	90D	2	
<i>prazosin cap</i>	90D	1	G
<i>reserpine tab</i>	90D	1	G

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Cardiovascular Agents			
Antiarrhythmics			
<i>amiodarone tab</i>	90D	1	G
<i>disopyramide phosphate cap</i>	90D	1	G
<i>flecainide tab</i>	90D	1	G
<i>mexiletine cap</i>	90D	1	G
MULTAQ TAB QL-60 QY 30 DY	90D; QL	3	
NORPACE CR CAP	90D	2	
<i>pacerone 100mg tab</i>	90D	3	
<i>pacerone 200mg tab</i>	90D	1	G
<i>procainamide vial</i>		1	G
<i>propafenone hcl er cap</i>	90D	3	
<i>propafenone tab</i>	90D	1	G
<i>quinidine gluconate cr tab</i>	90D	1	G
<i>quinidine sulfate er tab</i>	90D	1	G
<i>quinidine sulfate tab</i>	90D	1	G
<i>sorine tab</i>	90D	1	G
<i>sotalol tab</i>	90D	1	G
TIKOSYN CAP	90D	2	
Beta-adrenergic Blocking Agents			
<i>acebutolol cap</i>	90D	1	G
<i>atenolol tab</i>	90D	1	G
<i>atenolol/chlorthalidone tab</i>	90D	1	G
<i>betaxolol tab</i>	90D	1	G
<i>bisoprolol tab</i>	90D	1	G
<i>bisoprolol/hctz tab</i>	90D	1	G
BYSTOLIC 10MG TAB QL-30 QY 30 DY	90D; QL	2	
BYSTOLIC 2.5MG TAB QL-30 QY 30 DY	90D; QL	2	
BYSTOLIC 20MG TAB QL-60 QY 30 DY	90D; QL	2	
BYSTOLIC 5MG TAB QL-30 QY 30 DY	90D; QL	2	
<i>carvedilol tab</i>	90D	1	G
COREG CR CAP QL-30 QY 30 DY	90D; QL	2	
INNOPRAN XL 120MG CAP24 QL-60 QY 30 DY	90D; QL	3	
INNOPRAN XL 80MG CAP24 QL-30 QY 30 DY	90D; QL	3	

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Cardiovascular Agents			
Beta-adrenergic Blocking Agents			
<i>labetalol tab</i>	90D	1	G
<i>labetalol vial</i>		1	G
LEVATOL TAB	90D	3	
<i>metoprolol succinate er tab</i>	90D	1	G
<i>metoprolol tartrate tab</i>	90D	1	G
<i>metoprolol tartrate vial</i>		1	G
<i>metoprolol/hctz tab</i>	90D	1	G
<i>nadolol tab</i>	90D	1	G
<i>nadolol/bendroflumethiazide tab</i>	90D	3	
<i>pindolol tab</i>	90D	1	G
<i>propranolol er 120mg cap QL-60 QY 30 DY</i>	90D; QL	1	G
<i>propranolol er 160mg cap QL-30 QY 30 DY</i>	90D; QL	1	G
<i>propranolol er 60mg cap QL-30 QY 30 DY</i>	90D; QL	1	G
<i>propranolol er 80mg cap QL-30 QY 30 DY</i>	90D; QL	1	G
<i>propranolol soln oral</i>	90D	1	G
<i>propranolol tab</i>	90D	1	G
<i>propranolol vial</i>		1	G
<i>propranolol/hctz tab</i>	90D	1	G
<i>timolol tab</i>	90D	1	G
Calcium Channel Blocking Agents			
<i>afeditab cr tab</i>	90D	1	G
<i>amlodipine tab</i>	90D	1	G
<i>cartia xt cap</i>	90D	1	G
COVERA-HS TAB	90D	3	
<i>dilt-cd cap</i>	90D	1	G
<i>dilt-xr cap</i>	90D	1	G
<i>diltiazem cd cap</i>	90D	1	G
<i>diltiazem er 180mg tab24 QL-30 QY 30 DY</i>	90D; QL	3	
<i>diltiazem er 240mg tab24 QL-60 QY 30 DY</i>	90D; QL	3	
<i>diltiazem er 300mg tab24 QL-30 QY 30 DY</i>	90D; QL	3	
<i>diltiazem er 360mg tab24 QL-30 QY 30 DY</i>	90D; QL	3	
<i>diltiazem er 420mg tab24 QL-30 QY 30 DY</i>	90D; QL	3	

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Cardiovascular Agents			
Calcium Channel Blocking Agents			
<i>diltiazem er cap12</i>	90D	1	G
<i>diltiazem er cap24</i>	90D	1	G
<i>diltiazem tab</i>	90D	1	G
<i>diltiazem vial</i>		1	G
<i>diltzac cap</i>	90D	1	G
DYNACIRC CR TAB	90D	3	
<i>felodipine er tab</i>	90D	1	G
<i>isradipine cap</i>	90D	3	
<i>nicardipine cap</i>	90D	1	G
<i>nifediac cc tab, sr</i>	90D	1	G
<i>nifedical xl tab</i>	90D	1	G
<i>nifedipine cap</i>	90D; HRM	3	
<i>nifedipine er tab</i>	90D	1	G
<i>nimodipine cap</i>		1	G
<i>nisoldipine 17mg tab QL-30 QY 30 DY</i>	90D; QL	3	
<i>nisoldipine 20mg tab QL-30 QY 30 DY</i>	90D; QL	3	
<i>nisoldipine 25.5mg tab QL-60 QY 30 DY</i>	90D; QL	3	
<i>nisoldipine 30mg tab QL-60 QY 30 DY</i>	90D; QL	3	
<i>nisoldipine 34mg tab QL-30 QY 30 DY</i>	90D; QL	3	
<i>nisoldipine 40mg tab QL-30 QY 30 DY</i>	90D; QL	3	
<i>nisoldipine 8.5mg tab QL-30 QY 30 DY</i>	90D; QL	3	
<i>taztia xt cap</i>	90D	1	G
<i>verapamil ampul</i>		1	G
<i>verapamil hcl er cap,24hr</i>	90D	1	G
<i>verapamil hcl er tab</i>	90D	1	G
<i>verapamil hcl sr cap,24hr</i>	90D	1	G
<i>verapamil hcl tab</i>	90D	1	G
Cardiovascular Agents, Other			
DEMSER CAP		3	
<i>digoxin ampul</i>		1	G
<i>digoxin soln oral</i>	90D	1	G

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Cardiovascular Agents			
<i>Cardiovascular Agents, Other</i>			
<i>digoxin tab</i>	90D	1	G
LANOXIN TAB	90D	2	
<i>midodrine tab</i>	90D	1	G
RANEXA TAB QL-60 QY 30 DY	90D; QL	2	ST
SAMSCA 15MG TAB QL-30 QY 30 DY	QL	4	PA
SAMSCA 30MG TAB QL-60 QY 30 DY	QL	4	PA
<i>Diuretics</i>			
<i>acetazolamide cap</i>	90D	1	G
<i>acetazolamide tab</i>	90D	1	G
<i>amiloride /hctz tab</i>	90D	1	G
<i>amiloride tab</i>	90D	1	G
<i>bumetanide tab</i>	90D	1	G
<i>bumetanide vial</i>		1	G
<i>chlorothiazide tab</i>	90D	1	G
<i>chlorthalidone tab</i>	90D	1	G
DYRENIUM CAP	90D	3	
EDECIN TAB	90D	3	
<i>furosemide soln oral</i>	90D	1	G
<i>furosemide tab</i>	90D	1	G
<i>furosemide vial</i>		1	G
<i>hydrochlorothiazide cap</i>	90D	1	G
<i>hydrochlorothiazide tab</i>	90D	1	G
<i>indapamide tab</i>	90D	1	G
<i>methyclothiazide tab</i>	90D	1	G
<i>metolazone tab</i>	90D	1	G
THALITONE TAB	90D	2	
<i>torseamide tab</i>	90D	1	G
<i>triamterene/hctz cap</i>	90D	1	G
<i>triamterene/hctz tab</i>	90D	1	G
<i>Dyslipidemics</i>			
ADVICOR 20;1000MG TAB QL-60 QY 30 DY	90D; QL	3	
ADVICOR 20;500MG TAB QL-30 QY 30 DY	90D; QL	3	

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Cardiovascular Agents			
<i>Dyslipidemics</i>			
ADVICOR 20;750MG TAB QL-60 QY 30 DY	90D; QL	3	
ADVICOR 40;1000MG TAB QL-30 QY 30 DY	90D; QL	3	
ALTOPREV TAB QL-30 QY 30 DY	90D; QL	3	ST
ANTARA CAP QL-30 QY 30 DY	90D; QL	3	
<i>cholestyramine light packet</i>	90D	1	G
<i>cholestyramine light powder</i>	90D	1	G
<i>cholestyramine packet</i>	90D	1	G
<i>cholestyramine powder</i>	90D	1	G
<i>colestipol granules</i>	90D	1	G
<i>colestipol packet</i>	90D	1	G
<i>colestipol tab</i>	90D	1	G
CRESTOR TAB QL-30 QY 30 DY	90D; QL	2	
<i>fenofibrate micronized cap</i>	90D	1	G
<i>fenofibrate tab</i>	90D	1	G
FENOGLIDE TAB QL-30 QY 30 DY	90D; QL	3	
<i>gemfibrozil tab</i>	90D	1	G
LESCOL 20MG CAP QL-30 QY 30 DY	90D; QL	3	ST
LESCOL 40MG CAP QL-60 QY 30 DY	90D; QL	3	ST
LESCOL XL TAB QL-30 QY 30 DY	90D; QL	3	ST
LIPOFEN 150MG CAP QL-30 QY 30 DY	90D; QL	3	
LIPOFEN 50MG CAP QL-90 QY 30 DY	90D; QL	3	
LIVALO TAB QL-30 QY 30 DY	90D; QL	3	
<i>lovastatin tab</i>	90D	1	G
LOVAZA CAP QL-120 QY 30 DY	90D; QL	2	
NIACOR TAB	90D	2	
NIASPAN 1000MG TABCR QL-60 QY 30 DY	90D; QL	2	
NIASPAN 500MG TABCR QL-30 QY 30 DY	90D; QL	2	
NIASPAN 750MG TABCR QL-60 QY 30 DY	90D; QL	2	
<i>pravastatin tab</i>	90D	1	G
<i>prevalite packet</i>	90D	1	G
<i>prevalite powder</i>	90D	1	G
<i>simvastatin tab 10mg</i>	90D	1	G

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Cardiovascular Agents			
<i>Dyslipidemics</i>			
<i>simvastatin tab 20mg</i>	90D	1	G
<i>simvastatin tab 40mg</i>	90D	1	G
<i>simvastatin tab 5mg</i>	90D	1	G
<i>simvastatin tab 80mg</i>	90D	1	G; PA
TRICOR TAB QL-30 QY 30 DY	90D; QL	3	
TRIGLIDE TAB QL-30 QY 30 DY	90D; QL	3	
TRILIPIX CAP QL-30 QY 30 DY	90D; QL	3	
VYTORIN TAB 10/10MG QL-30 QY 30 DY	90D; QL	2	
VYTORIN TAB 10/20MG QL-30 QY 30 DY	90D; QL	2	
VYTORIN TAB 10/40MG QL-30 QY 30 DY	90D; QL	2	
VYTORIN TAB 10/80MG QL-30 QY 30 DY	90D; QL	2	PA
WELCHOL 3.75GM PACK QL-30 PACK 30 DY	90D; QL	3	ST
WELCHOL 625MG TAB QL-180 QY 30 DY	90D; QL	3	ST
ZETIA TAB QL-30 QY 30 DY	90D; QL	3	
<i>Renin-angiotensin-aldosterone System Inhibitors</i>			
<i>amlodipine/benazepril 10;20mg cap QL-30 QY 30 DY</i>	90D; QL	3	
<i>amlodipine/benazepril 10;40mg cap QL-30 QY 30 DY</i>	90D; QL	3	
<i>amlodipine/benazepril 2.5;10mg cap QL-30 QY 30 DY</i>	90D; QL	3	
<i>amlodipine/benazepril 5;10mg cap QL-30 QY 30 DY</i>	90D; QL	3	
<i>amlodipine/benazepril 5;20mg cap QL-30 QY 30 DY</i>	90D; QL	3	
<i>amlodipine/benazepril 5;40mg cap QL-30 QY 30 DY</i>	90D; QL	3	
ATACAND HCT TAB QL-30 QY 30 DY	90D; QL	3	
ATACAND TAB QL-30 QY 30 DY	90D; QL	3	
AVALIDE TAB QL-30 QY 30 DY	90D; QL	2	
AVAPRO TAB QL-30 QY 30 DY	90D; QL	2	
<i>benazepril tab</i>	90D	1	G
<i>benazepril/hctz tab</i>	90D	1	G
BENICAR HCT TAB QL-30 QY 30 DY	90D; QL	3	
BENICAR TAB QL-30 QY 30 DY	90D; QL	3	
<i>captopril tab</i>	90D	1	G
<i>captopril/hctz tab</i>	90D	1	G
DIOVAN HCT TAB QL-30 QY 30 DY	90D; QL	3	

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Cardiovascular Agents			
Renin-angiotensin-aldosterone System Inhibitors			
DIOVAN TAB QL-30 QY 30 DY	90D; QL	3	
<i>enalapril tab</i>	90D	1	G
<i>enalapril/hctz tab</i>	90D	1	G
<i>eplerenone tab</i>	90D	3	
<i>fosinopril tab</i>	90D	1	G
<i>fosinopril/hctz tab</i>	90D	1	G
<i>lisinopril tab</i>	90D	1	G
<i>lisinopril/hctz tab</i>	90D	1	G
<i>losartan pot/hctz tab QL-30 QY 30 DY</i>	90D; QL	1	G
<i>losartan potassium 100mg tab QL-30 QY 30 DY</i>	90D; QL	1	G
<i>losartan potassium 25mg tab QL-30 QY 30 DY</i>	90D; QL	1	G
<i>losartan potassium 50mg tab QL-30 QY 30 DY</i>	90D; QL	1	G
MICARDIS HCT TAB QL-30 QY 30 DY	90D; QL	2	
MICARDIS TAB QL-30 QY 30 DY	90D; QL	2	
<i>moexipril tab</i>	90D	1	G
<i>moexipril/hctz tab</i>	90D	1	G
<i>perindopril 2mg tab QL-30 QY 30 DY</i>	90D; QL	3	
<i>perindopril 4mg tab QL-30 QY 30 DY</i>	90D; QL	3	
<i>perindopril 8mg tab QL-60 QY 30 DY</i>	90D; QL	3	
<i>quinapril tab</i>	90D	1	G
<i>quinapril/hydrochlorothiazide tab</i>	90D	1	G
<i>ramipril cap</i>	90D	1	G
<i>spironolactone /hctz tab</i>	90D	1	G
<i>spironolactone tab</i>	90D	1	G
<i>trandolapril tab</i>	90D	1	G
TWYNSTA TAB QL-30 QY 30 DY	90D; QL	3	
Vasodilators			
DILATRATE SR CAP, CR	90D	2	
<i>hydralazine tab</i>	90D	1	G
<i>hydralazine vial</i>		1	G
<i>isosorbide dinitrate er tab</i>	90D	1	G
<i>isosorbide dinitrate tab</i>	90D	1	G

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Cardiovascular Agents			
Vasodilators			
<i>isosorbide dinitrate tab, subl</i>	90D	1	G
<i>isosorbide mononitrate er tab</i>	90D	1	G
<i>isosorbide mononitrate tab</i>	90D	1	G
<i>minoxidil tab</i>	90D	1	G
NITRO-BID OINT	90D	2	
NITRO-DUR PATCH QL-30 PTCH 30 DY	90D; QL	1	G
<i>nitroglycerin pumpspray</i>	90D	3	
<i>nitroglycerin vial</i>		1	G
NITROMIST SPRAY	90D	3	
NITROSTAT TAB, SUBL	90D	2	
Central Nervous System Agents			
Amphetamines, ADHD			
<i>amphetamine salt combo 1.25mg tab</i>	HRM	1	G
<i>amphetamine salt combo 1.875mg tab</i>	HRM	1	G
<i>amphetamine salt combo 2.5mg tab</i>	HRM	1	G
<i>amphetamine salt combo 3.125mg tab</i>	HRM	1	G
<i>amphetamine salt combo 3.75mg tab</i>	HRM	1	G
<i>amphetamine salt combo 5mg tab</i>	HRM	1	G
<i>amphetamine salt combo 7.5mg tab</i>	HRM	1	G
<i>amphetamine/dextroamphetamine er 10mg cap QL-30 QY 30 DY</i>	HRM; QL	3	ST
<i>amphetamine/dextroamphetamine er 15mg cap QL-30 QY 30 DY</i>	HRM; QL	3	ST
<i>amphetamine/dextroamphetamine er 20mg cap QL-30 QY 30 DY</i>	HRM; QL	3	ST
<i>amphetamine/dextroamphetamine er 25mg cap QL-30 QY 30 DY</i>	HRM; QL	3	ST
<i>amphetamine/dextroamphetamine er 30mg cap QL-60 QY 30 DY</i>	HRM; QL	3	ST
<i>amphetamine/dextroamphetamine er 5mg cap QL-30 QY 30 DY</i>	HRM; QL	3	ST
<i>dextroamphetamine sulfate er cap,24hr</i>	HRM	3	
<i>dextroamphetamine sulfate tab</i>	HRM	1	G

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Central Nervous System Agents			
<i>Non-amphetamines, ADHD</i>			
CONCERTA TAB 18MG QL-30 QY 30 DY	HRM; QL	3	ST
CONCERTA TAB 27MG QL-30 QY 30 DY	HRM; QL	3	ST
CONCERTA TAB 36MG QL-60 QY 30 DY	HRM; QL	3	ST
CONCERTA TAB 54MG QL-30 QY 30 DY	HRM; QL	3	ST
<i>dexmethylphenidate tab</i>	HRM	1	G
METADATE CD CAP QL-30 QY 30 DY	HRM; QL	3	ST
<i>metadate er tab</i>	HRM	1	G
<i>methylin er tab</i>	HRM	1	G
<i>methylin tab</i>	HRM	1	G
<i>methylphenidate sr tab</i>	HRM	1	G
<i>methylphenidate tab</i>	HRM	1	G
RITALIN LA 10MG CAP QL-30 QY 30 DY	HRM; QL	3	ST
RITALIN LA 20MG CAP QL-30 QY 30 DY	HRM; QL	3	ST
RITALIN LA 30MG CAP QL-60 QY 30 DY	HRM; QL	3	ST
RITALIN LA 40MG CAP QL-30 QY 30 DY	HRM; QL	3	ST
<i>Non-amphetamines, Other</i>			
AMPYRA TAB QL-60 QY 30 DY	QL	4	PA
NUVIGIL TAB QL-30 QY 30 DY	QL	3	PA
RILUTEK TAB		2	PA
XYREM SOLN ORAL QL-540ML 30 DY	QL	4	
Dental and Oral Agents			
<i>Dental and Oral Agents</i>			
<i>chlorhexidine gluconate oral rinse</i>		1	G
<i>doxycycline hyclate 20mg tabs</i>		3	
EVOXAC CAP	90D	2	
<i>periogard mouthwash</i>		1	G
<i>pilocarpine tab</i>	90D	1	G
<i>triamcinolone in orabase paste</i>		1	G
Dermatological Agents			
<i>Dermatological Agents</i>			
8-MOP CAP	90D	2	
AKNE-MYCIN OINT		3	

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Dermatological Agents			
<i>Dermatological Agents</i>			
<i>alclometasone dipropionate cream</i>	90D	1	G
<i>alclometasone dipropionate oint</i>	90D	1	G
ALTABAX OINT QL-15 GM 30 DY	QL	3	
<i>amcinonide cream</i>	90D	1	G
<i>amcinonide lotion</i>	90D	1	G
<i>amcinonide oint</i>	90D	1	G
AMEVIVE VIAL		4	PA
<i>ammonium lactate cream</i>	90D	1	G
<i>ammonium lactate lotion</i>	90D	1	G
<i>amnesteem cap</i>		3	
<i>apexicon e cream</i>	90D	3	
<i>augmented betameth dip cream</i>	90D	1	G
<i>augmented betameth dip gel</i>	90D	1	G
<i>augmented betameth dip lotion</i>	90D	1	G
<i>augmented betameth dip oint</i>	90D	1	G
AZELEX CREAM	90D	3	
BACTROBAN CREAM		3	
<i>beta-val cream</i>	90D	1	G
<i>beta-val lotion</i>	90D	1	G
<i>beta-val oint</i>	90D	1	G
<i>betamethasone diprop cream</i>	90D	1	G
<i>betamethasone diprop lotion</i>	90D	1	G
<i>betamethasone diprop oint</i>	90D	1	G
<i>calcipotriene soln non-oral</i>	90D	3	
CAPEX SHAMPOO	90D	2	
CARAC CREAM	90D	3	
<i>claravis cap</i>		3	
<i>clindamycin phos gel</i>		1	G
<i>clindamycin phos lotion</i>		1	G
<i>clindamycin phos soln</i>		1	G
<i>clindamycin phos swab</i>		1	G
<i>clindamycin/benzoyl peroxide gel</i>	90D	3	

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Dermatological Agents			
<i>Dermatological Agents</i>			
<i>clobetasol propionate e cream</i>	90D	1	G
<i>clobetasol propionate gel</i>	90D	1	G
<i>clobetasol propionate oint</i>	90D	1	G
<i>clobetasol propionate soln</i>	90D	1	G
CLOBEX LOTION	90D	3	
CLOBEX SHAMPOO	90D	3	
CLOBEX SPRAY, TOPICAL	90D	3	
CLODERM CREAM	90D	3	
CONDYLOX GEL		3	
CORDRAN LOTION	90D	3	
CORDRAN SP CREAM	90D	3	
CORDRAN TAPE	90D	3	
DERMA-SMOOTH/FS BODY OIL OIL	90D	2	
<i>desonide cream</i>	90D	1	G
<i>desonide lotion</i>	90D	1	G
<i>desonide oint</i>	90D	1	G
<i>desoximetasone cream</i>	90D	1	G
<i>desoximetasone gel</i>	90D	1	G
<i>desoximetasone oint</i>	90D	1	G
<i>diflorasone diacet cream</i>	90D	1	G
<i>diflorasone diacet oint</i>	90D	1	G
DOVONEX CREAM	90D	3	
ELIDEL CREAM QL-30 GM 30 DY	90D; QL	3	ST
<i>ery swab</i>		1	G
<i>erythromycin gel</i>		1	G
<i>erythromycin soln</i>		1	G
<i>erythromycin/benzoyl peroxide gel</i>		3	
FINACEA GEL	90D	3	
FINACEA PLUS KIT		3	
FLECTOR PTCH QL-60 PTCH 30 DY	90D; QL	3	
<i>fluocinolone acetonide cream</i>	90D	1	G
<i>fluocinolone acetonide oint</i>	90D	1	G

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Dermatological Agents			
<i>Dermatological Agents</i>			
<i>fluocinolone acetonide soln</i>	90D	1	G
<i>fluocinonide emollient base cream</i>	90D	1	G
<i>fluocinonide gel</i>	90D	1	G
<i>fluocinonide oint</i>	90D	1	G
<i>fluocinonide soln non-oral</i>	90D	1	G
FLUOROPLEX CREAM	90D	2	
<i>fluorouracil cream</i>	90D	1	G
<i>fluorouracil soln</i>	90D	1	G
<i>fluticasone propionate cream</i>	90D	1	G
<i>fluticasone propionate oint</i>	90D	1	G
<i>gentamicin sulfate cream</i>		1	G
<i>gentamicin sulfate oint</i>		1	G
<i>halobetasol propionate cream</i>	90D	1	G
<i>halobetasol propionate oint</i>	90D	1	G
HALOG CREAM	90D	3	
HALOG OINT	90D	3	
<i>hydrocortisone butyrate cream</i>	90D	1	G
<i>hydrocortisone butyrate oint</i>	90D	1	G
<i>hydrocortisone butyrate soln</i>	90D	1	G
<i>hydrocortisone cream</i>	90D	1	G
<i>hydrocortisone in absorbase oint</i>	90D	1	G
<i>hydrocortisone lotion</i>	90D	1	G
<i>hydrocortisone oint</i>	90D	1	G
<i>hydrocortisone valerate cream</i>	90D	1	G
<i>hydrocortisone valerate oint</i>	90D	1	G
<i>imiquimod cream QL-12 PACK 30 DY</i>	QL	3	
KENALOG AERO	90D	3	
<i>laclotion lotion</i>	90D	1	G
METROGEL	90D	3	
<i>metronidazole cream</i>	90D	1	G
<i>metronidazole gel</i>	90D	1	G
<i>metronidazole lotion</i>	90D	1	G

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Dermatological Agents			
<i>Dermatological Agents</i>			
<i>mometasone furoate cream</i>	90D	1	G
<i>mometasone furoate oint</i>	90D	1	G
<i>mometasone furoate soln</i>	90D	1	G
<i>mupirocin oint</i>		1	G
NORITATE CREAM	90D	3	
OXSORALEN LOTION		2	
OXSORALEN ULTRA CAP		4	
PANRETIN GEL		2	
<i>podofilox soln</i>		1	G
<i>prednicarbate cream</i>	90D	1	G
<i>prednicarbate oint</i>	90D	1	G
PROTOPIC OINT QL-30 GM 30 DY	90D; QL	3	ST
REGRANEX GEL QL-15 GM 30 DY	QL	4	PA
SANTYL OINT		3	
<i>scalacort lotion</i>	90D	1	G
<i>silver sulfadiazine cream</i>		1	G
<i>sodium chloride irrigation</i>		1	G
<i>sodium sulfacet lotion</i>		3	
SOLARAZE GEL QL-100 GM 30 DY	QL	2	
SORIATANE CAP QL-60 QY 30 DY	QL	3	
<i>sotret cap</i>		3	
<i>ssd cream</i>		1	G
SULFAMYLON CREAM		3	
SULFAMYLON PACKET		3	
TARGRETIN GEL QL-60 GM 30 DY	QL	4	PA
TAZORAC CREAM QL-30 GM 30 DY	QL	3	
TAZORAC GEL QL-30 GM 30 DY	QL	3	
TEXACORT SOLN NON-ORAL	90D	3	
<i>thermazene cream</i>		1	G
<i>tretinoin cream</i>	90D	1	G
<i>tretinoin gel</i>	90D	1	G
<i>triamcinolone acetonide cream</i>	90D	1	G

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Dermatological Agents			
<i>Dermatological Agents</i>			
<i>triamcinolone acetonide in absorbase oint</i>	90D	1	G
<i>triamcinolone acetonide lotion</i>	90D	1	G
<i>triamcinolone acetonide oint</i>	90D	1	G
<i>triderm cream</i>	90D	1	G
VANOS CREAM	90D	3	
VECTICAL OINT		3	
VEREGEN OINT QL-15 GM 30 DY	QL	3	
VOLTAREN GEL QL-1000 GM 30 DY	QL	3	
ZONALON CREAM QL-45 GM 30 DY	QL	3	
ZYCLARA 3.75% CREAM QL-28 PACK 30 DY	QL	3	
Enzyme Replacements/ Modifiers			
<i>Enzyme Replacements/ Modifiers</i>			
ADAGEN VIAL		4	PA
ALDURAZYME VIAL		4	PA
BUPHENYL TAB		4	PA
CEREDASE VIAL		4	PA
CEREZYME VIAL		4	PA
CYSTADANE POWDER		3	PA
CYSTAGON CAP	90D	3	PA
ELAPRASE VIAL		4	PA
FABRAZYME VIAL		4	PA
NAGLAZYME VIAL		4	PA
ORFADIN CAP		4	PA
VPRIV VIAL		4	PA
ZAVESCA CAP		4	PA
ZENPEP CAP	90D	2	
Gastrointestinal Agents			
<i>Antispasmodics, Gastrointestinal</i>			
CANTIL TAB	90D	3	
<i>dicyclomine cap</i>	90D; HRM	1	G

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Gastrointestinal Agents			
Antispasmodics, Gastrointestinal			
<i>dicyclomine syrup</i>	90D; HRM	1	G
<i>dicyclomine tab</i>	90D; HRM	1	G
<i>dicyclomine vial</i>	HRM	1	G
<i>diphenoxylate/atropine liquid</i>	HRM	1	G
<i>diphenoxylate/atropine tab</i>	HRM	1	G
<i>glycopyrrolate tab</i>	90D	3	
<i>glycopyrrolate vial</i>		3	
<i>loperamide caps</i>	90D	1	G
<i>methscopolamine bromide tab</i>	90D	3	
MOTOFEN TAB	HRM	3	
<i>propantheline bromide tab</i>	90D; HRM	3	
Gastrointestinal Agents, Other			
AMITIZA CAP QL-60 QY 30 DY	90D; QL	2	
CHENODAL TAB QL-90 QY 30 DY	QL	4	PA
<i>constulose soln oral</i>	90D	1	G
CORTIFOAM		2	
<i>enulose soln oral</i>	90D	1	G
GASTROCROM SOLN ORAL	90D	2	
<i>gavilyte-c soln oral QL-1 KIT QY 30 DY</i>	QL	1	G
<i>gavilyte-g soln oral QL-1 KIT QY 30 DY</i>	QL	1	G
<i>gavilyte-n QL-1 KIT QY 30 DY</i>	QL	1	G
<i>generlac soln oral</i>	90D	1	G
GOLYTELY QL-1 KIT QY 30 DY	QL	3	
HALFLYTELY BOWEL PREP KIT/FLAVOR PACKS QL-1 KIT QY 30 DY	QL	3	
KRISTALOSE PACKET	90D	3	
<i>lactulose soln oral</i>	90D	1	G
<i>metoclopramide soln oral</i>	90D	1	G
<i>metoclopramide tab</i>	90D	1	G
<i>metoclopramide vial</i>		1	G

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Gastrointestinal Agents			
<i>Gastrointestinal Agents, Other</i>			
MOVIPREP QL-1 KIT QY 30 DY	QL	3	
NULYTELY QL-1 KIT QY 30 DY	QL	2	
OSMOPREP TAB		3	
<i>peg 3350 QL-1 KIT QY 30 DY</i>	QL	1	G
<i>polyethylene glycol 3350 powder</i>		1	G
<i>proctosol hc cream</i>		1	G
<i>proctozone-hc cream</i>		1	G
SUPREP BOWL PREP QL-1 KIT QY 30 DY	QL	3	
<i>trilyte soln oral QL-1 KIT QY 30 DY</i>	QL	1	G
<i>ursodiol cap 300mg</i>	90D	1	G
<i>ursodiol tab 250mg</i>	90D	3	
<i>ursodiol tab 500mg</i>	90D	3	
VISICOL TAB		3	
Histamine2 (H2) Blocking Agents			
<i>cimetidine soln oral</i>	90D	1	G
<i>cimetidine tab</i>	90D	1	G
<i>cimetidine vial</i>		1	G
<i>famotidine iv</i>		3	
<i>famotidine suspension</i>	90D	3	
<i>famotidine tab</i>	90D	1	G
<i>famotidine vial</i>		1	G
<i>nizatadine oral soln</i>	90D	3	
<i>nizatadine cap</i>	90D	1	G
<i>ranitidine cap</i>	90D	1	G
<i>ranitidine syrup</i>	90D	3	
<i>ranitidine tab</i>	90D	1	G
<i>ranitidine vial</i>		1	G
Irritable Bowel Syndrome Agents			
LOTRONEX TAB QL-60 QY 30 DY	QL	2	PA
Protectants			
<i>misoprostol tab</i>	90D	1	G
<i>sucralfate tab</i>	90D	1	G

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Gastrointestinal Agents			
<i>Proton Pump Inhibitors</i>			
ACIPHEX TAB QL-30 QY 30 DY	90D; QL	3	ST
DEXILANT CAPS QL-30 QY 30 DY	90D; QL	3	ST
<i>lansoprazole capr QL-30 QY 30 DY</i>	90D; QL	3	
NEXIUM CAP QL-30 QY 30 DY	90D; QL	2	
NEXIUM IV		2	
NEXIUM PACK QL-30 PACK 30 DY	90D; QL	2	
<i>omeprazole 10mg cap QL-30 QY 30 DY</i>	90D; QL	1	G
<i>omeprazole 20mg cap</i>	90D	1	G
<i>omeprazole 40mg cap QL-60 QY 30 DY</i>	90D; QL	1	G
<i>pantoprazole tab QL-30 QY 30 DY</i>	90D; QL	1	G
Genitourinary Agents			
<i>Antispasmodics, Urinary</i>			
DETROL LA CAP QL-30 QY 30 DY	90D; QL	3	
DETROL TAB	90D	3	
ENABLEX TAB QL-30 QY 30 DY	90D; QL	3	
<i>flavoxate tab</i>	90D	1	G
GELNIQUE GEL QL-30 PACK 30 DY	90D; QL	3	
<i>oxybutynin er 10mg tab QL-30 QY 30 DY</i>	90D; QL	3	
<i>oxybutynin er 15mg tab QL-60 QY 30 DY</i>	90D; QL	3	
<i>oxybutynin er 5mg tab QL-30 QY 30 DY</i>	90D; QL	3	
<i>oxybutynin syrup</i>	90D	1	G
<i>oxybutynin tab</i>	90D	1	G
OXYTROL PATCH QL-8 PTCH 28 DY	90D; QL	3	
SANCTURA XR CAP QL-30 QY 30 DY	90D; QL	2	
<i>trosipium tab QL-60 QY 30 DY</i>	90D; QL	1	G
VESICARE TAB QL-30 QY 30 DY	90D; QL	2	
<i>Benign Prostatic Hypertrophy Agents</i>			
AVODART CAP QL-30 QY 30 DY	90D; QL	2	
<i>doxazosin mesylate tab</i>	90D	1	G
<i>finasteride tab</i>	90D	1	G
JALYN CAP QL-30 QY 30 DY	90D; QL	2	
RAPAFLO CAP QL-30 QY 30 DY	90D; QL	3	

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Genitourinary Agents			
<i>Benign Prostatic Hypertrophy Agents</i>			
<i>tamsulosin cap QL-60 QY 30 DY</i>	90D; QL	1	G
<i>terazosin cap</i>	90D	1	G
<i>Genitourinary Agents, Other</i>			
<i>bethanechol tab</i>	90D	1	G
CLEOCIN VAGINAL SUPP		2	
<i>clindamycin phos cream</i>		1	G
CLINDESSE CREAM		3	
ELMIRON CAP		2	
GYNAZOLE-1 CREAM		3	
<i>metronidazole vaginal gel</i>		1	G
<i>terconazole cream</i>		1	G
<i>terconazole vaginal supp</i>		3	
<i>vandazole gel</i>		1	G
<i>zazole cream</i>		1	G
<i>Phosphate Binders</i>			
<i>calcium acet cap</i>	90D	3	
<i>eliphos tab</i>	90D	1	G
FOSRENOL CHEW QL-90 QY 30 DY	90D; QL	3	
RENVELA 2.4GM PACK QL-90 QY 30 DY	90D; QL	2	
RENVELA 800MG TABS	90D	2	
Hormonal Agents, Stimulant/ Replacement/ Modifying (Adrenal)			
<i>Glucocorticoids/ Mineralocorticoids</i>			
<i>a-hydrocort solr</i>		1	G
<i>a-methapred vial</i>		1	G
CELESTONE SOLN ORAL	90D	2	
<i>cortisone acet tab</i>	90D	1	G
<i>dexamethasone elixir</i>	90D	1	G
<i>dexamethasone intensol drops</i>	90D	1	G
<i>dexamethasone sod phos vial</i>		1	G
<i>dexamethasone tab</i>	90D	1	G
<i>fludrocortisone tab</i>	90D	1	G
<i>hydrocortisone tab</i>	90D	1	G

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Hormonal Agents, Stimulant/ Replacement/ Modifying (Adrenal)			
Glucocorticoids/ Mineralocorticoids			
<i>methylprednisolone acet vial</i>		1	G
<i>methylprednisolone sod succ vial</i>		1	G
<i>methylprednisolone tab</i>	90D	1	G
<i>millipred tab</i>	90D	3	
<i>prednisolone sod phos soln oral</i>	90D	1	G
<i>prednisolone syrup</i>	90D	1	G
<i>prednisone intensol conc oral</i>	90D	1	G
<i>prednisone soln oral</i>	90D	1	G
<i>prednisone tab</i>	90D	1	G
Hormonal Agents, Stimulant/ Replacement/ Modifying (Pituitary)			
Hormonal Agents, Stimulant/ Replacement/ Modifying (Pituitary)			
<i>chorionic gonadotropin vial</i>		1	G
<i>desmopressin acet nasal aerosol</i>	90D	1	G
<i>desmopressin acet nasal soln</i>	90D	1	G
<i>desmopressin acet tab</i>	90D	1	G
<i>desmopressin acet vial</i>		1	G
EGRIFTA SOLR 1MG QL-60 QY 30 DY	QL	4	PA
GENOTROPIN CARTRIDGE		4	PA
GENOTROPIN MINIQUICK 0.2MG SOLR		3	PA
GENOTROPIN MINIQUICK 0.4MG SOLR		4	PA
GENOTROPIN MINIQUICK 0.6MG SOLR		4	PA
GENOTROPIN MINIQUICK 0.8MG SOLR		4	PA
GENOTROPIN MINIQUICK 1.2MG SOLR		4	PA
GENOTROPIN MINIQUICK 1.4MG SOLR		4	PA
GENOTROPIN MINIQUICK 1.6MG SOLR		4	PA
GENOTROPIN MINIQUICK 1.8MG SOLR		4	PA
GENOTROPIN MINIQUICK 1MG SOLR		4	PA
GENOTROPIN MINIQUICK 2MG SOLR		4	PA
HUMATROPE CARTRIDGE 12MG		4	PA
HUMATROPE CARTRIDGE 24MG		4	PA
HUMATROPE CARTRIDGE 6MG		3	PA
HUMATROPE COMBO PACK VIAL 5MG		4	PA

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Hormonal Agents, Stimulant/ Replacement/ Modifying (Pituitary)			
<i>Hormonal Agents, Stimulant/ Replacement/ Modifying (Pituitary)</i>			
INCRELEX VIAL		3	PA
METHERGINE TAB		3	
NORDITROPIN NORDIFLEX PEN		4	PA
NUTROPIN AQ NUSPIN 5 CARTRIDGE		4	PA
NUTROPIN AQ PEN		4	PA
NUTROPIN AQ VIAL		4	PA
NUTROPIN VIAL		4	PA
OMNITROPE CARTRIDGE 10MG/1.5ML		3	PA
OMNITROPE VIAL 5.8MG		3	PA
OMNITROPE VIAL 5MG/1.5ML		3	PA
SAIZEN CLICK EASY PEN		4	PA
SAIZEN VIAL		4	PA
SEROSTIM VIAL		4	PA
TEV-TROPIN VIAL		3	PA
ZORBTIVE VIAL		4	PA
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)			
<i>Anabolic Steroids</i>			
ANADROL-50 TAB		2	PA
<i>oxandrolone tab 10mg QL-60 QY 30 DY</i>	QL	4	PA
<i>oxandrolone tab 2.5mg QL-120 QY 30 DY</i>	QL	3	PA
<i>Androgens</i>			
ANDROGEL GEL		2	PA
ANDROGEL PUMP 1% GEL		2	PA
ANDROGEL PUMP 1.62% GEL		2	PA
<i>androxy tab</i>		1	G; PA
<i>danazol cap</i>		1	G
<i>testosterone cypionate vial</i>		1	G
<i>testosterone enanthate vial</i>		1	G
TESTRED CAP	HRM	3	PA
<i>Estrogens</i>			
ACTIVELLA 0.5;0.1MG TAB	90D	3	
ALORA PATCH QL-8 PTCH 28 DY	90D; QL	3	

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)			
<i>Estrogens</i>			
ANGELIQ TAB QL-30 QY 30 DY	90D; QL	3	
CENESTIN TAB QL-30 QY 30 DY	90D; HRM; QL	3	
CLIMARA PRO PATCH QL-4 PTCH 28 DY	90D; QL	3	
COMBIPATCH PATCH QL-8 PTCH 28 DY	90D; QL	3	
DEPO-ESTRADIOL VIAL		3	
DIVIGEL GEL QL-30 GM 30 DY	90D; QL	3	
ENJUVIA TAB QL-30 QY 30 DY	90D; HRM; QL	3	
ESTRACE CREAM	90D	3	
ESTRADERM PATCH QL-8 PTCH 28 DY	90D; QL	3	
<i>estradiol patch</i>	90D	1	G
<i>estradiol tab</i>	90D	1	G
<i>estradiol/norethindrone 0.5; 0.1mg tab</i>	90D	3	
<i>estradiol/norethindrone 1;0.5mg tab</i>	90D	3	
ESTRASORB EMUL QL-56 POUCHES 28 DY	90D; QL	3	
ESTRING RING QL-1 RING 90 DY	90D; QL	3	
<i>estropipate tab</i>	90D; HRM	1	G
EVAMIST SPRAY QL-2 BOTTLES 30 DY	QL	3	
FEMHRT LOW DOSE TAB	90D	3	
FEMRING RING QL-1 RING 84 DY	90D; QL	3	
FEMTRACE TAB	90D	3	
<i>jinteli QL-30 QY 30 DY</i>	90D; QL	3	
MENEST TAB QL-30 QY 30 DY	90D; HRM; QL	3	
MENOSTAR PATCH QL-4 QY 28 DY	90D; QL	3	
<i>ortho-est tab</i>	90D; HRM	1	G
PREFEST TAB	90D	3	
PREMARIN CREAM	90D; HRM	2	

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)			
Estrogens			
PREMARIN TAB QL-30 QY 30 DY	90D; HRM; QL	2	
PREMPHASE TAB QL-30 QY 30 DY	90D; HRM; QL	2	
PREMPRO TAB QL-30 QY 30 DY	90D; HRM; QL	2	
VAGIFEM TAB	90D	3	
VIVELLE-DOT PATCH QL-8 PTCH 28 DY	90D; QL	2	
Progestins			
<i>amethyst tab QL-28 QY 28 DY</i>	90D; QL	3	
<i>apri tab QL-28 QY 28 DY</i>	90D; QL	3	
<i>aranelle tab QL-28 QY 28 DY</i>	90D; QL	3	
<i>aviane tab QL-28 QY 28 DY</i>	90D; QL	3	
<i>balziva tab QL-28 QY 28 DY</i>	90D; QL	3	
<i>camila tab QL-28 QY 28 DY</i>	90D; QL	1	G
<i>cesia tab QL-28 QY 28 DY</i>	90D; QL	1	G
CRINONE GEL		3	
<i>cryselle-28 tab QL-28 QY 28 DY</i>	90D; QL	1	G
<i>enpresse-28 tab QL-28 QY 28 DY</i>	90D; QL	3	
<i>errin tab QL-28 QY 28 DY</i>	90D; QL	1	G
<i>gianvi tab QL-28 QY 28 DY</i>	90D; QL	3	
<i>jolivette tab QL-28 QY 28 DY</i>	90D; QL	1	G
<i>junel fe tab QL-28 QY 28 DY</i>	90D; QL	1	G
<i>junel tab QL-28 QY 28 DY</i>	90D; QL	1	G
<i>kariva tab QL-28 QY 28 DY</i>	90D; QL	3	
<i>kelnor 1/35 tab QL-28 QY 28 DY</i>	90D; QL	3	
<i>leena tab QL-28 QY 28 DY</i>	90D; QL	3	
<i>lessina-28 tab QL-28 QY 28 DY</i>	90D; QL	3	
<i>levora tab QL-28 QY 28 DY</i>	90D; QL	3	
LO LOESTRIN FE TAB QL-28 QY 28 DY	90D; QL	3	
LOESTRIN 24 FE TAB QL-28 QY 28 DY	90D; QL	3	
LOSEASONIQUE TAB QL-91 QY 90 DY	90D; QL	3	
<i>low-ogestrel tab QL-28 QY 28 DY</i>	90D; QL	1	G

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)			
Progestins			
<i>lutera tab QL-28 QY 28 DY</i>	90D; QL	3	
MAKENA VIAL		4	PA
<i>medroxyprogesterone acet tab</i>	90D	1	G
<i>medroxyprogesterone acet vial QL-1ML 90 DY</i>	90D; QL	3	
<i>microgestin fe tab QL-28 QY 28 DY</i>	90D; QL	1	G
<i>microgestin tab QL-28 QY 28 DY</i>	90D; QL	1	G
<i>mononessa tab QL-28 QY 28 DY</i>	90D; QL	3	
<i>necon 0.5/35-28 tabs QL-28 QY 28 DY</i>	90D; QL	3	
<i>necon 1/35-28 tabs QL-28 QY 28 DY</i>	90D; QL	3	
<i>necon 1/50-28 tab QL-28 QY 28 DY</i>	90D; QL	3	
<i>necon 10/11-28 tabs QL-28 QY 28 DY</i>	90D; QL	1	G
<i>necon 7/7/7 tabs QL-28 QY 28 DY</i>	90D; QL	3	
<i>next choice tab</i>		1	G
<i>nora-be tab QL-28 QY 28 DY</i>	90D; QL	1	G
<i>norethindrone acet tab</i>	90D	1	G
<i>nortrel tab QL-28 QY 28 DY</i>	90D; QL	3	
<i>ocella tab QL-28 QY 28 DY</i>	90D; QL	3	
<i>ogestrel tab QL-28 QY 28 DY</i>	90D; QL	3	
ORTHO EVRA PATCH QL-3 PTCH 28 DY	90D; QL	3	
<i>portia-28 tab QL-28 QY 28 DY</i>	90D; QL	3	
<i>previfem tab QL-28 QY 28 DY</i>	90D; QL	3	
PROMETRIUM CAP	90D	2	
<i>quasense tab QL-91 QY 90 DY</i>	90D; QL	3	
<i>reclipsen tab QL-28 QY 28 DY</i>	90D; QL	3	
SEASONIQUE TAB QL-91 QY 90 DY	90D; QL	3	
<i>solia tab QL-28 QY 28 DY</i>	90D; QL	3	
<i>sprintec 28 tab QL-28 QY 28 DY</i>	90D; QL	3	
<i>sronyx tab QL-28 QY 28 DY</i>	90D; QL	3	
<i>tri-legest fe tab QL-28 QY 28 DY</i>	90D; QL	3	
<i>tri-previfem tab QL-28 QY 28 DY</i>	90D; QL	1	G
<i>tri-sprintec tab QL-28 QY 28 DY</i>	90D; QL	1	G
<i>trinessa tab QL-28 QY 28 DY</i>	90D; QL	1	G

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)			
<i>Progestins</i>			
<i>trivora-28 tab QL-28 QY 28 DY</i>	90D; QL	3	
<i>velivet tab QL-28 QY 28 DY</i>	90D; QL	1	G
<i>zeosa QL-28.00 QTY 28 DY</i>	90D; QL	3	
<i>zovia tab QL-28 QY 28 DY</i>	90D; QL	3	
<i>Selective Estrogen Receptor Modifying Agents</i>			
EVISTA TAB QL-30 QY 30 DY	90D; QL	2	
Hormonal Agents, Stimulant/ Replacement/ Modifying (Thyroid)			
<i>Hormonal Agents, Stimulant/ Replacement/ Modifying (Thyroid)</i>			
<i>levothroid tab</i>	90D	1	G
<i>levothyroxine tab</i>	90D	1	G
<i>levoxyl tab</i>	90D	1	G
<i>liothyronine tab</i>	90D	1	G
SYNTHROID TAB	90D	2	
THYROLAR TAB	90D	3	
TIROSINT CAP QL-30 QY 30 DY	90D; QL	2	
<i>unithroid tab</i>	90D	1	G
Hormonal Agents, Suppressant (Adrenal)			
<i>Hormonal Agents, Suppressant (Adrenal)</i>			
LYSODREN TAB		2	
Hormonal Agents, Suppressant (Parathyroid)			
<i>Hormonal Agents, Suppressant (Parathyroid)</i>			
SENSIPAR 30MG TAB QL-60 QY 30 DY	QL	3	PA
SENSIPAR 60MG TAB QL-60 QY 30 DY	QL	4	PA
SENSIPAR 90MG TAB QL-120 QY 30 DY	QL	4	PA
Hormonal Agents, Suppressant (Pituitary)			
<i>Hormonal Agents, Suppressant (Pituitary)</i>			
<i>cabergoline tab</i>	90D	3	
<i>leuprolide acet 1mg kit</i>		3	PA
LUPRON DEPOT KIT		4	PA
LUPRON DEPOT-PED KIT		4	PA
<i>octreotide inj</i>		3	PA
SANDOSTATIN LAR DEPOT KIT		4	PA

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Hormonal Agents, Suppressant (Pituitary)			
<i>Hormonal Agents, Suppressant (Pituitary)</i>			
SOMATULINE DEPOT QL-1 INJ 28 DY	QL	4	PA
SOMAVERT VIAL		4	PA
SYNAREL AERO		4	PA
TRELSTAR DEPOT 3.75MG SUSR QL-1 VIAL 30 DY	QL	4	
TRELSTAR LA 11.25MG SUSR QL-1 VIAL 90 DY	QL	4	
TRELSTAR MIXJECT 22.5MG QL-1 VIAL 180 DY	QL	4	
Hormonal Agents, Suppressant (Sex Hormones/ Modifiers)			
<i>Antiandrogens</i>			
<i>bicalutamide tab QL-30 QY 30 DY</i>	90D; QL	1	G
<i>flutamide cap</i>	90D	1	G
NILANDRON TAB		2	
Hormonal Agents, Suppressant (Thyroid)			
<i>Antithyroid Agents</i>			
<i>methimazole tab</i>	90D	1	G
<i>propylthiouracil tab</i>	90D	1	G
Immunological Agents			
<i>Immune Suppressants</i>			
<i>azathioprine soln</i>		1	G
<i>azathioprine tab</i>	90D	1	G
CELLCEPT SUSPENSION	B v D	3	PA
<i>cyclosporine cap</i>	B v D	1	G; PA
<i>cyclosporine modified cap</i>	B v D	1	G; PA
<i>cyclosporine modified soln oral</i>	B v D	1	G; PA
<i>engraf cap</i>	B v D	1	G; PA
<i>engraf soln oral</i>	B v D	1	G; PA
<i>methotrexate tab</i>	90D	1	G
<i>methotrexate vial</i>		1	G
<i>mycophenolate mofetil cap</i>	B v D	3	PA
<i>mycophenolate mofetil tab</i>	B v D	3	PA
NEORAL CAP	B v D	3	PA
NEORAL SOLN ORAL	B v D	3	PA
RAPAMUNE ORAL SOLN	B v D	3	PA

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Immunological Agents			
<i>Immune Suppressants</i>			
RAPAMUNE TAB	B v D	4	PA
SANDIMMUNE CAP	B v D	3	PA
SANDIMMUNE SOLN ORAL	B v D	3	PA
<i>tacrolimus 0.5mg cap</i>	B v D	3	PA
<i>tacrolimus 1mg cap</i>	B v D	3	PA
<i>tacrolimus 5mg cap</i>	B v D	4	PA
ZORTRESS 0.25MG TABS	B v D	3	PA
ZORTRESS 0.5MG TABS	B v D	4	PA
ZORTRESS 0.75MG TABS	B v D	4	PA
<i>Immunizing Agents, Passive</i>			
CARIMUNE NAONFILTERED VIAL		4	PA
<i>gammagard liquid vial</i>		4	PA
GAMMAGARD S/D VIAL		4	PA
GAMMAPLEX SOLN	B v D	4	PA
GAMUNEX VIAL		4	PA
<i>privigen vial</i>		4	PA
VIVAGLOBIN VIAL		4	PA
<i>Immunomodulators</i>			
ACTEMRA VIAL QL-2 VIALS 28 DY	QL	4	PA
ACTIMMUNE VIAL		4	
ARCALYST VIAL QL-8 VIALS 30 DY	QL	4	PA
AVONEX QL-4 INJ 30 DY	QL	4	PA
BETASERON KIT QL-15 SYR 30 DY	QL	4	PA
CIMZIA KIT QL- 6ML 28 DY	QL	4	PA
COPAXONE KIT QL-30 INJ 30 DY	QL	4	PA
ENBREL 25MG KIT QL-16 INJ 30 DY	QL	4	PA
ENBREL 25MG SOLN QL-16 SYR 30 DY	QL	4	PA
ENBREL 50MG/ML SOLN QL-8 SYR 28 DY	QL	4	PA
ENBREL PEN 50MG/ML SOLN QL-8 SYR 28 DY	QL	4	PA
EXTAVIA KIT QL-15 SYR 30 DY	QL	4	PA
GILENYA 0.5MG CAP QL-30 QY 30 DY	QL	4	PA
HUMIRA 20MG/0.4ML KIT QL-2 SYR 30 DY	QL	4	PA
HUMIRA 40MG/0.8ML KIT QL-6 SYR 30 DY	QL	4	PA
HUMIRA PEN 40MG/0.8ML QL-6 SYR 30 DY	QL	4	PA

Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Immunological Agents			
<i>Immunomodulators</i>			
ILARIS VIAL QL-1 VIAL QY 56 DY	QL	4	PA
INFERGEN VIAL		4	PA
INTRON-A INJ 10MU		4	PA
INTRON-A INJ 3MU		3	PA
INTRON-A INJ 5MU		4	PA
INTRON-A INJ 6000000U		4	PA
KINERET SYR QL-30 SYR 30 DY	QL	4	PA
<i>leflunomide tab</i>	90D	1	G
ORENCIA VIAL		4	PA
PEG-INTRON KIT QL-4 VIALS 30 DY	QL	4	PA
PEG-INTRON REDIPEN QL-4 PENS 30 DY	QL	4	PA
PEGASYS KIT QL-1 KIT 28 DY	QL	4	PA
REBIF SYRINGE QL-12 INJ 28 DY	QL	4	PA
REMICADE VIAL		4	PA
RIDAURA CAP	90D	2	
SIMPONI SYRINGE QL-1 SYR 30 DY	QL	4	PA
STELARA SYR QL-5 INJ 365 DY	QL	4	PA
TYSABRI VIAL		4	PA
<i>Vaccines</i>			
ACTHIB VIAL		3	
ADACEL VIAL		3	
BOOSTRIX SYRINGE		3	
CERVARIX SYRINGE		3	PA
CERVARIX VIAL		3	PA
COMVAX VIAL		3	
DAPTACEL VIAL		3	
DECAVAC SYRINGE		2	
DIPHTHERIA/TETANUS TOXOID PEDIATRIC INJ		2	
ENGERIX-B INJ	B v D	2	PA
GARDASIL VIAL		3	PA
HAVRIX INJ		3	
IMOVAX RABIES INJ		3	

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Immunological Agents			
<i>Vaccines</i>			
INFANRIX VIAL		2	
IPOL VIAL		2	
IXIARO SUSP		3	
JE-VAX VIAL		3	
KINRIX SYR QL-1 INJ 365 DY	QL	3	
M-M-R II VIAL		2	
MENACTRA SYRINGE		3	
MENOMUNE-A/C/Y/W-135 VIAL		2	
MENVEO VIAL		3	
PEDIARIX VIAL		3	
PEDVAX HIB VIAL		3	
PENTACEL KIT QL-3 INJ 30 DY	QL	3	
PROQUAD VIAL		3	
RABAVERT KIT		3	
RECOMBIVAX HB VIAL	B v D	3	PA
ROTARIX SUSPENSION		2	
ROTATEQ SUSPENSION		2	
TETANUS TOXOID ADSORBED VIAL		2	
TETANUS/DIPHThERIA TOXOIDS-ADSORBED VIAL		2	
TRIHIBIT KIT		3	
TRIPEDIA VIAL		3	
TWINRIX VIAL		3	
TYPHIM VI VIAL		3	
VAQTA VIAL		3	
VARIVAX VIAL		2	
YF-VAX VIAL		2	
ZOSTAVAX VIAL QL-1 INJ 365 DY	QL	3	PA
Inflammatory Bowel Disease Agents			
<i>Glucocorticoids</i>			
<i>budesonide ec cap</i>	90D	3	
ENTOCORT EC CAP	90D	3	
<i>hydrocortisone enema</i>		1	G

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Inflammatory Bowel Disease Agents			
<i>Salicylates</i>			
APRISO CAP QL-120 QY 30 DY	90D; QL	2	
ASACOL 400MG TAB	90D	2	
<i>balsalazide cap</i>	90D	1	G
CANASA SUPP RECTAL	90D	2	
DIPENTUM CAP	90D	3	
LIALDA TAB QL-120 QY 30 DY	90D; QL	3	
<i>mesalamine enema</i>	90D	1	G
PENTASA CAP, CR	90D	3	
<i>Sulfonamides</i>			
<i>sulfasalazine tab</i>	90D	1	G
<i>sulfazine ec tab</i>	90D	1	G
Metabolic Bone Disease Agents			
<i>Metabolic Bone Disease Agents</i>			
ACTONEL 150MG TAB QL-1 QY 30 DY	90D; QL	3	ST
ACTONEL 30MG TAB QL-30 QY 30 DY	QL	3	ST
ACTONEL 35MG TAB QL-4 QY 28 DY	90D; QL	3	ST
ACTONEL 5MG TAB QL-30 QY 30 DY	90D; QL	3	ST
<i>alendronate tab</i>	90D	1	G
BONIVA TAB QL-1 QY 30 DY	90D; B v D; QL	2	PA
<i>calcitonin-salmon aero</i>	90D	1	G
<i>calcitriol ampul</i>	B v D	1	G; PA
<i>calcitriol cap</i>	90D; B v D	1	G; PA
<i>calcitriol soln oral</i>	90D; B v D	1	G; PA
<i>etidronate tab</i>	90D	3	
FORTEO QL-1 PEN 28 DY	QL	4	PA
<i>fortical nasal soln</i>	90D	1	G
FOSAMAX SOLN ORAL QL-300ML 28 DY	90D; QL	3	
HECTOROL CAP	B v D	3	PA
<i>pamidronate vial</i>	B v D	3	PA
SKELID TAB	90D	3	

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Metabolic Bone Disease Agents			
<i>Metabolic Bone Disease Agents</i>			
ZEMPLAR CAP QL-30 QY 30 DY	B v D; QL	2	PA
ZOMETA VIAL		4	PA
Miscellaneous Therapeutic Agents			
<i>Miscellaneous Therapeutic Agents</i>			
<i>alcohol preps pads</i>	90D	1	G
BOTOX VIAL QL-1 VIAL 90 DY	QL	3	PA
DYSPORE VIAL QL-1 VIAL 90 DY	QL	4	PA
<i>gauze pads 2"x2" bandage</i>	90D	1	G
INSULIN PEN NEEDLE	90D	2	
INSULIN SAFETY SYRINGE	90D	3	
INSULIN SYRINGE	90D	2	
KUVAN TAB		4	PA
<i>levocarnitine tab</i>	90D	3	
MEGACE ES ORAL SUSP QL-150ML 30 DY	90D; QL	3	
<i>megestrol acet suspension</i>	90D	1	G
<i>megestrol acet tab</i>	90D	1	G
XENAZINE 12.5MG TAB QL-90 QY 30 DY	QL	4	PA
XENAZINE 25MG TAB QL-120 QY 30 DY	QL	4	PA
Ophthalmic Agents			
<i>Ophthalmic Agents, Other</i>			
<i>ak-tob 0.3% ophth drops</i>		1	G
AZASITE DROPS QL-2.5ML 14 DY	QL	2	
<i>bacitracin oint</i>		1	G
<i>bacitracin/polymyxin b oint</i>		1	G
BESIVANCE SUSP QL-5ML 30 DY	QL	3	
CILOXAN OINT		2	
<i>ciprofloxacin drops</i>		1	G
<i>erythromycin oint</i>		1	G
<i>gentak oint</i>		1	G
<i>gentamicin sulfate opht drops</i>		1	G
<i>gentasol drops</i>		1	G
LACRISERT INSERT		3	

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Ophthalmic Agents			
<i>Ophthalmic Agents, Other</i>			
<i>levofloxacin drops</i>		3	
MOXEZA DROPS QL-3ML 30 DY	QL	3	
NATACYN SUSPENSION		2	
<i>neomycin /bacitracin /hydrocortisone oint</i>		1	G
<i>neomycin /bacitracin /polymyxin oint</i>		1	G
<i>neomycin /polymyxin /gramicidin drops</i>		1	G
<i>ofloxacin 0.3% ophth soln</i>		1	G
RESTASIS QL-64 VIALS 30 DY	90D; QL	2	
<i>romycin oint</i>		1	G
<i>sodium sulfacet ophth drops</i>		1	G
<i>tobramycin sulfate 0.3% ophth drops</i>		1	G
<i>tobrasol 0.3% ophth drops</i>		1	G
TOBREX 0.3% OPHTH OINT		2	
<i>trifluridine drops</i>		1	G
<i>trimethoprim sulf/poly b sulfate drops</i>		1	G
<i>tropicamide drops</i>	90D	1	G
VIGAMOX DROPS QL-3ML 30 DY	QL	3	
ZYMAR DROPS QL-5ML 30 DY	QL	3	
ZYMAXID DROPS QL-2.5ML 30 DY	QL	3	
<i>Ophthalmic Anti-allergy Agents</i>			
<i>ak-con drops</i>		1	G
ALAMAST DROPS QL-20ML 30 DY	QL	3	
ALOCRIAL DROPS QL-10ML 30 DY	QL	3	
ALOMIDE DROPS		3	
<i>azelastine drops</i>		3	
BEPREVE DROPS QL-10ML 30 DY	90D; QL	3	
<i>cromolyn drops</i>		1	G
EMADINE DROPS	90D	3	
<i>epinastine drops</i>	90D	3	
LASTACAFT DROPS QL-3ML 30 DY	90D; QL	3	
PATADAY DROPS QL-2.5ML 30 DY	90D; QL	3	
PATANOL DROPS QL-5ML QY 30 DY	90D; QL	3	

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Ophthalmic Agents			
<i>Ophthalmic Anti-inflammatories</i>			
ACUVAIL OPHTH DROPS QL-60 VIALS 30 DY	QL	3	
ALREX SUSP QL-15ML 30 DY	QL	2	
BLEPHAMIDE S.O.P. OINT		2	
BLEPHAMIDE SUSPENSION		2	
BROMDAY OPHTHALMIC SOLN QL-1.7ML QY 30 DY	QL	3	
<i>bromfenac ophthalmic soln QL-3ML QY 30 DY</i>	QL	3	
<i>dexamethasone sod phos drops</i>		1	G
<i>diclofenac drops</i>		1	G
DUREZOL DROPS		3	
FLAREX SUSPENSION		3	
<i>fluorometholone suspension</i>		1	G
<i>flurbiprofen drops</i>		1	G
FML FORTE SUSPENSION		2	
FML OINT		2	
<i>ketorolac trometh 0.4% ophth soln QL-10ML 30 DY</i>	QL	1	G
<i>ketorolac trometh 0.5% ophth soln QL-10ML 30 DY</i>	QL	1	G
LOTEMAX SUSPENSION		2	
MAXIDEX SUSPENSION		2	
<i>neomycin /poly/hydrocort opht susp</i>		1	G
<i>neomycin /polymyxin /dexameth oint</i>		1	G
<i>neomycin /polymyxin /dexameth suspension</i>		1	G
NEVANAC SUSP QL-3ML 30 DY	QL	3	
<i>poly-dex oint</i>		1	G
<i>poly-dex suspension</i>		1	G
POLY-PRED SUSPENSION		2	
PRED MILD SUSPENSION		2	
PRED-G S.O.P. OINT		2	
PRED-G SUSPENSION		2	
<i>prednisolone acet ophth susp</i>		1	G
<i>prednisolone sod phos ophth drops</i>		1	G
<i>sulfacetamide/predn sod phosp drops</i>		1	G
TOBRADEX OINT		3	

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Ophthalmic Agents			
<i>Ophthalmic Anti-inflammatories</i>			
TOBRADEX ST SUSP		3	
<i>tobramycin /dexamethasone susp</i>		1	G
VEXOL SUSPENSION		3	
ZYLET SUSPENSION		2	
<i>Ophthalmic Antiglaucoma Agents</i>			
ALPHAGAN P OPHTH DROPS QL-10ML 30 DY	90D; QL	2	
<i>apraclonidine drops</i>	90D	1	G
AZOPT SUSPENSION	90D	3	
<i>betaxolol drops</i>	90D	1	G
BETIMOL DROPS	90D	3	
BETOPTIC-S SUSPENSION	90D	3	
<i>brimonidine tart 0.15% ophth drops QL-10ML 30 DY</i>	90D; QL	3	
<i>brimonidine tart 0.2% ophth drops</i>	90D	1	G
<i>carteolol drops</i>	90D	1	G
COMBIGAN DROPS QL-10ML 30 DY	90D; QL	2	
<i>dorzolamide drops</i>	90D	1	G
<i>dorzolamide/timolol drops QL-10ML 30 DY</i>	90D; QL	1	G
ISTALOL DROPS QL-5ML 30 DY	90D; QL	2	
<i>levobunolol drops</i>	90D	1	G
<i>methazolamide tab</i>	90D	1	G
<i>metipranolol drops</i>	90D	1	G
PHOSPHOLINE IODIDE DROPS	90D	2	
PILOPINE HS GEL	90D	2	
<i>timolol drops</i>	90D	1	G
<i>timolol drops gel</i>	90D	1	G
<i>Ophthalmic Prostaglandin and Prostanamide Analogs</i>			
<i>latanoprost QL-2.5ML 30 DY</i>	90D; QL	1	G
LUMIGAN 0.01% QL-5ML QY 30 DY	90D; QL	2	
LUMIGAN 0.03% QL-5ML QY 30 DY	90D; QL	2	
TRAVATAN Z QL-5ML 30 DY	90D; QL	3	

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Otic Agents			
<i>Otic Agents</i>			
<i>acetic acid soln</i>		1	G
<i>acetic acid/hydrocort</i>		3	
CIPRO HC SUSPENSION		3	
CIPRODEX SUSPENSION		2	
COLY-MYCIN S SUSPENSION		3	
CORTISPORIN-TC DROPS		3	
<i>cortomycin otic soln</i>		1	G
<i>cortomycin otic susp</i>		1	G
DERMOTIC DROPS		2	
<i>neomycin /poly/hydrocort otic susp</i>		1	G
<i>neomycin /polymyxin /hc otic soln</i>		1	G
<i>ofloxacin 0.3% otic soln</i>		1	G
Respiratory Tract Agents			
<i>Anti-inflammatories, Inhaled Corticosteroids</i>			
ADVAIR DISKUS QL-1 DISKUS 30 DY	90D; QL	2	
ADVAIR HFA QL-1 INHALER 30 DY	90D; QL	2	
ALVESCO HFA QL-2 INHALERS 30 DY	90D; QL	3	
ASMANEX INHALER QL-1 INHALER 30 DY	90D; QL	2	
<i>budesonide neb QL-60 VIALS 30 DY</i>	QL	3	PA
DULERA HFA INHALER QL-1 INHALER 30 DY	90D; QL	3	
FLOVENT DISKUS QL-1 DISKUS 30 DY	90D; QL	2	
FLOVENT HFA INHALER QL-2 INHALERS 30 DY	90D; QL	2	
PULMICORT FLEXHALER QL-2 INHALERS 30 DY	90D; QL	3	
QVAR INHALER	90D	3	
SYMBICORT AERO QL-1 INHALER 30 DY	90D; QL	2	
<i>Antihistamines</i>			
ASTEPRO QL-1 BOTTLE 25 DY	90D; QL	2	
<i>azelastine nasal spray</i>	90D	3	
<i>carbinoxamine liquid</i>	90D	1	G
<i>carbinoxamine tab</i>	90D	1	G
<i>clemastine syrup</i>	90D	1	G
<i>clemastine tab</i>	90D	1	G

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Respiratory Tract Agents			
Antihistamines			
<i>cyproheptadine syrup</i>	90D; HRM	1	G
<i>cyproheptadine tab</i>	90D; HRM	1	G
<i>dexchlorpheniramine syrup</i>	90D; HRM	1	G
<i>diphenhydramine cap</i>	90D; HRM	1	G
<i>hydroxyzine pamoate cap</i>	90D; HRM	1	G
<i>hydroxyzine syrup</i>	90D; HRM	1	G
<i>hydroxyzine tab</i>	90D; HRM	1	G
<i>hydroxyzine vial</i>	HRM	1	G
<i>levocetirizine dihydrochloride tabs QL-30 QY 30 DY</i>	90D; QL	3	ST
<i>meclizine tab</i>	90D	3	
PATANASE QL-1 BOTTLE 25 DY	90D; QL	3	
<i>promethazine vc syrup</i>	HRM	1	G
SEMPREX-D CAP	90D	3	
Antileukotrienes			
SINGULAIR QL-30 QY 30 DY	90D; QL	2	
<i>zafirlukast tab QL-60 QY 30 DY</i>	90D; QL	3	
ZYFLO 600MG TAB12 QL-120 QY 30 DY	90D; QL	3	
Bronchodilators, Anticholinergic			
ATROVENT HFA QL-2 INHALERS 30 DY	90D; QL	2	
COMBIVENT INHALER QL-2 INHALERS 30 DY	90D; QL	2	
<i>ipratropium bromide nasal soln</i>	90D	1	G
<i>ipratropium bromide soln, neb</i>	B v D	1	G; PA
<i>ipratropium bromide/albuterol sulfate, neb</i>	B v D	3	PA
SPIRIVA HANDIHALER CAP QL-30 QY 30 DY	90D; QL	2	
Bronchodilators, Phosphodiesterase Inhibitors (Xanthines)			
<i>aminophylline tab</i>	90D	1	G

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Respiratory Tract Agents			
Bronchodilators, Phosphodiesterase Inhibitors (Xanthines)			
<i>aminophylline vial</i>		1	G
ELIXOPHYLLIN ELIXIR	90D	2	
THEO-24 100MG CAP QL-30 QY 30 DY	90D; QL	3	
THEO-24 200MG CAP QL-30 QY 30 DY	90D; QL	3	
THEO-24 300MG CAP QL-60 QY 30 DY	90D; QL	3	
THEO-24 400MG CAP QL-30 QY 30 DY	90D; QL	3	
<i>theochron tab</i>	90D	1	G
<i>theophylline er tab</i>	90D	1	G
<i>theophylline er tab, sr</i>	90D	1	G
Bronchodilators, Sympathomimetic			
<i>albuterol sulf 0.083% neb</i>	B v D	1	G; PA
<i>albuterol sulf 0.5% neb</i>	B v D	1	G; PA
<i>albuterol sulf 0.63mg/3ml neb</i>	B v D	3	PA
<i>albuterol sulf 1.25mg/3ml neb</i>	B v D	3	PA
<i>albuterol sulf er tab</i>	90D	1	G
<i>albuterol sulf syrup</i>	90D	1	G
<i>albuterol sulf tab</i>	90D	1	G
BROVANA NEB QL-60 VIALS 30 DY	QL	3	PA
<i>epinephrine syringe</i>		1	G
EPIPEN QL-2 INJ 30 DY	QL	2	
EPIPEN-JR QL-2 INJ 30 DY	QL	2	
FORADIL AERO CAP QL-60 QY 30 DY	90D; QL	2	
<i>levalbuterol neb QL-90 VIALS 30 DY</i>	QL	3	PA
<i>metaproterenol sulfate syrup</i>	90D	1	G
<i>metaproterenol sulfate tab</i>	90D	1	G
PERFOROMIST NEB QL-60 VIALS 30 DY	QL	3	PA
PROAIR HFA INHALER QL-2 INHALERS 30 DY	90D; QL	2	
PROVENTIL HFA QL-2 INHALERS 30 DY	90D; QL	3	
SEREVENT DISKUS QL-1 DISKUS 30 DY	90D; QL	3	
<i>terbutaline sulfate tab</i>	90D	1	G
TWINJECT QL-2 INJ 30 DY	QL	2	
VENTOLIN HFA QL-2 INHALERS 30 DY	90D; QL	2	

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Respiratory Tract Agents			
<i>Bronchodilators, Sympathomimetic</i>			
XOPENEX HFA QL-2 INHALERS 30 DY	90D; QL	3	
<i>Mast Cell Stabilizers</i>			
<i>cromolyn neb</i>	B v D	1	G; PA
<i>Pulmonary Antihypertensives</i>			
ADCIRCA TAB QL-60 QY 30 DY	QL	4	PA
LETAIRIS TAB QL-30 QY 30 DY	QL	4	PA
REVATIO TAB QL-90 QY 30 DY	QL	4	PA
TRACLEER TAB QL-60 QY 30 DY	QL	4	PA
VENTAVIS AMPUL		4	PA
<i>Respiratory Tract Agents, Other</i>			
<i>acetylcysteine vial</i>	B v D	1	G; PA
ARALAST NP VIAL		4	PA
BECONASE AQ QL-2 BOTTLES 30 DY	90D; QL	3	
DALIRESP QL-30 QY 30 DY	90D; QL	3	PA
<i>flunisolide aero</i>	90D	1	G
<i>fluticasone propionate spray</i>	90D	1	G
NASONEX QL-2 BOTTLES 30 DY	90D; QL	2	
OMNARIS QL-1 BOTTLE 30 DY	90D; QL	3	
PROLASTIN VIAL		4	PA
PROLASTIN-C VIAL		4	PA
PULMOZYME SOLN NON-ORAL	B v D	4	PA
RHINOCORT AQUA QL-2 BOTTLES 30 DY	90D; QL	3	
TOBI VIAL, NEB QL-56 VIALS 28 DY	B v D; QL	4	PA
TYZINE DROPS		3	
TYZINE PEDIATRIC NASAL DROPS		3	
XOLAIR VIAL		4	PA
ZEMAIRA VIAL		4	PA
Sedatives/Hypnotics			
<i>Sedatives/Hypnotics</i>			
LUNESTA TAB QL-30 QY 30 DY	QL	3	
SILENOR TABS QL-30 QY 30 DY	QL	3	
<i>zaleplon cap QL-30 QY 30 DY</i>	QL	3	

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Sedatives/Hypnotics			
<i>Sedatives/Hypnotics</i>			
<i>zolpidem tartrate tab</i>		1	G
Skeletal Muscle Relaxants			
<i>Skeletal Muscle Relaxants</i>			
<i>carisoprodol tab</i>	90D; HRM	1	G
<i>carisoprodol/aspirin tab</i>	90D; HRM	3	
<i>carisoprodol/aspirin/codeine tab</i>	HRM	3	
<i>chlorzoxazone tab</i>	90D; HRM	1	G
<i>cyclobenzaprine tab</i>	90D; HRM	1	G
<i>metaxalone tab QL-120 QY 30 DY</i>	90D; HRM; QL	3	ST
<i>methocarbamol tab</i>	90D; HRM	1	G
<i>orphenadrine citrate er tab, sr</i>	90D; HRM	1	G
<i>orphenadrine compound ds tab</i>	90D; HRM	3	
<i>orphenadrine/asa/caffeine tab</i>	90D; HRM	3	
<i>tizanidine tab</i>	90D	1	G
Therapeutic Nutrients/Minerals/ Electrolytes			
<i>Electrolytes/Minerals</i>			
<i>aminosyn ii iv</i>	B v D	3	PA
AMINOSYN IV	B v D	3	PA
AMINOSYN M IV	B v D	3	PA
AMINOSYN-HBC IV	B v D	3	PA
AMINOSYN-HF IV	B v D	3	PA
AMINOSYN-PF IV	B v D	3	PA
CLINIMIX E/DEXTROSE IV	B v D	3	PA
CLINIMIX/DEXTROSE IV	B v D	3	PA
CLINISOL SF 15% IV	B v D	3	PA

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Therapeutic Nutrients/Minerals/ Electrolytes			
<i>Electrolytes/Minerals</i>			
<i>dextrose 10% flex container</i>		1	G
DEXTROSE 10%/NACL 0.2% IV		1	G
DEXTROSE 10%/NACL 0.45% IV		1	G
<i>dextrose 2.5%/nacl 0.45% iv</i>		1	G
<i>dextrose 5% iv</i>		1	G
DEXTROSE 5%/ELECTROLYTE #48 VIAFLEX		1	G
<i>dextrose 5%/nacl iv</i>		1	G
FREAMINE HBC IV	B v D	3	PA
FREAMINE III IV	B v D	3	PA
HEPATAMINE IV	B v D	3	PA
HEPATASOL IV	B v D	3	PA
INTRALIPID EMULSION	B v D	3	PA
<i>intralipid emulsion</i>	B v D	3	PA
K-TAB TAB, SR	90D	3	
<i>kcl/d10w/nacl iv</i>		1	G
<i>kcl/d5w/lr iv</i>		1	G
<i>kcl/d5w/nacl iv</i>		1	G
<i>klor-con m tab, sr</i>	90D	1	G
<i>klor-con packet</i>	90D	1	G
<i>klor-con tab, sr</i>	90D	1	G
LACTATED RINGERS IV		1	G
LIPOSYN II	B v D	3	PA
LIPOSYN III	B v D	3	PA
LIPOSYN III VIAL	B v D	3	PA
<i>magnesium sulfate syringe</i>		1	G
NEPHRAMINE IV	B v D	3	PA
<i>potassium chloride 0.15%/d5w iv</i>		1	G
<i>potassium chloride er cap, cr</i>	90D	1	G
<i>potassium chloride er tab, sr</i>	90D	1	G
<i>potassium chloride iv</i>		1	G
<i>potassium chloride sr tab</i>	90D	1	G
<i>potassium chloride tab, sr</i>	90D	1	G

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Drug Name	Drug Notes	Advantra Freedom (PPO) Advantra Advantage (HMO)	
		Tier	Plan Notes
Therapeutic Nutrients/Minerals/ Electrolytes			
<i>Electrolytes/Minerals</i>			
<i>potassium chloride vial</i>		1	G
<i>potassium chloride/ nacl iv</i>		1	G
<i>potassium chloride/d5w iv</i>		1	G
<i>potassium chloride/d5w/nacl iv</i>		1	G
<i>potassium citrate er tab</i>	90D	1	G
<i>premasol iv</i>	B v D	3	PA
PROCALAMINE IV	B v D	3	PA
PROSOL IV	B v D	3	PA
<i>ringers inj iv</i>		1	G
<i>sodium chloride iv</i>		1	G
<i>sodium fluoride 1mg tab</i>	90D	1	G
TPN ELECTROLYTE FTV		3	
<i>travasol iv</i>	B v D	3	PA
TROPHAMINE IV	B v D	3	PA
<i>Vitamins</i>			
<i>prenatab</i>	90D	1	G; PA

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Advantra Freedom (PPO) and Advantra Advantage (HMO) Formulary Index

Drug Name	Page	Drug Name	Page	Drug Name	Page
8					
8-MOP CAP.....	43	<i>acyclovir sodium</i>	29	ALINIA TAB.....	23
		<i>acyclovir susp</i>	29	<i>allopurinol tab</i>	18
		<i>acyclovir tab</i>	29	ALOCRIAL DROPS QL-10ML	
		ADACEL VIAL.....	61	30 DY.....	65
A		ADAGEN VIAL.....	48	ALOMIDE DROPS.....	65
ABILIFY DISCMELT TAB		ADCIRCA TAB QL-60 QY		ALORA PATCH QL-8 PTCH	
QL-60 QY 30 DY.....	24	30 DY.....	71	28 DY.....	54
ABILIFY SOLN ORAL QL-		ADVAIR DISKUS QL-1		ALPHAGAN P OPPTH	
900 ML QY 30 DY.....	24	DISKUS 30 DY.....	68	DROPS QL-10ML 30 DY.....	67
ABILIFY TAB QL-30 QY 30		ADVAIR HFA QL-1		ALREX SUSP QL-15ML 30	
DY.....	24	INHALER 30 DY.....	68	DY.....	66
ABILIFY VIAL.....	24	ADVICOR 20;1000MG TAB		ALTABAX OINT QL-15 GM	
ABSTRAL TAB, SUBL QL-		QL-60 QY 30 DY.....	38	30 DY.....	44
120 QY 30 DY.....	1	ADVICOR 20;500MG TAB		ALTOPREV TAB QL-30 QY	
<i>acarbose tab</i>	30	QL-30 QY 30 DY.....	38	30 DY.....	39
<i>acebutolol cap</i>	35	ADVICOR 20;750MG TAB		ALVESCO HFA QL-2	
<i>acetazolamide cap</i>	38	QL-60 QY 30 DY.....	39	INHALERS 30 DY.....	68
<i>acetazolamide tab</i>	38	ADVICOR 40;1000MG TAB		<i>amantadine cap</i>	23
<i>acetic acid soln</i>	68	QL-30 QY 30 DY.....	39	<i>amantadine tab</i>	23
<i>acetic acid/hydrocort</i>	68	<i>afeditab cr tab</i>	36	<i>amcinonide cream</i>	44
<i>acetylcysteine vial</i>	71	AFINITOR TAB QL-30 QY		<i>amcinonide lotion</i>	44
ACIPHEX TAB QL-30 QY		30 DY.....	22	<i>amcinonide oint</i>	44
30 DY.....	51	AGGRENOX CAP QL-60		<i>a-methapred vial</i>	52
ACTEMRA VIAL QL-2		QY 30 DY.....	34	<i>amethyst tab QL-28 QY 28</i>	
VIALS 28 DY.....	60	<i>a-hydrocort solr</i>	52	DY.....	56
ACTHIB VIAL.....	61	<i>ak-con drops</i>	65	AMEVIVE VIAL.....	44
<i>acticin cream</i>	23	AKNE-MYCIN OINT.....	43	<i>amifostine vial</i>	21
ACTIMMUNE VIAL.....	60	<i>ak-tob 0.3% ophth drops</i>	64	<i>amikacin sulfate vial</i>	5
ACTIVELLA 0.5;0.1MG		ALAMAST DROPS QL-		<i>amiloride /hctz tab</i>	38
TAB.....	54	20ML 30 DY.....	65	<i>amiloride tab</i>	38
ACTONEL 150MG TAB		ALBENZA TAB.....	22	<i>aminophylline tab</i>	69
QL-1 QY 30 DY.....	63	<i>albuterol sulf 0.083% neb</i>	70	<i>aminophylline vial</i>	70
ACTONEL 30MG TAB		<i>albuterol sulf 0.5% neb</i>	70	<i>aminosyn ii iv</i>	72
QL-30 QY 30 DY.....	63	<i>albuterol sulf 0.63mg/3ml neb</i>		AMINOSYN IV.....	72
ACTONEL 35MG TAB QL-4		.....	70	AMINOSYN M IV.....	72
QY 28 DY.....	63	<i>albuterol sulf 1.25mg/3ml neb</i>		AMINOSYN-HBC IV.....	72
ACTONEL 5MG TAB QL-30		.....	70	AMINOSYN-HF IV.....	72
QY 30 DY.....	63	<i>albuterol sulf er tab</i>	70	AMINOSYN-PF IV.....	72
ACTOPLUS MET 500MG;		<i>albuterol sulf syrup</i>	70	<i>amiodarone tab</i>	35
15MG TAB QL-90 QY 30		<i>albuterol sulf tab</i>	70	AMITIZA CAP QL-60 QY 30	
DY.....	30	<i>alclometasone dipropionate</i>		DY.....	49
ACTOPLUS MET 850MG;		<i>cream</i>	44	<i>amitriptyline tab</i>	15
15MG TAB QL-90 QY 30		<i>alclometasone dipropionate</i>		<i>amlodipine tab</i>	36
DY.....	30	<i>ointment</i>	44	<i>amlodipine/benazepril</i>	
ACTOS TAB QL-30 QY 30		<i>alcohol preps pads</i>	64	10;20mg cap QL-30 QY 30	
DY.....	30	ALDURAZYME VIAL.....	48	DY.....	40
ACUVAIL OPPTH DROPS		<i>alendronate tab</i>	63	<i>amlodipine/benazepril</i>	
QL-60 VIALS 30 DY.....	66	ALIMTA VIAL.....	21	10;40mg cap QL-30 QY 30	
<i>acyclovir cap</i>	29	ALINIA SUSPENSION.....	22	DY.....	40

Advantra Freedom (PPO) and Advantra Advantage (HMO) Formulary Index

Drug Name	Page	Drug Name	Page	Drug Name	Page
A					
<i>amlodipine/benazepril</i> 2.5;10mg cap QL-30 QY 30 DY	40	<i>amphetamine/dextroamphetamine</i> er 30mg cap QL-60 QY 30 DY	42	ARANESP 150MCG SOLN QL-4ML 28 DY.....	33
<i>amlodipine/benazepril 5;10mg</i> cap QL-30 QY 30 DY.....	40	<i>amphetamine/dextroamphetamine</i> er 5mg cap QL-30 QY 30 DY.	42	ARANESP 200MCG SOLN QL-4ML 28 DY.....	33
<i>amlodipine/benazepril 5;20mg</i> cap QL-30 QY 30 DY.....	40	AMPHOTERICIN B SOLN....	17	ARANESP 25MCG SOLN QL-4ML 28 DY.....	33
<i>amlodipine/benazepril 5;40mg</i> cap QL-30 QY 30 DY.....	40	<i>ampicillin cap</i>	8	ARANESP 300MCG SOLN QL-4ML 28 DY.....	33
<i>ammonium lactate cream</i>	44	<i>ampicillin suspension</i>	8	ARANESP 40MCG SOLN QL-4ML 28 QY.....	33
<i>ammonium lactate lotion</i>	44	<i>ampicillin vial</i>	8	ARANESP 500MCG SOLN QL-4ML 28 QY.....	33
<i>amnesteem cap</i>	44	<i>ampicillin-sulbactam vial</i>	8	AMPYRA TAB QL-60 QY 30 DY	43
<i>amoxapine tab</i>	15	ANADROL-50 TAB.....	54	ANAGRELIDE cap	34
<i>amoxicillin cap</i>	8	<i>anagrelide cap</i>	34	<i>anastrozole tab QL-30 QY 30</i> DY	21
<i>amoxicillin chew</i>	8	<i>anastrozole tab QL-30 QY 30</i> DY	21	ANCOBON CAP.....	17
<i>amoxicillin suspension</i>	8	ANDROGEL GEL.....	54	ANDROGEL PUMP 1% GEL	54
<i>amoxicillin tab</i>	8	ANDROGEL PUMP 1.62% GEL.....	54	ANDROGEL PUMP 1.62% GEL.....	54
<i>amoxicillin/clav pota chew</i>	8	<i>androxy tab</i>	54	ANGELIQ TAB QL-30 QY 30 DY	55
<i>amoxicillin/clav pota er tab</i>	8	ANGELIQ TAB QL-30 QY 30 DY	55	ANTABUSE TAB.....	16
<i>amoxicillin/clav pota susp</i>	8	ANTABUSE TAB.....	16	ANTARA CAP QL-30 QY 30 DY.....	39
<i>amoxicillin/clav pota tab</i>	8	ANTARA CAP QL-30 QY 30 DY.....	39	<i>apap/caffeine/dihydrocodeine</i> tab QL-150 QY 30 DY.....	1
<i>amphetamine salt combo</i> 1.25mg tab	42	<i>apap/caffeine/dihydrocodeine</i> tab QL-150 QY 30 DY.....	1	<i>apap/codeine elixir QL-4950</i> QY 30 DY.....	1
<i>amphetamine salt combo</i> 1.875mg tab	42	<i>apap/codeine elixir QL-4950</i> QY 30 DY.....	1	<i>apap/codeine tab QL-390 QY</i> 30 DY.....	1
<i>amphetamine salt combo</i> 2.5mg tab	42	<i>apap/codeine tab QL-390 QY</i> 30 DY.....	1	<i>apexicon e cream</i>	44
<i>amphetamine salt combo</i> 3.125mg tab	42	<i>apexicon e cream</i>	44	APIDRA SOLOSTAR	31
<i>amphetamine salt combo</i> 3.75mg tab	42	APIDRA SOLOSTAR	31	APIDRA VIAL	31
<i>amphetamine salt combo 5mg</i> tab	42	APIDRA VIAL	31	APOKYN CARTRIDGE.....	23
<i>amphetamine salt combo</i> 7.5mg tab	42	APOKYN CARTRIDGE.....	23	<i>apraclonidine drops</i>	67
<i>amphetamine/dextroamphetamine</i> er 10mg cap QL-30 QY 30 DY	42	<i>apraclonidine drops</i>	67	<i>apri tab QL-28 QY 28 DY</i>	56
<i>amphetamine/dextroamphetamine</i> er 15mg cap QL-30 QY 30 DY	42	<i>apri tab QL-28 QY 28 DY</i>	56	APRISO CAP QL-120 QY 30 DY.....	63
<i>amphetamine/dextroamphetamine</i> er 20mg cap QL-30 QY 30 DY	42	APRISO CAP QL-120 QY 30 DY.....	63	APTIVUS CAP.....	28
<i>amphetamine/dextroamphetamine</i> er 25mg cap QL-30 QY 30 DY	42	APTIVUS CAP.....	28	APTIVUS SOLN ORAL.....	28
		APTIVUS SOLN ORAL.....	28	ARALAST NP VIAL	71
		ARALAST NP VIAL	71	<i>aranelle tab QL-28 QY 28 DY</i>	56
		<i>aranelle tab QL-28 QY 28 DY</i>	56	ARANESP 100MCG SOLN QL-4ML 28 QY.....	33
		ARANESP 100MCG SOLN QL-4ML 28 QY.....	33	ARANESP 150MCG SOLN QL-4ML 28 DY.....	33
		ARANESP 150MCG SOLN QL-4ML 28 DY.....	33	ARANESP 200MCG SOLN QL-4ML 28 DY.....	33
		ARANESP 200MCG SOLN QL-4ML 28 DY.....	33	ARANESP 25MCG SOLN QL-4ML 28 DY.....	33
		ARANESP 25MCG SOLN QL-4ML 28 DY.....	33	ARANESP 300MCG SOLN QL-4ML 28 DY.....	33
		ARANESP 300MCG SOLN QL-4ML 28 DY.....	33	ARANESP 40MCG SOLN QL-4ML 28 QY.....	33
		ARANESP 40MCG SOLN QL-4ML 28 QY.....	33	ARANESP 500MCG SOLN QL-4ML 28 QY.....	33
		ARANESP 500MCG SOLN QL-4ML 28 QY.....	33	ARCAALYST VIAL QL-8 VIALS 30 DY	60
		ARCAALYST VIAL QL-8 VIALS 30 DY	60	ARIXTRA 10MG SYRINGE..	32
		ARIXTRA 10MG SYRINGE..	32	ARIXTRA 2.5MG SYRINGE.	32
		ARIXTRA 2.5MG SYRINGE.	32	ARIXTRA 5MG SYRINGE....	32
		ARIXTRA 5MG SYRINGE....	32	ARIXTRA 7.5MG SYRINGE.	32
		ARIXTRA 7.5MG SYRINGE.	32	ARTHROTEC TAB.....	4
		ARTHROTEC TAB.....	4	ASACOL 400MG TAB.....	63
		ASACOL 400MG TAB.....	63	<i>ascomp/codeine cap</i>	1
		<i>ascomp/codeine cap</i>	1	ASMANEX INHALER QL-1 INHALER 30 DY.....	68
		ASMANEX INHALER QL-1 INHALER 30 DY.....	68	ASTEPRO QL-1 BOTTLE 25 DY.....	68
		ASTEPRO QL-1 BOTTLE 25 DY.....	68	ATACAND HCT TAB QL-30 QY 30 DY	40
		ATACAND HCT TAB QL-30 QY 30 DY	40	ATACAND TAB QL-30 QY 30 DY	40
		ATACAND TAB QL-30 QY 30 DY	40	<i>atenolol tab</i>	35
		<i>atenolol tab</i>	35	<i>atenolol/chlorthalidone tab</i>	35
		<i>atenolol/chlorthalidone tab</i>	35	ATRIPLA TAB QL-30 QY 30 DY.....	27
		ATRIPLA TAB QL-30 QY 30 DY.....	27	ATROVENT HFA QL-2 INHALERS 30 DY	69
		ATROVENT HFA QL-2 INHALERS 30 DY	69	<i>augmented betameth dip</i> <i>cream</i>	44
		<i>augmented betameth dip</i> <i>cream</i>	44	<i>augmented betameth dip gel</i> ...	44
		<i>augmented betameth dip gel</i> ...	44	<i>augmented betameth dip</i> <i>lotion</i>	44
		<i>augmented betameth dip</i> <i>lotion</i>	44	<i>augmented betameth dip oint</i> ..	44
		<i>augmented betameth dip oint</i> ..	44	AVALIDE TAB QL-30 QY 30 DY.....	40
		AVALIDE TAB QL-30 QY 30 DY.....	40	AVANDAMET TAB QL-60 QY 30 DY	30
		AVANDAMET TAB QL-60 QY 30 DY	30	AVANDARYL 1;4MG TAB QL-60 QY 30 DY	30
		AVANDARYL 1;4MG TAB QL-60 QY 30 DY	30		

Advantra Freedom (PPO) and Advantra Advantage (HMO) Formulary Index

Drug Name	Page	Drug Name	Page	Drug Name	Page
A		<i>baclofen tab</i>	26	BLEPHAMIDE	
AVANDARYL 2;4MG TAB		BACTROBAN CREAM	44	SUSPENSION	66
QL-60 QY 30 DY	30	BACTROBAN NASAL		BONIVA TAB QL-1 QY 30	
AVANDARYL 2;8MG TAB		OINT	6	DY	63
QL-30 QY 30 DY	30	<i>balsalazide cap</i>	63	BOOSTRIX SYRINGE.....	61
AVANDARYL 4;4MG TAB		<i>balziva tab QL-28 QY 28 DY..</i>	56	BOTOX VIAL QL-1 VIAL	
QL-60 QY 30 DY	30	BANZEL SUSP 40MG/ML		90 DY	64
AVANDARYL 4;8MG TAB		QL-2400 QY 30 DY	10	<i>brimonidine tart 0.15% ophth</i>	
QL-30 QY 30 DY	30	BANZEL TAB 200MG QL-		<i>drops QL-10ML 30 DY.....</i>	67
AVANDIA 2MG TAB QL-60		240 QY 30 DY	10	<i>brimonidine tart 0.2% ophth</i>	
QY 30 DY	30	BANZEL TAB 400MG QL-		<i>drops.....</i>	67
AVANDIA 4MG TAB QL-60		240 QY 30 DY	10	BROMDAY OPHTHALMIC	
QY 30 DY	30	BARACLUDGE SOLN ORAL		SOLN QL-1.7ML QY 30 DY .	66
AVANDIA 8MG TAB QL-30		QL-630 ML 30 DY	29	<i>bromfenac ophthalmic soln</i>	
QY 30 DY	30	BARACLUDGE TAB QL-30		QL-3ML QY 30 DY	66
AVAPRO TAB QL-30 QY 30		QY 30 DY	29	<i>bromocriptine cap.....</i>	23
DY.....	40	BECONASE AQ QL-2		<i>bromocriptine tab</i>	23
AVASTIN VIAL	21	BOTTLES 30 DY.....	71	BROVANA NEB QL-60	
AVELOX ABC PACK QL-30		<i>benazepril tab</i>	40	VIALS 30 DY	70
QY 30 DY	9	<i>benazepril/hctz tab.....</i>	40	<i>budeprion sr tab</i>	13
AVELOX IV	10	BENICAR HCT TAB QL-30		<i>budeprion xl tab QL-30 QY</i>	
AVELOX TAB QL-30 QY 30		QY 30 DY	40	30 DY.....	13
DY.....	10	BENICAR TAB QL-30 QY		<i>budesonide ec cap</i>	62
<i>aviane tab QL-28 QY 28 DY..</i>	56	30 DY	40	<i>budesonide neb QL-60 VIALS</i>	
AVODART CAP QL-30 QY		<i>benztropine tab</i>	23	30 DY.....	68
30 DY	51	BEPREVE DROPS QL-10ML		<i>bumetanide tab</i>	38
AVONEX QL-4 INJ 30 DY....	60	30 DY	65	<i>bumetanide vial.....</i>	38
AXERT TAB QL-8 QY 30		BESIVANCE SUSP QL-5ML		BUPHENYL TAB	48
DY.....	19	30 DY	64	<i>buproban tab.....</i>	13
AZASITE DROPS QL-2.5ML		<i>betamethasone diprop cream ..</i>	44	<i>bupropion sr tab.....</i>	13
14 DY	64	<i>betamethasone diprop lotion...</i>	44	<i>bupropion tab.....</i>	13
<i>azathioprine soln</i>	59	<i>betamethasone diprop oint.....</i>	44	<i>buspiron tab</i>	29
<i>azathioprine tab</i>	59	BETASERON KIT QL-15		<i>butalbital/apap/caffeine/codeine</i>	
<i>azelastine drops</i>	65	SYR 30 DY	60	<i>cap QL-180 QY 30 DY.....</i>	1
<i>azelastine nasal spray</i>	68	<i>beta-val cream</i>	44	<i>butorphanol tart aero</i>	1
AZELEX CREAM	44	<i>beta-val lotion.....</i>	44	BYETTA PEN QL-1 PEN 30	
AZILECT TAB QL-30 QY 30		<i>beta-val oint.....</i>	44	DY.....	30
DY.....	23	<i>betaxolol drops</i>	67	BYSTOLIC 10MG TAB	
<i>azithromycin suspension.....</i>	9	<i>betaxolol tab</i>	35	QL-30 QY 30 DY	35
<i>azithromycin tab</i>	9	<i>bethanechol tab.....</i>	52	BYSTOLIC 20MG TAB	
<i>azithromycin vial</i>	9	BETIMOL DROPS.....	67	QL-60 QY 30 DY	35
AZOPT SUSPENSION	67	BETOPTIC-S SUSPENSION .	67	BYSTOLIC 2.5MG TAB	
<i>aztreonam vial</i>	8	<i>bicalutamide tab QL-30 QY</i>		QL-30 QY 30 DY	35
		30 DY.....	59	BYSTOLIC 5MG TAB	
		BILTRICIDE TAB.....	22	QL-30 QY 30 DY	35
		<i>bisoprolol tab</i>	35		
		<i>bisoprolol/hctz tab</i>	35	C	
<i>baciim vial</i>	6	<i>bleomycin sulfate vial.....</i>	21	<i>cabergoline tab</i>	58
<i>bacitracin oint.....</i>	64	BLEPHAMIDE S.O.P. OINT..	66		
<i>bacitracin/polymyxin b oint.....</i>	64				

Advantra Freedom (PPO) and Advantra Advantage (HMO)

Formulary Index

Drug Name	Page	Drug Name	Page	Drug Name	Page
C					
<i>calcipotriene soln non-oral</i>	44	<i>cefadroxil cap</i>	7	<i>cesia tab QL-28 QY 28 DY</i>	56
<i>calcitonin-salmon aero</i>	63	<i>cefadroxil suspension</i>	7	CHANTIX DOSE PACK	
<i>calcitriol ampul</i>	63	<i>cefadroxil tab</i>	7	QL-53 QY 30 DY	16
<i>calcitriol cap</i>	63	<i>cefazolin iv</i>	7	CHANTIX TAB QL-60 QY	
<i>calcitriol soln oral</i>	63	<i>cefazolin vial</i>	7	30 DY	16
<i>calcium acet cap</i>	52	<i>cefdinir cap</i>	7	CHENODAL TAB QL-90 QY	
<i>camila tab QL-28 QY 28 DY</i> ..	56	<i>cefdinir suspension</i>	7	30 DY	49
CAMPATH VIAL	22	<i>cefditoren pivoxil tab</i>	7	<i>chloramphenicol succ vial</i>	6
CAMPRAL TAB QL-180 QY		CEFEPIME IV	7	<i>chlordiazepoxide/amitriptyline</i>	
30 DY	16	<i>cefepime vial</i>	7	<i>tab</i>	29
CANASA SUPP RECTAL	63	<i>cefotaxime vial</i>	7	<i>chlorhexidine gluconate oral</i>	
CANCIDAS VIAL	17	CEFOTETAN VIAL.....	7	<i>rinse</i>	43
CANTIL TAB	48	CEFOTETAN/DEXTROSE		<i>chloroquine tab</i>	23
CAPASTAT SULFATE VIAL.	20	IV	7	<i>chlorothiazide tab</i>	38
CAPEX SHAMPOO.....	44	CEFOXITIN IV	7	<i>chlorpromazine ampul</i>	26
CAPITAL/CODEINE SUSP		<i>cefoxitin vial</i>	7	<i>chlorpromazine tab</i>	26
QL-4950 QY 30 DY	1	<i>cefpodoxime proxetil</i>		<i>chlorpropamide tab</i>	30
<i>captopril tab</i>	40	<i>suspension</i>	7	<i>chlorthalidone tab</i>	38
<i>captopril/hctz tab</i>	40	<i>cefpodoxime proxetil tab</i>	7	<i>chlorzoxazone tab</i>	72
CARAC CREAM	44	<i>cefprozil suspension</i>	7	<i>cholestyramine light packet</i>	39
<i>carbamazepine chew</i>	12	<i>cefprozil tab</i>	7	<i>cholestyramine light powder</i> ...	39
<i>carbamazepine er cp12</i>	12	<i>ceftazidime vial</i>	7	<i>cholestyramine packet</i>	39
<i>carbamazepine er tab</i>	12	<i>ceftriaxone vial</i>	7	<i>cholestyramine powder</i>	39
<i>carbamazepine suspension</i>	12	<i>ceftriaxone/dextrose iv</i>	7	<i>chorionic gonadotropin vial</i>	53
<i>carbamazepine tab</i>	12	<i>cefuroxime axetil suspension</i> ...	7	<i>ciclopirox lotion</i>	17
CARBATROL CAP.....	12	<i>cefuroxime axetil tab</i>	8	<i>ciclopirox nail lacquer soln</i>	17
<i>carbidopa/levodopa cr tab</i>	23	<i>cefuroxime vial</i>	8	<i>ciclopirox olamine cream</i>	17
<i>carbidopa/levodopa odt tab</i>	23	CEFUROXIME/DEXTROSE		<i>cilostazol tab</i>	34
<i>carbidopa/levodopa sr tab</i>	23	IV	8	CILOXAN OINT.....	64
<i>carbidopa/levodopa tab</i>	23	CELEBREX 100MG CAP		<i>cimetidine soln oral</i>	50
<i>carbinoxamine liquid</i>	68	QL-30 QY 30 DY	4	<i>cimetidine tab</i>	50
<i>carbinoxamine tab</i>	68	CELEBREX 200MG CAP		<i>cimetidine vial</i>	50
CARIMUNE		QL-60 QY 30 DY	4	CIMZIA KIT QL- 6ML 28	
NAONFILTERED VIAL.....	60	CELEBREX 400MG CAP		DY.....	60
<i>carisoprodol tab</i>	72	QL-60 QY 30 DY	4	CINRYZE VIAL QL-20	
<i>carisoprodol/aspirin tab</i>	72	CELEBREX 50MG CAP		VIALS 30 DY	34
<i>carisoprodol/aspirin/codeine</i>		QL-60 QY 30 DY	4	CIPRO HC SUSPENSION	68
<i>tab</i>	72	CELESTONE SOLN ORAL...	52	CIPRO SUSPENSION	10
<i>carteolol drops</i>	67	CELLCEPT SUSPENSION	59	CIPRODEX SUSPENSION	68
<i>cartia xt cap</i>	36	CELONTIN CAP	11	<i>ciprofloxacin drops</i>	64
<i>carvedilol tab</i>	35	CENESTIN TAB QL-30 QY		<i>ciprofloxacin er 1000mg tab</i>	
CAYSTON VIAL	8	30 DY	55	QL-14 QY 30 DY.....	10
CEDAX CAP.....	7	<i>cephalexin cap</i>	8	<i>ciprofloxacin er 500mg tab</i>	
CEDAX SUSPENSION	7	<i>cephalexin suspension</i>	8	QL-60 QY 30 DY.....	10
CEENU CAP	20	<i>cephalexin tab</i>	8	<i>ciprofloxacin tab</i>	10
<i>cefaclor cap</i>	7	CEREDASE VIAL	48	<i>ciprofloxacin vial</i>	10
<i>cefaclor er tab</i>	7	CEREZYME VIAL	48	<i>cisplatin inj</i>	20
		CERVARIX SYRINGE	61	<i>citalopram soln oral</i>	14
		CERVARIX VIAL	61	<i>citalopram tab</i>	14

Advantra Freedom (PPO) and Advantra Advantage (HMO) Formulary Index

Drug Name	Page	Drug Name	Page	Drug Name	Page
C					
		<i>clotrimazole/betameth diprop lotion</i>	17	CRESTOR TAB QL-30 QY 30 DY	39
<i>claravis cap</i>	44	<i>clozapine tab 100mg</i>	24	CRINONE GEL.....	56
<i>clarithromycin er tab QL-28 QY 14 DY</i>	9	<i>clozapine tab 200mg</i>	24	CRIXIVAN CAP	28
<i>clarithromycin suspension</i>	9	<i>clozapine tab 25mg</i>	24	<i>cromolyn drops</i>	65
<i>clarithromycin tab</i>	9	<i>clozapine tab 50mg</i>	24	<i>cromolyn neb</i>	71
<i>clemastine syrup</i>	68	<i>codeine sulfate tab</i>	1	<i>cryselle-28 tab QL-28 QY 28 DY</i>	56
<i>clemastine tab</i>	68	COLCRYS TAB QL-120 QY 30 DY	18	CUBICIN VIAL	6
CLEOCIN CAP	6	<i>colestipol granules</i>	39	CUPRIMINE CAP	15
CLEOCIN VAGINAL SUPP ..	52	<i>colestipol packet</i>	39	<i>cyclobenzaprine tab</i>	72
CLIMARA PRO PATCH QL-4 PTCH 28 DY	55	<i>colestipol tab</i>	39	<i>cyclophosphamide tab</i>	20
<i>clindamycin cap</i>	6	<i>colistimethate vial</i>	6	<i>cyclosporine cap</i>	59
<i>clindamycin pediatric granules</i>	6	COLY-MYCIN S SUSPENSION	68	<i>cyclosporine modified cap</i>	59
<i>clindamycin phos cream</i>	52	COMBIGAN DROPS QL-10ML 30 DY	67	<i>cyclosporine modified soln oral</i>	59
<i>clindamycin phos gel</i>	44	COMBIPATCH PATCH QL-8 PTCH 28 DY	55	CYKLOKAPRON AMPUL	34
<i>clindamycin phos lotion</i>	44	COMBIVENT INHALER QL-2 INHALERS 30 DY	69	CYMBALTA 20MG CAP QL-60 QY 30 DY	14
<i>clindamycin phos soln</i>	44	COMBIVIR TAB.....	27	CYMBALTA 30MG CAP QL-90 QY 30 DY	14
<i>clindamycin phos swab</i>	44	<i>compro suppository</i>	16	CYMBALTA 60MG CAP QL-60 QY 30 DY	14
<i>clindamycin phos vial</i>	6	COMTAN TAB.....	24	<i>cyproheptadine syrup</i>	69
<i>clindamycin/benzoyl peroxide gel</i>	44	COMVAX VIAL	61	<i>cyproheptadine tab</i>	69
CLINDESSE CREAM	52	CONCERTA TAB 18MG QL-30 QY 30 DY	43	CYSTADANE POWDER	48
CLINIMIX E/DEXTROSE IV	72	CONCERTA TAB 27MG QL-30 QY 30 DY	43	CYSTAGON CAP	48
CLINIMIX/DEXTROSE IV....	72	CONCERTA TAB 36MG QL-60 QY 30 DY	43		
CLINISOL SF 15% IV	72	CONCERTA TAB 54MG QL-30 QY 30 DY	43	D	
<i>clobetasol propionate e cream</i>	45	CONDYLOX GEL	45	DACOGEN VIAL	21
<i>clobetasol propionate gel</i>	45	<i>constulose soln oral</i>	49	DALIRESP QL-30 QY 30 DY.....	71
<i>clobetasol propionate oint</i>	45	COPAXONE KIT QL-30 INJ 30 DY	60	<i>danazol cap</i>	54
<i>clobetasol propionate soln</i>	45	CORDRAN LOTION.....	45	<i>dantrolene cap</i>	26
CLOBEX LOTION	45	CORDRAN SP CREAM.....	45	DAPSONE TAB	19
CLOBEX SHAMPOO.....	45	CORDRAN TAPE	45	DAPTACEL VIAL	61
CLOBEX SPRAY,TOPICAL ..	45	COREG CR CAP QL-30 QY 30 DY	35	DARAPRIM TAB	23
CLODERM CREAM	45	CORTIFOAM	49	DECAVAC SYRINGE.....	61
<i>clomipramine cap</i>	15	<i>cortisone acet tab</i>	52	<i>demeclocycline tab</i>	10
<i>clonidine patch QL-5 PTCH 30 DY</i>	34	CORTISPORIN-TC DROPS ...	68	DEMSEER CAP	37
<i>clonidine tab</i>	34	<i>cortomycin otic soln</i>	68	DENAVIR CREAM QL-2 GM 30 DY.....	29
CLORPRES TAB	34	<i>cortomycin otic susp</i>	68	<i>depade tab</i>	16
<i>clorpres tab</i>	34	COUMADIN TAB.....	32	DEPEN TITRATAS TAB.....	15
<i>clotrimazole 1% topical soln</i> ..	17	COVERA-HS TAB.....	36	DEPO-ESTRADIOL VIAL....	55
<i>clotrimazole 10mg troche</i>	17			DERMA-SMOOTH/FS BODY OIL OIL	45
<i>clotrimazole/betameth diprop cream</i>	17			DERMOTIC DROPS	68

Advantra Freedom (PPO) and Advantra Advantage (HMO)

Formulary Index

Drug Name	Page	Drug Name	Page	Drug Name	Page
D					
<i>desipramine tab</i>	15	<i>dicyclomine cap</i>	48	<i>divalproex tabec</i>	11
<i>desmopressin acet nasal aerosol</i>	53	<i>dicyclomine syrup</i>	49	DIVIGEL GEL QL-30 GM	
<i>desmopressin acet nasal soln.</i>	53	<i>dicyclomine tab</i>	49	30 DY	55
<i>desmopressin acet tab</i>	53	<i>dicyclomine vial</i>	49	DOCETAXEL VIAL	21
<i>desmopressin acet vial</i>	53	<i>didanosine cap</i>	27	<i>donepezil odt tab QL-30 QY</i>	
<i>desonide cream</i>	45	<i>diflorasone diacet cream</i>	45	30 DY.....	13
<i>desonide lotion</i>	45	<i>diflorasone diacet oint</i>	45	<i>donepezil tab QL-30 QY 30</i>	
<i>desonide oint</i>	45	<i>diflunisal tab</i>	4	DY	13
<i>desoximetasone cream</i>	45	<i>digoxin ampul</i>	37	<i>dorzolamide drops</i>	67
<i>desoximetasone gel</i>	45	<i>digoxin soln oral</i>	37	<i>dorzolamide/timolol drops</i>	
<i>desoximetasone oint</i>	45	<i>digoxin tab</i>	38	QL-10ML 30 DY.....	67
DETROL LA CAP QL-30		<i>dihydroergotamine mesylate ampul</i>	19	DOVONEX CREAM	45
QY 30 DY	51	DILANTIN CAP	12	<i>doxazosin mesylate tab</i>	51
DETROL TAB	51	DILANTIN INFATAB.....	12	<i>doxepin cap</i>	15
<i>dexamethasone elixir</i>	52	DILANTIN SUSPENSION.....	12	<i>doxepin conc oral</i>	15
<i>dexamethasone intensol drops</i>	52	DILATRATE SR CAP, CR	41	<i>doxycycline hyclate 100mg</i>	
<i>dexamethasone sod phos drops</i>	66	<i>dilt-cd cap</i>	36	<i>doxycycline hyclate 20mg tabs</i>	10
<i>dexamethasone sod phos vial.</i>	52	<i>diltiazem cd cap</i>	36	.....	43
<i>dexamethasone tab</i>	52	<i>diltiazem er 180mg tab24</i>		<i>doxycycline hyclate caps</i>	10
<i>dexchlorpheniramine syrup</i>	69	QL-30 QY 30 DY.....	36	<i>doxycycline hyclate vial</i>	10
DEXILANT CAPS QL-30		<i>diltiazem er 240mg tab24</i>		<i>doxycycline monohydrate</i>	
QY 30 DY	51	QL-60 QY 30 DY.....	36	150mg cap.....	10
<i>dexmethylphenidate tab</i>	43	<i>diltiazem er 300mg tab24</i>		<i>doxycycline monohydrate tab.</i>	10
<i>dextroamphetamine sulfate er cap,24hr</i>	42	QL-30 QY 30 DY.....	36	<i>dronabinol cap 10mg QL-60</i>	
<i>dextroamphetamine sulfate tab</i>	42	<i>diltiazem er 360mg tab24</i>		QY 30 DY.....	16
<i>dextrose 10% flex container</i>	73	QL-30 QY 30 DY.....	36	<i>dronabinol cap 2.5mg QL-60</i>	
DEXTROSE 10%/NACL		<i>diltiazem er 420mg tab24</i>		QY 30 DY.....	16
0.2% IV.....	73	<i>diltiazem er cap12</i>	37	<i>dronabinol cap 5mg QL-60</i>	
DEXTROSE 10%/NACL		<i>diltiazem er cap24</i>	37	QY 30 DY.....	16
0.45% IV.....	73	<i>diltiazem tab</i>	37	DROXIA CAP	21
<i>dextrose 2.5%/nacl 0.45% iv.</i>	73	<i>diltiazem vial</i>	37	DUETACT TAB QL-30 QY	
<i>dextrose 5% iv</i>	73	<i>dilt-xr cap</i>	36	30 DY	30
DEXTROSE		<i>diltzac cap</i>	37	DULERA HFA INHALER	
5%/ELECTROLYTE #48		DIOVAN HCT TAB QL-30		QL-1 INHALER 30 DY.....	68
VIAFLEX	73	QY 30 DY	40	<i>duramorph ampul</i>	1
<i>dextrose 5%/nacl iv</i>	73	DIOVAN TAB QL-30 QY 30		DUREZOL DROPS.....	66
DIBENZYLINE CAP.....	34	DY.....	41	DYNACIRC CR TAB	37
<i>diclofenac drops</i>	66	DIPENTUM CAP.....	63	DYRENIUM CAP	38
<i>diclofenac ec tab</i>	4	<i>diphenhydramine cap</i>	69	DYSPORT VIAL QL-1 VIAL	
<i>diclofenac potassium tab</i>	4	<i>diphenoxylate/atropine liquid.</i>	49	90 DY	64
<i>diclofenac tab</i>	4	<i>diphenoxylate/atropine tab</i>	49	E	
<i>diclofenac xr tab</i>	4	DIPHTHERIA/TETANUS		<i>econazole nitrate cream</i>	17
<i>dicloxacillin cap</i>	8	TOXOID PEDIATRIC INJ	61	EDECIN TAB	38
		<i>dipyridamole tab</i>	34	EDURANT TAB QL-30 QY	
		<i>disopyramide phosphate cap.</i>	35	30 DY	27
		<i>divalproex 125mg sprink cap.</i>	11	<i>e.e.s. 400 tab</i>	9
		<i>divalproex er tab24</i>	11		

Advantra Freedom (PPO) and Advantra Advantage (HMO) Formulary Index

Drug Name	Page	Drug Name	Page	Drug Name	Page
E		ENBREL PEN 50MG/ML SOLN QL-8 SYR 28 DY.....	60	<i>ergotamine tartrate/caffeine tab</i>	19
E.E.S. GRANULES.....	9	<i>endocet 325;10mg tab QL-360 QY 30 DY</i>	1	<i>errin tab QL-28 QY 28 DY</i>	56
EFFIENT TAB QL-30 QY 30 DY.....	34	<i>endocet 325;5mg tab QL-360 QY 30 DY</i>	1	<i>ery swab</i>	45
EGRIFTA SOLR 1MG QL-60 QY 30 DY	53	<i>endocet 325;7.5mg tab QL-360 QY 30 DY</i>	1	ERYPED SUSPENSION.....	9
ELAPRASE VIAL	48	<i>endocet 500;7.5mg tab QL-240 QY 30 DY</i>	1	<i>ery-tab 500mg tbec</i>	9
ELIDEL CREAM QL-30 GM 30 DY	45	<i>endocet 650;10mg tab QL-180 QY 30 DY</i>	1	<i>ery-tab tab</i>	9
<i>eliphos tab</i>	52	<i>endodan tab QL-360 QY 30 DY</i>	1	ERYTHROCIN LACTOBIONATE VIAL	9
ELITEK VIAL.....	21	<i>enoxaparin 100mg/ml syringe</i>	32	<i>erythrocin stearate tab</i>	9
ELIXOPHYLLIN ELIXIR.....	70	<i>enoxaparin 120mg/0.8ml syringe</i>	32	<i>erythromycin base tab</i>	9
ELMIRON CAP	52	<i>enoxaparin 150mg/ml syringe</i>	32	<i>erythromycin ethylsuccinate tab</i>	9
EMADINE DROPS.....	65	<i>enoxaparin 30mg/0.3ml syringe</i>	32	<i>erythromycin gel</i>	45
EMBEDA 100MG CAP.....	1	<i>enoxaparin 40mg/0.4ml syringe</i>	32	<i>erythromycin oint</i>	64
EMBEDA 20MG CAP QL-60 QY 30 DY	1	<i>enoxaparin 60mg/0.6ml syringe</i>	32	<i>erythromycin soln</i>	45
EMBEDA 30MG CAP QL-60 QY 30 DY	1	<i>enoxaparin 80mg/0.8ml syringe</i>	32	<i>erythromycin/benzoyl peroxide gel</i>	45
EMBEDA 50MG CAP QL-60 QY 30 DY	1	<i>enpresse-28 tab QL-28 QY 28 DY</i>	56	<i>erythromycin/sulfisoxazole suspension</i>	9
EMBEDA 60MG CAP QL-60 QY 30 DY	1	ENTOCORT EC CAP	62	ESTRACE CREAM	55
EMBEDA 80MG CAP QL-60 QY 30 DY	1	<i>enulose soln oral</i>	49	ESTRADERM PATCH QL-8 PTCH 28 DY	55
EMCYT CAP	20	<i>epinastine drops</i>	65	<i>estradiol patch</i>	55
EMEND 125MG CAP QL-6 QY 30 DY	16	<i>epinephrine syringe</i>	70	<i>estradiol tab</i>	55
EMEND 40MG CAP QL-1 QY 30 DY	16	EPIPEN QL-2 INJ 30 DY	70	<i>estradiol/norethindrone 0.5; 0.1mg tab</i>	55
EMEND 80MG CAP QL-6 QY 30 DY	16	EPIPEN-JR QL-2 INJ 30 DY	70	<i>estradiol/norethindrone 1;0.5mg tab</i>	55
EMEND CAP TRIFLD QL-6 QY 30 DY	16	<i>epitol tab</i>	12	ESTRASORB EMUL QL-56	55
EMSAM PATCH QL-30 PTCH 30 DY	14	EPIVIR HBV SOLN ORAL... ..	29	POUCHES 28 DY	55
EMTRIVA CAP.....	27	EPIVIR HBV TAB	29	ESTRING RING QL-1 RING 90 DY	55
EMTRIVA SOLN ORAL	27	EPIVIR SOLN ORAL.....	27	<i>estropipate tab</i>	55
ENABLEX TAB QL-30 QY 30 DY	51	<i>eplerenone tab</i>	41	<i>ethambutol tab</i>	20
<i>enalapril tab</i>	41	EPZICOM TAB	27	<i>ethosuximide cap</i>	11
<i>enalapril/hctz tab</i>	41	EQUETRO CAP.....	30	<i>ethosuximide syrup</i>	11
ENBREL 25MG KIT QL-16 INJ 30 DY	60	ERAXIS VIAL	17	<i>etidronate tab</i>	63
ENBREL 25MG SOLN QL-16 SYR 30 DY	60	<i>ergoloid mesylates tab</i>	13	<i>etodolac cap</i>	4
ENBREL 50MG/ML SOLN QL-8 SYR 28 DY	60	ERGOMAR TAB, SUBL.....	19	<i>etodolac er tab</i>	4
				<i>etodolac tab</i>	4
				EURAX CREAM.....	23
				EURAX LOTION.....	23
				EVAMIST SPRAY QL-2 BOTTLES 30 DY.....	55
				EVISTA TAB QL-30 QY 30 DY.....	58
				EVOXAC CAP.....	43

Advantra Freedom (PPO) and Advantra Advantage (HMO) Formulary Index

Drug Name	Page	Drug Name	Page	Drug Name	Page
E		<i>fentanyl cit oral buccal lpop</i>		<i>flurbiprofen tab</i>	5
EXALGO 12MG TAB QL-150 QY 30 DY	1	<i>QL-120 QY 30 DY</i>	1	<i>flutamide cap</i>	59
EXALGO 16MG TAB QL-120 QY 30 DY	1	<i>fentanyl patch</i>	1	<i>fluticasone propionate cream</i> ..	46
EXALGO 8MG TAB QL-240 QY 30 DY	1	FENTORA TAB QL-120 QY 30 DY	1	<i>fluticasone propionate oint</i>	46
EXELDERM CREAM	17	FINACEA GEL	45	<i>fluticasone propionate spray</i> ...	71
EXELDERM SOLN NON-ORAL.....	17	FINACEA PLUS KIT	45	<i>fluvoxamine tab</i>	14
EXELON PATCH QL-30 QY 30 DY	13	<i>finasteride tab</i>	51	FML FORTE SUSPENSION ..	66
EXELON SOLN ORAL QL-180ML 30 DY	13	FIRMAGON 120MG VIAL QL-2 VIALS 28 DY	21	FML OINT.....	66
<i>exemestane tab</i>	22	FLAREX SUSPENSION	66	<i>fomepizole vial</i>	15
EXJADE TAB	15	<i>flavoxate tab</i>	51	FORADIL AERO CAP QL-60 QY 30 DY	70
EXTAVIA KIT QL-15 SYR 30 DY	60	<i>flecainide tab</i>	35	FORTEO QL-1 PEN 28 DY...	63
F		FLECTOR PTCH QL-60 PTCH 30 DY	45	<i>fortical nasal soln</i>	63
FABRAZYME VIAL	48	FLOVENT DISKUS QL-1 DISKUS 30 DY.....	68	FOSAMAX SOLN ORAL QL-300ML 28 DY.....	63
FACTIVE TAB QL-7 QY 30 DY	10	FLOVENT HFA INHALER QL-2 INHALERS 30 DY	68	<i>foscarnet inj</i>	27
<i>famciclovir tab QL-60 QY 30 DY</i>	29	<i>fluconazole in dextrose iv</i>	17	<i>fosinopril tab</i>	41
<i>famotidine iv</i>	50	FLUCONAZOLE IN NACL... <i>fluconazole suspension</i>	17	<i>fosinopril/hetz tab</i>	41
<i>famotidine suspension</i>	50	<i>fluconazole tab</i>	17	FOSRENOL CHEW QL-90 QY 30 DY	52
<i>famotidine tab</i>	50	<i>fludrocortisone tab</i>	52	FRAGMIN INJ 10000U.....	33
<i>famotidine vial</i>	50	<i>flunisolide aero</i>	71	FRAGMIN INJ 12500U.....	33
FANAPT TAB QL-60 QY 30 DY	24	<i>fluocinolone acetonide cream</i> ..	45	FRAGMIN INJ 15000U.....	33
FANAPT TITR PACK QL-1 QY 365 DY	24	<i>fluocinolone acetonide oint</i>	45	FRAGMIN INJ 18000U.....	33
FARESTON TAB	20	<i>fluocinolone acetonide soln</i>	46	FRAGMIN INJ 25000U.....	33
FASLODEX SYRINGE	20	<i>fluocinonide emollient base cream</i>	46	FRAGMIN INJ 2500U.....	33
FAZACLO ODT TAB	24	<i>fluocinonide gel</i>	46	FRAGMIN INJ 5000U.....	33
FELBATOL SUSPENSION ...	12	<i>fluocinonide oint</i>	46	FRAGMIN INJ 7500U.....	33
FELBATOL TAB	12	<i>fluocinonide soln non-oral</i>	46	FREAMINE HBC IV	73
<i>felodipine er tab</i>	37	<i>fluorometholone suspension</i>	66	FREAMINE III IV	73
FEMHRT LOW DOSE TAB... RING 84 DY	55	FLUOROPLEX CREAM.....	46	FROVA TAB QL-12 QY 30 DY	19
FEMTRACE TAB	55	<i>fluorouracil cream</i>	46	<i>furosemide soln oral</i>	38
<i>fenofibrate micronized cap</i>	39	<i>fluorouracil soln</i>	46	<i>furosemide tab</i>	38
<i>fenofibrate tab</i>	39	<i>fluorouracil vial</i>	21	<i>furosemide vial</i>	38
FENOGLIDE TAB QL-30 QY 30 DY	39	<i>fluoxetine cap</i>	14	FUZEON KIT QL-60 VIALS 30 DY	28
<i>fenopropfen calcium tab</i>	5	<i>fluoxetine soln oral</i>	14	G	
		<i>fluoxetine tab</i>	14	<i>gabapentin cap</i>	11
		<i>fluoxetine wkly cap QL-4 QY 28 DY</i>	14	<i>gabapentin soln oral</i>	11
		<i>fluphenazine conc oral</i>	26	<i>gabapentin tab</i>	11
		<i>fluphenazine decanoate vial</i> ...	26	GABITRIL 12MG TAB QL-120 QY 30 DY	11
		<i>fluphenazine elixir</i>	26	GABITRIL 16MG TAB QL-90 QY 30 DY	11
		<i>fluphenazine tab</i>	26	GABITRIL 2MG TAB QL-30 QY 30 DY	11
		<i>fluphenazine vial</i>	26	<i>flurbiprofen drops</i>	66

Advantra Freedom (PPO) and Advantra Advantage (HMO) Formulary Index

Drug Name	Page	Drug Name	Page	Drug Name	Page
G				H	
GABITRIL 4MG TAB QL-240 QY 30 DY	11	GENOTROPIN MINIQUICK 1.8MG SOLR.....	53	HALFLYTELY BOWEL PREP KIT/FLAVOR PACKS QL-1 KIT QY 30 DY.....	49
<i>galantamine cap,24hr QL-30 QY 30 DY.....</i>	13	GENOTROPIN MINIQUICK 2MG SOLR.....	53	<i>halobetasol propionate cream.....</i>	46
<i>galantamine soln oral QL-200ML 30 DY.....</i>	13	<i>gentak oint</i>	64	<i>halobetasol propionate oint.....</i>	46
<i>galantamine tab QL-60 QY 30 DY</i>	13	<i>gentamicin sulfate cream.....</i>	46	HALOG CREAM.....	46
<i>gammagard liquid vial</i>	60	<i>gentamicin sulfate oint</i>	46	HALOG OINT.....	46
GAMMAGARD S/D VIAL....	60	<i>gentamicin sulfate opht drops.....</i>	64	<i>haloperidol conc oral.....</i>	26
GAMMAPLEX SOLN.....	60	<i>gentamicin sulfate vial</i>	5	<i>haloperidol decanoate vial.....</i>	26
GAMUNEX VIAL	60	<i>gentamicin/0.9% sod chl iv.....</i>	5	<i>haloperidol lactate vial</i>	26
<i>ganciclovir cap</i>	27	<i>gentasol drops.....</i>	64	<i>haloperidol tab</i>	26
GARDASIL VIAL.....	61	GEODON CAP QL-60 QY 30 DY	24	HAVRIX INJ	61
GASTROCROM SOLN ORAL.....	49	GEODON VIAL QL-60ML 30 DY	24	HECTOROL CAP	63
<i>gauze pads 2"x2" bandage.....</i>	64	<i>gianvi tab QL-28 QY 28 DY... ..</i>	56	<i>heparin sod vial.....</i>	33
<i>gavilyte-c soln oral QL-1 KIT QY 30 DY.....</i>	49	GILENYA 0.5MG CAP QL-30 QY 30 DY	60	<i>heparin/d5w iv.....</i>	33
<i>gavilyte-g soln oral QL-1 KIT QY 30 DY.....</i>	49	GLEEVEC 100MG TAB QL-90 QY 30 DY	22	<i>heparin/nacl iv.....</i>	33
<i>gavilyte-n QL-1 KIT QY 30 DY</i>	49	GLEEVEC 400MG TAB QL-60 QY 30 DY	22	HEPATAMINE IV	73
GELNIQUE GEL QL-30 PACK 30 DY	51	<i>glimepiride tab.....</i>	30	HEPATASOL IV	73
<i>gemcitabine vial.....</i>	21	<i>glipizide er tab.....</i>	30	HEPSERA TAB QL-30 QY 30 DY	29
<i>gemfibrozil tab</i>	39	<i>glipizide tab</i>	30	HERCEPTIN VIAL.....	22
<i>generlac soln oral.....</i>	49	<i>glipizide xl tab.....</i>	30	HEXALEN CAP.....	20
<i>gengraf cap.....</i>	59	<i>glipizide/metformin tab.....</i>	30	HUMALOG INSULIN PEN... ..	31
<i>gengraf soln oral.....</i>	59	GLUCAGEN HYPOKIT QL-2 INJ 1 DY	31	HUMALOG MIX 50/50 VIAL.....	31
GENOTROPIN CARTRIDGE	53	GLUCAGON EMERG KIT QL-1 INJ 1 DY	31	HUMALOG MIX 50/50 HUMALOG MIX 75/25	31
GENOTROPIN MINIQUICK 0.2MG SOLR.....	53	<i>glyburide micronized tab.....</i>	30	HUMALOG MIX 75/25 INSULIN PEN.....	31
GENOTROPIN MINIQUICK 0.4MG SOLR.....	53	<i>glyburide tab.....</i>	30	HUMALOG MIX 75/25 VIAL.....	31
GENOTROPIN MINIQUICK 0.6MG SOLR.....	53	<i>glyburide/metformin tab</i>	30	HUMATROPE CARTRIDGE 12MG	53
GENOTROPIN MINIQUICK 0.8MG SOLR.....	53	<i>glycopyrrolate tab.....</i>	49	HUMATROPE CARTRIDGE 24MG	53
GENOTROPIN MINIQUICK 1.2MG SOLR.....	53	<i>glycopyrrolate vial.....</i>	49	HUMATROPE CARTRIDGE 6MG.....	53
GENOTROPIN MINIQUICK 1.4MG SOLR.....	53	GOLYTELY QL-1 KIT QY 30 DY	49	HUMATROPE COMBO PACK VIAL 5MG.....	53
GENOTROPIN MINIQUICK 1.6MG SOLR.....	53	<i>granisetron 1mg tab QL-30 QY 30 DY.....</i>	16	HUMIRA 20MG/0.4ML KIT QL-2 SYR 30 DY	60
		GRIFULVIN V TAB	17	HUMIRA 40MG/0.8ML KIT QL-6 SYR 30 DY	60
		<i>griseofulvin micro susp</i>	18	HUMIRA PEN 40MG/0.8ML QL-6 SYR 30 DY	60
		GRIS-PEG TAB.....	17	HUMULIN 50/50 VIAL	32
		<i>guanabenz tab.....</i>	34		
		<i>guanfacine tab</i>	34		
		GUANIDINE TAB	19		
		GYNAZOLE-1 CREAM.....	52		

Advantra Freedom (PPO) and Advantra Advantage (HMO) Formulary Index

Drug Name	Page	Drug Name	Page	Drug Name	Page
H					
HUMULIN 70/30 INSULIN PEN	32	hydrocortisone in absorbase oint	46	INTELENCE 200MG TAB	27
HUMULIN 70/30 VIAL	32	hydrocortisone lotion	46	QL-60 QY 30 DY	73
HUMULIN N U-100 INSULIN PEN	32	hydrocortisone oint	46	INTRALIPID EMULSION	73
HUMULIN N VIAL	32	hydrocortisone tab	52	intralipid emulsion	73
HUMULIN R U-500 (CONC) VIAL	32	hydrocortisone valerate cream	46	INTRON-A INJ 10MU	61
HUMULIN R VIAL	32	hydrocortisone valerate oint	46	INTRON-A INJ 3MU	61
hydralazine tab	41	hydromorphone 10mg/ml ampule	2	INTRON-A INJ 5MU	61
hydralazine vial	41	hydromorphone 1mg/ml syr	2	INTRON-A INJ 6000000U	61
hydrochlorothiazide cap	38	hydromorphone 2mg/ml syr	2	INVANZ VIAL	8
hydrochlorothiazide tab	38	hydromorphone tab	2	INVEGA 1.5MG TAB24	24
hydrocodone bit/apap 10/750mg tab	1	hydroxychloroquine sulfate tab	23	QL-30 QY 30 DY	24
hydrocodone/apap soln oral	2	hydroxyurea cap	21	INVEGA 3MG TAB24	24
hydrocodone/apap tab 10/325mg	2	hydroxyzine pamoate cap	69	QL-30 QY 30 DY	24
hydrocodone/apap tab 10/500mg	2	hydroxyzine syr	69	INVEGA 6MG TAB24	24
hydrocodone/apap tab 10/650mg	2	hydroxyzine tab	69	QL-60 QY 30 DY	24
hydrocodone/apap tab 10/660mg	2	hydroxyzine vial	69	INVEGA 9MG TAB24	24
hydrocodone/apap tab 5/325mg	2			QL-30 QY 30 DY	24
hydrocodone/apap tab 5/500mg	2	I		INVEGA SUST VIAL	28
hydrocodone/apap tab 7.5/325mg	2	ibuprofen tab	5	INJ 28 DY	24
hydrocodone/apap tab 7.5/500mg	2	ILARIS VIAL	61	INVIRASE CAP	28
hydrocodone/apap tab 7.5/650mg	2	QY 56 DY	61	INVIRASE TAB	28
hydrocodone/apap tab 7.5/750mg	2	imipramine tab	15	IPOL VIAL	62
hydrocodone/apap-hs tab	2	imiquimod cream	46	ipratropium bromide nasal soln	69
hydrocodone/ibuprofen tab	2	PACK 30 DY	46	ipratropium bromide soln, neb	69
hydrocortisone butyrate cream	46	IMOVAX RABIES INJ	61	ipratropium bromide/albuterol sulfate, neb	69
hydrocortisone butyrate oint	46	INCRELEX VIAL	54	IRESSA TAB	22
hydrocortisone butyrate soln	46	indapamide tab	38	QL-30 QY 30 DY	22
hydrocortisone cream	46	INDOCIN SUSPENSION	5	ISENTRESS TAB	28
hydrocortisone enema	62	indomethacin cap	5	QL-60 QY 30 DY	28
		indomethacin er cap	5	isonarif cap	20
		INFANRIX VIAL	62	isoniazid syr	20
		INFERGEN VIAL	61	isoniazid tab	20
		INNOHEP VIAL	33	isosorbide dinitrate er tab	41
		INNOPRAN XL 120MG	35	isosorbide dinitrate tab	41
		CAP24	35	isosorbide dinitrate tab, subl	42
		INNOPRAN XL 80MG	35	isosorbide mononitrate er tab	42
		CAP24	35	isosorbide mononitrate tab	42
		INSULIN PEN NEEDLE	64	isotonic gentamicin iv	5
		INSULIN SAFETY	64	isradipine cap	37
		SYRINGE	64	ISTALOL DROPS	67
		INSULIN SYRINGE	64	QL-5ML	67
		INTELENCE 100MG TAB	64	ISTODAX VIAL	21
		QL-120 QY 30 DY	27	itraconazole cap	18
				IXEMPRA KIT VIAL	21
				IXIARO SUSP	62

Advantra Freedom (PPO) and Advantra Advantage (HMO) Formulary Index

Drug Name	Page	Drug Name	Page	Drug Name	Page
J					
JALYN CAP QL-30 QY 30 DY.....	51	<i>klor-con packet</i>	73	<i>letrozole tab QL-30 QY 30 DY</i>	22
<i>jantoven tab</i>	33	<i>klor-con tab, sr</i>	73	<i>leucovorin calcium soln</i>	15
JANUMET TAB QL-60 QY 30 DY.....	31	KOMBIGLYZE XR 1000MG; 2.5MG TAB QL-60 QY 30 DY.....	31	<i>leucovorin calcium tab</i>	15
JANUVIA TAB QL-30 QY 30 DY.....	31	KOMBIGLYZE XR 1000MG; 5MG TAB QL-30 QY 30 DY. KOMBIGLYZE XR 500MG; 5MG TAB QL-30 QY 30 DY.	31	LEUKERAN TAB.....	20
JE-VAX VIAL.....	62	KRISTALOSE PACKET.....	49	LEUKINE VIAL.....	33
<i>jinteli QL-30 QY 30 DY</i>	55	K-TAB TAB, SR.....	73	<i>leuprolide acet 1mg kit</i>	58
<i>jolivette tab QL-28 QY 28 DY</i>	56	KUVAN TAB.....	64	<i>levabuterol neb QL-90 VIALS 30 DY</i>	70
<i>junel fe tab QL-28 QY 28 DY.</i> <i>junel tab QL-28 QY 28 DY</i>	56	L		LEVATOL TAB.....	36
K		<i>labetalol tab</i>	36	LEVEMIR FLEXPEN.....	32
KADIAN CAP,24HR.....	2	<i>labetalol vial</i>	36	LEVEMIR VIAL.....	32
KALETRA 100;25MG TAB ...	28	<i>laclotion lotion</i>	46	<i>levetiracetam 1000mg tab</i>	10
KALETRA 200;50MG TAB ...	28	LACRISERT INSERT.....	64	<i>levetiracetam 250mg tab QL- 180 QY 30 DY</i>	10
KALETRA ORAL SOLN.....	28	LACTATED RINGERS IV.....	73	<i>levetiracetam 500mg tab QL- 180 QY 30 DY</i>	11
<i>kariva tab QL-28 QY 28 DY</i> ...	56	<i>lactulose soln oral</i>	49	<i>levetiracetam 750mg tab</i>	11
<i>kcl/d10w/nacl iv</i>	73	<i>lamotrigine 100mg tab QL-90 QY 30 DY</i>	12	<i>levetiracetam soln oral</i>	11
<i>kcl/d5w/lr iv</i>	73	<i>lamotrigine 150mg tab</i>	12	<i>levetiracetam vial</i>	11
<i>kcl/d5w/nacl iv</i>	73	<i>lamotrigine 200mg tab</i>	12	<i>levobunolol drops</i>	67
<i>kelnor 1/35 tab QL-28 QY 28 DY</i>	56	<i>lamotrigine 25mg tab</i>	12	<i>levocarnitine tab</i>	64
KENALOG AERO.....	46	<i>lamotrigine chew tab</i>	12	<i>levocetirizine dihydrochloride tabs QL-30 QY 30 DY</i>	69
KETEK TAB QL-20 QY 10 DY.....	9	LANOXIN TAB.....	38	<i>levofloxacin drops</i>	65
<i>ketoconazole 200mg tab</i>	18	<i>lansoprazole capr QL-30 QY 30 DY</i>	51	<i>levora tab QL-28 QY 28 DY</i> ...	56
<i>ketoconazole cream</i>	18	LANTUS SOLOSTAR.....	32	<i>levorphanol tartrate tab</i>	2
<i>ketoconazole shampoo</i>	18	LANTUS VIAL.....	32	<i>levothroid tab</i>	58
<i>ketoprofen cap</i>	5	LASTACAFT DROPS QL- 3ML 30 DY.....	65	<i>levothyroxine tab</i>	58
<i>ketoprofen er cap</i>	5	<i>latanoprost QL-2.5ML 30 DY.</i> LATUDA TAB QL-30 QY 30 DY.....	67	<i>levoxyl tab</i>	58
<i>ketorolac trometh 0.4% ophth soln QL-10ML 30 DY</i>	66	<i>leena tab QL-28 QY 28 DY</i> ...	56	LEXAPRO ORAL SOLN QL-600 ML 30 DY.....	14
<i>ketorolac trometh 0.5% ophth soln QL-10ML 30 DY</i>	66	<i>leflunomide tab</i>	61	LEXAPRO TAB QL-45 QY 30 DY.....	14
<i>ketorolac trometh 10mg tab QL-20 QY 5 DY</i>	5	LESCOL 20MG CAP QL-30 QY 30 DY.....	39	LEXIVA SUSPENSION.....	28
<i>ketorolac trometh vial 15mg QL-20 VIALS 5 DY</i>	5	LESCOL 40MG CAP QL-60 QY 30 DY.....	39	LEXIVA TAB.....	28
KINERET SYR QL-30 SYR 30 DY.....	61	LESCOL XL TAB QL-30 QY 30 DY.....	39	LIALDA TAB QL-120 QY 30 DY.....	63
KINRIX SYR QL-1 INJ 365 DY.....	62	<i>lessina-28 tab QL-28 QY 28 DY</i>	56	<i>lidocaine jelly</i>	4
<i>kionex powder</i>	15	LETAIRIS TAB QL-30 QY 30 DY.....	71	<i>lidocaine oint</i>	4
<i>klor-con m tab, sr</i>	73			<i>lidocaine soln</i>	4
				<i>lidocaine vial</i>	4
				<i>lidocaine viscous soln</i>	4
				<i>lidocaine/prilocaine cream</i>	4
				LIDODERM PTCH QL-90 PTCH 30 DY.....	4
				LINDANE LOTN QL-60 ML 30 DY.....	23

Advantra Freedom (PPO) and Advantra Advantage (HMO) Formulary Index

Drug Name	Page	Drug Name	Page	Drug Name	Page
L		LUMIGAN 0.03% QL-5ML		<i>megestrol acet suspension</i>	64
<i>lindane shamp QL-60ML 30</i>		QY 30 DY	67	<i>megestrol acet tab</i>	64
<i>DY</i>	23	LUNESTA TAB QL-30 QY		<i>meloxicam suspension</i>	5
<i>liothyronine tab</i>	58	30 DY	71	<i>meloxicam tab</i>	5
LIPOFEN 150MG CAP		LUPRON DEPOT KIT	58	MENACTRA SYRINGE.....	62
QL-30 QY 30 DY	39	LUPRON DEPOT-PED KIT...	58	MENEST TAB QL-30 QY 30	
LIPOFEN 50MG CAP QL-90		<i>lutera tab QL-28 QY 28 DY</i> ...	57	DY.....	55
QY 30 DY	39	LYRICA 100MG CAP QL-90		MENOMUNE-A/C/Y/W-135	
LIPOSYN II.....	73	QY 30 DY	11	VIAL.....	62
LIPOSYN III	73	LYRICA 150MG CAP QL-90		MENOSTAR PATCH QL-4	
LIPOSYN III VIAL	73	QY 30 DY	11	QY 28 DY	55
<i>lisinopril tab</i>	41	LYRICA 200MG CAP QL-90		MENTAX CREAM	18
<i>lisinopril/hctz tab</i>	41	QY 30 DY	11	MENVEO VIAL.....	62
<i>lithium carbonate cap</i>	30	LYRICA 225MG CAP QL-60		<i>meperidine inj</i>	2
<i>lithium carbonate er tab</i>	30	QY 30 DY	11	<i>meperidine soln oral</i>	2
<i>lithium carbonate tab</i>	30	LYRICA 25MG CAP QL-90		<i>meperidine tab</i>	2
<i>lithium citrate soln oral</i>	30	QY 30 DY	11	<i>meperidine vial</i>	2
LITHOBID TAB, SR	30	LYRICA 300MG CAP QL-60		<i>meprobamate tab</i>	29
LIVALO TAB QL-30 QY 30		QY 30 DY	11	MEPRON SUSPENSION	23
DY	39	LYRICA 50MG CAP QL-90		<i>mercaptapurine tab</i>	21
LO LOESTRIN FE TAB		QY 30 DY	11	<i>meropenem vial</i>	8
QL-28 QY 28 DY	56	LYRICA 75MG CAP QL-90		<i>mesalamine enema</i>	63
LODOSYN TAB	24	QY 30 DY	11	<i>mesna vial</i>	21
LOESTRIN 24 FE TAB		LYSODREN TAB.....	58	MESNEX TAB	21
QL-28 QY 28 DY	56			MESTINON SYRUP.....	19
<i>loperamide caps</i>	49	M		MESTINON TIMESPAN	
<i>losartan potassium 100mg tab</i>		<i>magnesium sulfate syringe</i>	73	TAB, SR.....	19
QL-30 QY 30 DY.....	41	MAKENA VIAL	57	METADATE CD CAP QL-30	
<i>losartan potassium 25mg tab</i>		<i>malathion lotion</i>	23	QY 30 DY	43
QL-30 QY 30 DY.....	41	<i>maprotiline tab</i>	15	<i>metadate er tab</i>	43
<i>losartan potassium 50mg tab</i>		<i>margesic-h cap QL-240 QY</i>		<i>metaproterenol sulfate syrup</i> ...	70
QL-30 QY 30 DY.....	41	30 DY.....	2	<i>metaproterenol sulfate tab</i>	70
<i>losartan pot/hctz tab QL-30</i>		MARPLAN TAB	14	<i>metaxalone tab QL-120 QY</i>	
QY 30 DY.....	41	MATULANE CAP	20	30 DY.....	72
LOSEASONIQUE TAB		MAXALT TAB QL-12 QY 30		<i>metformin er tab</i>	31
QL-91 QY 90 DY	56	DY.....	19	<i>metformin tab</i>	31
LOTEMAX SUSPENSION ...	66	MAXALT-MLT TAB QL-12		<i>methadone 10mg/ml conc oral</i>	
LOTRONEX TAB QL-60 QY		QY 30 DY	19	.....	2
30 DY	50	MAXIDEX SUSPENSION	66	METHADONE 10MG/ML	
<i>lovastatin tab</i>	39	<i>mebendazole chew</i>	22	VIAL.....	2
LOVAZA CAP QL-120 QY		<i>meclizine tab</i>	69	METHADONE ORAL SOLN	
30 DY	39	<i>meclofenamate cap</i>	5	.....	2
<i>low-ogestrel tab QL-28 QY 28</i>		<i>medroxyprogesterone acet tab</i> .	57	<i>methadone tab</i>	2
DY	56	<i>medroxyprogesterone acet vial</i>		<i>methadose tab</i>	2
<i>loxapine succinate cap</i>	26	QL-1ML 90 DY.....	57	<i>methazolamide tab</i>	67
LUMIGAN 0.01% QL-5ML		<i>mefloquine tab</i>	23	<i>methenamine hippurate tab</i>	6
QY 30 DY	67	MEGACE ES ORAL SUSP		METHERGINE TAB.....	54
		QL-150ML 30 DY.....	64	<i>methimazole tab</i>	59
				<i>methocarbamol tab</i>	72

Advantra Freedom (PPO) and Advantra Advantage (HMO) Formulary Index

Drug Name	Page	Drug Name	Page	Drug Name	Page
M					
		<i>mirtazapine odt tab QL-30 QY 30 DY</i>	14	NAMENDA SOLN ORAL QL-360ML 30 DY	13
<i>methotrexate tab</i>	59	<i>mirtazapine tab</i>	14	NAMENDA TAB QL-60 QY 30 DY	13
<i>methotrexate vial</i>	59	<i>misoprostol tab</i>	50	NAMENDA TITR PAK TAB QL-49 QY 28 DY	13
<i>methscopolamine bromide tab</i>	49	<i>mitoxantrone vial</i>	21	<i>naproxen 275mg tab</i>	5
<i>methyclothiazide tab</i>	38	M-M-R II VIAL.....	62	<i>naproxen 550mg tab</i>	5
<i>methyldopa tab</i>	34	<i>moexipril tab</i>	41	<i>naproxen dr tabec 375 & 500mg</i>	5
<i>methyldopa/hctz tab</i>	34	<i>moexipril/hctz tab</i>	41	<i>naproxen oral suspension</i>	5
<i>methylin er tab</i>	43	<i>mometasone furoate cream</i>	47	<i>naproxen tab 250 & 375mg tabs</i>	5
<i>methylin tab</i>	43	<i>mometasone furoate oint</i>	47	<i>naratriptan tab QL-9 QY 30 DY</i>	19
<i>methylphenidate sr tab</i>	43	<i>mometasone furoate soln</i>	47	NASONEX QL-2 BOTTLES 30 DY	71
<i>methylphenidate tab</i>	43	<i>mononessa tab QL-28 QY 28 DY</i>	57	NATACYN SUSPENSION	65
<i>methylprednisolone acet vial</i>	53	MONUROL PACKET.....	6	<i>nateglinide tab QL-90 QY 30 DY</i>	31
<i>methylprednisolone sod succ vial</i>	53	<i>morphine sulfate er tab, sr</i>	2	NAVANE CAP.....	26
<i>methylprednisolone tab</i>	53	<i>morphine sulfate soln oral</i>	2	NEBUPENT VIAL.....	23
<i>metipranolol drops</i>	67	<i>morphine sulfate supp rectal</i>	2	<i>necon 0.5/35-28 tabs QL-28 QY 28 DY</i>	57
<i>metoclopramide soln oral</i>	49	<i>morphine sulfate tab</i>	3	<i>necon 10/11-28 tabs QL-28 QY 28 DY</i>	57
<i>metoclopramide tab</i>	49	<i>morphine sulfate vial</i>	3	<i>necon 1/35-28 tabs QL-28 QY 28 DY</i>	57
<i>metoclopramide vial</i>	49	MOTOFEN TAB.....	49	<i>necon 1/50-28 tab QL-28 QY 28 DY</i>	57
<i>metolazone tab</i>	38	MOVIPREP QL-1 KIT QY 30 DY	50	<i>nefazodone tab</i>	14
<i>metoprolol succinate er tab</i>	36	MOXATAG TAB QL-10 QY 10 DY	8	<i>neomycin /bacitracin /hydrocortisone oint</i>	65
<i>metoprolol tartrate tab</i>	36	MOXEZA DROPS QL-3ML 30 DY	65	<i>neomycin /bacitracin /polymyxin oint</i>	65
<i>metoprolol tartrate vial</i>	36	MULTAQ TAB QL-60 QY 30 DY	35	<i>neomycin /poly/hydrocort opht susp</i>	66
<i>metoprolol/hctz tab</i>	36	<i>mupirocin oint</i>	47	<i>neomycin /poly/hydrocort otic susp</i>	68
METROGEL.....	46	MYCAMINE VIAL.....	18	<i>neomycin /polymyxin /dexameth oint</i>	66
<i>metronidazole cap</i>	6	MYCOBUTIN CAP.....	19	<i>neomycin /polymyxin /dexameth suspension</i>	66
<i>metronidazole cream</i>	46	<i>mycophenolate mofetil cap</i>	59	<i>neomycin /polymyxin /gramicidin drops</i>	65
<i>metronidazole gel</i>	46	<i>mycophenolate mofetil tab</i>	59	<i>neomycin /polymyxin /hc otic soln</i>	68
<i>metronidazole iv</i>	6	MYTELASE TAB.....	19		
<i>metronidazole lotion</i>	46	N			
<i>metronidazole tab</i>	6	<i>nabumetone tab</i>	5		
<i>metronidazole vaginal gel</i>	52	<i>nadolol tab</i>	36		
<i>mexiletine cap</i>	35	<i>nadolol/bendroflumethiazide tab</i>	36		
MICARDIS HCT TAB QL-30 QY 30 DY	41	<i>nafacillin vial</i>	8		
MICARDIS TAB QL-30 QY 30 DY	41	NAFTIN CREAM.....	18		
<i>microgestin fe tab QL-28 QY 28 DY</i>	57	NAFTIN GEL.....	18		
<i>microgestin tab QL-28 QY 28 DY</i>	57	NAGLAZYME VIAL.....	48		
<i>midodrine tab</i>	38	<i>nalbuphine vial</i>	3		
<i>migergot supp rectal</i>	19	NALFON CAP.....	5		
MIGRANAL QL-8 VIALS 28 DY	19	<i>naloxone syringe</i>	16		
<i>millipred tab</i>	53	<i>naltrexone tab</i>	16		
<i>minocycline cap</i>	10				
<i>minoxidil tab</i>	42				

Advantra Freedom (PPO) and Advantra Advantage (HMO) Formulary Index

Drug Name	Page	Drug Name	Page	Drug Name	Page
N		NITRO-BID OINT	42	<i>nystatin oint</i>	18
<i>neomycin sulfate tab</i>	5	NITRO-DUR PATCH QL-30		<i>nystatin oral susp</i>	18
NEORAL CAP	59	PTCH 30 DY	42	<i>nystatin powder</i>	18
NEORAL SOLN ORAL	59	<i>nitrofurantoin</i>		<i>nystatin tab</i>	18
NEPHRAMINE IV	73	<i>macrocrystalline cap</i>	6	<i>nystatin/triamcinolone cream</i> ..	18
NEULASTA SYRINGE	33	<i>nitrofurantoin monohydrate</i>		<i>nystatin/triamcinolone oint</i>	18
NEUMEGA VIAL	33	<i>cap</i>	6	<i>nystop powder</i>	18
NEUPOGEN INJ	33	<i>nitrofurantoin suspension</i>	6	O	
NEVANAC SUSP QL-3ML		<i>nitroglycerin pumpspray</i>	42	<i>ocella tab QL-28 QY 28 DY</i> ...	57
30 DY	66	<i>nitroglycerin vial</i>	42	<i>octreotide inj</i>	58
NEXAVAR TAB QL-120 QY		NITROMIST SPRAY	42	<i>ofloxacin 0.3% opht soln</i>	65
30 DY	22	NITROSTAT TAB, SUBL.....	42	<i>ofloxacin 0.3% otic soln</i>	68
NEXIUM CAP QL-30 QY 30		<i>nizatadine oral soln</i>	50	<i>ofloxacin tab</i>	10
DY.....	51	<i>nizatidine cap</i>	50	<i>ogestrel tab QL-28 QY 28 DY</i>	
NEXIUM IV	51	<i>nora-be tab QL-28 QY 28 DY</i>	57	.....	57
NEXIUM PACK QL-30		NORDITROPIN		<i>omeprazole 10mg cap QL-30</i>	
PACK 30 DY	51	NORDIFLEX PEN	54	<i>QY 30 DY</i>	51
<i>next choice tab</i>	57	<i>norethindrone acet tab</i>	57	<i>omeprazole 20mg cap</i>	51
NIACOR TAB	39	NORITATE CREAM.....	47	<i>omeprazole 40mg cap QL-60</i>	
NIASPAN 1000MG TABCR		NORPACE CR CAP	35	<i>QY 30 DY</i>	51
QL-60 QY 30 DY	39	<i>nortrel tab QL-28 QY 28 DY</i> ..	57	OMNARIS QL-1 BOTTLE	
NIASPAN 500MG TABCR		<i>nortriptyline cap</i>	15	30 DY	71
QL-30 QY 30 DY	39	<i>nortriptyline soln oral</i>	15	OMNITROPE CARTRIDGE	
NIASPAN 750MG TABCR		NORVIR CAP	28	10MG/1.5ML	54
QL-60 QY 30 DY	39	NORVIR SOLN ORAL	28	OMNITROPE VIAL 5.8MG..	54
<i>nicardipine cap</i>	37	NORVIR TAB.....	28	OMNITROPE VIAL	
NICOTROL NS SPRAY		NOVOLIN 70/30 VIAL	32	5MG/1.5ML	54
QL-4 BOTTLES 30 DY.....	16	NOVOLIN N VIAL	32	<i>ondansetron 4mg/2ml vial</i>	16
<i>nifediac cc tab, sr</i>	37	NOVOLIN R VIAL	32	<i>ondansetron ir tab</i>	16
<i>nifedical xl tab</i>	37	NOVOLOG FLEXPEN	32	ONGLYZA TAB QL-30 QY	
<i>nifedipine cap</i>	37	NOVOLOG MIX 70/30		30 DY	31
<i>nifedipine er tab</i>	37	FLEXPEN	32	ONSOLIS QL-120 QY 30	
NILANDRON TAB.....	59	NOVOLOG MIX 70/30		DY.....	3
<i>nimodipine cap</i>	37	VIAL	32	OPANA ER TAB 10MG	
<i>nisoldipine 17mg tab QL-30</i>		NOVOLOG VIAL	32	QL-60 QY 30 DY	3
<i>QY 30 DY</i>	37	NOVOLOG VIAL	32	OPANA ER TAB 20MG	
<i>nisoldipine 20mg tab QL-30</i>		NOXAFIL ORAL SUSP QL-		QL-60 QY 30 DY	3
<i>QY 30 DY</i>	37	630 ML 30 DY	18	OPANA ER TAB 30MG	
<i>nisoldipine 25.5mg tab QL-60</i>		NULYTELY QL-1 KIT QY		QL-60 QY 30 DY	3
<i>QY 30 DY</i>	37	30 DY	50	OPANA ER TAB 30MG	
<i>nisoldipine 30mg tab QL-60</i>		NUTROPIN AQ NUSPIN 5		QL-60 QY 30 DY	3
<i>QY 30 DY</i>	37	CARTRIDGE.....	54	OPANA ER TAB 40MG	3
<i>nisoldipine 34mg tab QL-30</i>		NUTROPIN AQ PEN.....	54	OPANA ER TAB 5MG	
<i>QY 30 DY</i>	37	NUTROPIN AQ VIAL.....	54	QL-60 QY 30 DY	3
<i>nisoldipine 40mg tab QL-30</i>		NUTROPIN VIAL	54	ORAMORPH SR TAB.....	3
<i>QY 30 DY</i>	37	NUVIGIL TAB QL-30 QY 30		ORAP TAB	26
<i>nisoldipine 8.5mg tab QL-30</i>		DY	43	ORENCIA VIAL	61
<i>QY 30 DY</i>	37	<i>nyamyc powder</i>	18	ORFADIN CAP	48
		<i>nystatin cream</i>	18		

Advantra Freedom (PPO) and Advantra Advantage (HMO) Formulary Index

Drug Name	Page	Drug Name	Page	Drug Name	Page
O					
<i>orphenadrine citrate er tab, sr</i>	72	<i>oxycodone/apap 500;7.5mg tab QL-240 QY 30 DY</i>	3	PCE TAB	9
<i>orphenadrine compound ds tab</i>	72	<i>oxycodone/apap 650;10mg tab QL-180 QY 30 DY</i>	3	PEDIARIX VIAL	62
<i>orphenadrine/asa/caffeine tab.</i>	72	<i>oxycodone/aspirin tab QL-360 QY 30 DY</i>	3	<i>pedi-dri powder</i>	18
ORTHO EVRA PATCH QL-3 PTCH 28 DY	57	<i>oxycodone/ibuprofen tab QL-28 QY 7 DY</i>	3	PEDVAX HIB VIAL	62
<i>ortho-est tab</i>	55	OXYCONTIN 10MG TAB12 QL-60 QY 30 DY	3	<i>peg 3350 QL-1 KIT QY 30 DY</i>	50
OSMOPREP TAB	50	OXYCONTIN 15MG TAB12 QL-60 QY 30 DY	3	PEGANONE TAB	12
OXACILLIN IV	8	OXYCONTIN 20MG TAB12 QL-60 QY 30 DY	3	PEGASYS KIT QL-1 KIT 28 DY	61
OXACILLIN VIAL	9	OXYCONTIN 30MG TAB12 QL-60 QY 30 DY	3	PEG-INTRON KIT QL-4 VIALS 30 DY	61
<i>oxandrolone tab 10mg QL-60 QY 30 DY</i>	54	OXYCONTIN 40MG TAB12 QL-60 QY 30 DY	3	PEG-INTRON REDIPEN QL-4 PENS 30 DY	61
<i>oxandrolone tab 2.5mg QL-120 QY 30 DY</i>	54	OXYCONTIN 60MG TAB12 QL-60 QY 30 DY	3	<i>penicillin g potassium vial</i>	9
<i>oxaprozin tab</i>	5	OXYCONTIN 80MG TAB12 QL-60 QY 30 DY	3	PENICILLIN G PROCAINE SYRINGE	9
<i>oxcarbazepine oral susp</i>	12	OXYTROL PATCH QL-8 PTCH 28 DY	51	<i>penicillin g vial</i>	9
<i>oxcarbazepine tab</i>	12			<i>penicillin v potassium suspension</i>	9
OXISTAT CREAM	18	P		<i>penicillin v potassium tab</i>	9
OXISTAT LOTION	18	<i>pacerone 100mg tab</i>	35	PENNSAID DROPS QL-300ML 30 DAYS	1
OXSORALEN LOTION	47	<i>pacerone 200mg tab</i>	35	PENTACEL KIT QL-3 INJ 30 DY	62
OXSORALEN ULTRA CAP ..	47	<i>paclitaxel vial</i>	21	PENTASA CAP, CR	63
<i>oxybutynin er 10mg tab QL-30 QY 30 DY</i>	51	<i>pamidronate vial</i>	63	<i>pentazocine/apap tab QL-180 QY 30 DY</i>	4
<i>oxybutynin er 15mg tab QL-60 QY 30 DY</i>	51	PANRETIN GEL	47	<i>pentazocine/naloxone tab</i>	4
<i>oxybutynin er 5mg tab QL-30 QY 30 DY</i>	51	<i>pantoprazole tab QL-30 QY 30 DY</i>	51	<i>pentoxifylline er tab, sr</i>	34
<i>oxybutynin syrup</i>	51	<i>paromomycin sulfate cap</i>	23	PERFOROMIST NEB QL-60 VIALS 30 DY	70
<i>oxybutynin tab</i>	51	<i>paroxetine er 12.5mg tab QL-90 QY 30 DY</i>	14	<i>perindopril 2mg tab QL-30 QY 30 DY</i>	41
<i>oxycodone 10mg tab</i>	3	<i>paroxetine er 25mg tab QL-90 QY 30 DY</i>	14	<i>perindopril 4mg tab QL-30 QY 30 DY</i>	41
<i>oxycodone 15mg tab</i>	3	<i>paroxetine er 37.5mg tab QL-60 QY 30 DY</i>	14	<i>perindopril 8mg tab QL-60 QY 30 DY</i>	41
<i>oxycodone 20mg tab</i>	3	<i>paroxetine suspension</i>	14	<i>perio gard mouthwash</i>	43
<i>oxycodone 20mg/ml conc oral</i>	3	<i>paroxetine tab</i>	14	<i>permethrin cream</i>	23
<i>oxycodone 30mg tab</i>	3	PASER PACKET	20	<i>perphenazine tab</i>	26
<i>oxycodone 5mg tab</i>	3	PATADAY DROPS QL-2.5ML 30 DY	65	<i>perphenazine/amitriptyline tab</i>	15
<i>oxycodone-apap 325;10mg tab QL-360 QY 30 DY</i>	3	PATANASE QL-1 BOTTLE 25 DY	69	<i>pfizerpen-g vial</i>	9
<i>oxycodone/apap 325;2.5mg tab QL-360 QY 30 DY</i>	3	PATANOL DROPS QL-5ML QY 30 DY	65	<i>phenadoz suppository</i>	16
<i>oxycodone/apap 325;5mg tab QL-360 QY 30 DY</i>	3			<i>phenelzine tab</i>	14
<i>oxycodone/apap 325;7.5mg tab QL-360 QY 30 DY</i>	3			PHENYTEK CAP	13
<i>oxycodone/apap 500;5mg cap QL-240 QY 30 DY</i>	3			<i>phenytoin ampul</i>	13
				<i>phenytoin er cap</i>	13
				<i>phenytoin suspension</i>	13

Advantra Freedom (PPO) and Advantra Advantage (HMO)

Formulary Index

Drug Name	Page	Drug Name	Page	Drug Name	Page
P		PRED-G SUSPENSION.....	66	<i>prochlorperazine tab</i>	16
PHOSPHOLINE IODIDE		<i>prednicarbate cream</i>	47	PROCRIT VIAL 10000U QL-	
DROPS.....	67	<i>prednicarbate oint</i>	47	12ML 28 DY	33
<i>pilocarpine tab</i>	43	<i>prednisolone acet ophth susp..</i>	66	PROCRIT VIAL 20000U QL-	
PILOPINE HS GEL	67	<i>prednisolone sod phos ophth</i>		12ML 28 DY	33
<i>pindolol tab</i>	36	<i>drops</i>	66	PROCRIT VIAL 2000U QL-	
PIPERACILLIN VIAL.....	9	<i>prednisolone sod phos soln</i>		12ML 28 DY	33
<i>piperacillin/tazobactam vial...</i>	9	<i>oral</i>	53	PROCRIT VIAL 3000U QL-	
<i>piroxicam cap</i>	5	<i>prednisolone syrup</i>	53	12ML 28 DY	33
PLAVIX 300MG TAB QL-1		<i>prednisone intensol conc oral.</i>	53	PROCRIT VIAL 40000U	
QY 365 DY	34	<i>prednisone soln oral</i>	53	QL-8 ML 28 DY	34
PLAVIX 75MG TAB QL-30		<i>prednisone tab</i>	53	PROCRIT VIAL 4000U QL-	
QY 30 DY	34	PREFEST TAB	55	12ML 28 DY	34
<i>podofilox soln</i>	47	PREMARIN CREAM	55	<i>proctosol hc cream</i>	50
<i>poly-dex oint</i>	66	PREMARIN TAB QL-30 QY		<i>proctozone-hc cream</i>	50
<i>poly-dex suspension</i>	66	30 DY	56	PROGLYCEM SUSPENSION	
<i>polyethylene glycol 3350</i>		<i>premasol iv</i>	74	.....	31
<i>powder</i>	50	PREMPHASE TAB QL-30		PROLASTIN VIAL.....	71
POLY-PRED SUSPENSION...	66	QY 30 DY	56	PROLASTIN-C VIAL.....	71
<i>portia-28 tab QL-28 QY 28</i>		PREMPRO TAB QL-30 QY		PROMACTA TAB QL-30 QY	
<i>DY</i>	57	30 DY	56	30 DY	34
<i>potassium chloride</i>		<i>prenatab</i>	74	<i>promethazine supp rectal</i>	17
<i>0.15%/d5w iv</i>	73	<i>prevalite packet</i>	39	<i>promethazine syringe</i>	17
<i>potassium chloride er cap, cr.</i>	73	<i>prevalite powder</i>	39	<i>promethazine syrup</i>	17
<i>potassium chloride er tab, sr..</i>	73	<i>previfem tab QL-28 QY 28</i>		<i>promethazine tab</i>	17
<i>potassium chloride iv</i>	73	<i>DY</i>	57	<i>promethazine vc syrup</i>	69
<i>potassium chloride/ nacl iv</i>	74	PREZISTA 150MG TAB.....	28	<i>promethazine vial</i>	17
<i>potassium chloride sr tab</i>	73	PREZISTA 400MG TAB.....	28	<i>promethegan supp rectal</i>	17
<i>potassium chloride tab, sr</i>	73	PREZISTA 600MG TAB.....	28	PROMETRIUM CAP.....	57
<i>potassium chloride vial</i>	74	PREZISTA 75MG TAB.....	28	<i>propafenone hcl er cap</i>	35
<i>potassium chloride/d5w iv</i>	74	PRIFTIN TAB	20	<i>propafenone tab</i>	35
<i>potassium chloride/d5w/nacl</i>		PRIMAQUINE PHOSPHATE		<i>propantheline bromide tab</i>	49
<i>iv</i>	74	TAB.....	23	<i>propranolol er 120mg cap</i>	
<i>potassium citrate er tab</i>	74	PRIMAXIN IM VIAL.....	8	QL-60 QY 30 DY.....	36
PRADAXA CAPS QL-60 QY		PRIMAXIN IV VIAL	8	<i>propranolol er 160mg cap</i>	
30 DY	33	<i>primidone tab</i>	11	QL-30 QY 30 DY.....	36
<i>pramipexole tab QL-90 QY 30</i>		PRIMSOL SOLN ORAL	6	<i>propranolol er 60mg cap</i>	
<i>DY</i>	24	PRISTIQ TAB QL-30 QY 30		QL-30 QY 30 DY.....	36
PRANDIN TAB 0.5MG QL-		DY.....	14	<i>propranolol er 80mg cap</i>	
120 QY 30 DY	31	<i>privigen vial</i>	60	QL-30 QY 30 DY.....	36
PRANDIN TAB 1MG QL-		PROAIR HFA INHALER		<i>propranolol soln oral</i>	36
120 QY 30 DY	31	QL-2 INHALERS 30 DY	70	<i>propranolol tab</i>	36
PRANDIN TAB 2MG QL-		<i>probenecid tab</i>	18	<i>propranolol vial</i>	36
240 QY 30 DY	31	<i>probenecid/colchicine tab</i>	19	<i>propranolol/hctz tab</i>	36
<i>pravastatin tab</i>	39	<i>procainamide vial</i>	35	<i>propylthiouracil tab</i>	59
<i>prazosin cap</i>	34	PROCALAMINE IV	74	PROQUAD VIAL	62
PRED MILD SUSPENSION ..	66	<i>prochlorperazine edisylate</i>		PROSOL IV	74
PRED-G S.O.P. OINT	66	<i>vial</i>	16	PROTOPIC OINT QL-30 GM	
		<i>prochlorperazine supp rectal ..</i>	16	30 DY	47

Advantra Freedom (PPO) and Advantra Advantage (HMO) Formulary Index

Drug Name	Page	Drug Name	Page	Drug Name	Page
P		RELPAZ TAB QL-9 QY 30		<i>risperidone odt 0.5mg QL-90</i>	
<i>protriptyline tab</i>	15	DY.....	19	<i>QY 30 DY</i>	25
PROVENTIL HFA QL-2		REMICADE VIAL.....	61	<i>risperidone odt 1mg QL-60</i>	
INHALERS 30 DY.....	70	REVELA 2.4GM PACK		<i>QY 30 DY</i>	25
PULMICORT FLEXHALER		QL-90 QY 30 DY.....	52	<i>risperidone odt 2mg QL-60</i>	
QL-2 INHALERS 30 DY.....	68	REVELA 800MG TABS.....	52	<i>QY 30 DY</i>	25
PULMOZYME SOLN NON-ORAL.....	71	RESCRIPTOR TAB.....	27	<i>risperidone odt 3mg QL-90</i>	
<i>pyrazinamide tab</i>	20	<i>reserpine tab</i>	34	<i>QY 30 DY</i>	25
<i>pyridostigmine bromide tab</i>	19	RESTASIS QL-64 VIALS 30		<i>risperidone odt 4mg QL-120</i>	
		DY.....	65	<i>QY 30 DY</i>	25
		RETROVIR IV.....	27	<i>risperidone soln oral</i>	25
		REVATIO TAB QL-90 QY 30		RITALIN LA 10MG CAP	
		DY.....	71	QL-30 QY 30 DY.....	43
		REVLIMID CAP QL-30 QY		RITALIN LA 20MG CAP	
		30 DY.....	20	QL-30 QY 30 DY.....	43
		REYATAZ 100MG CAP.....	28	RITALIN LA 30MG CAP	
		REYATAZ 150MG CAP.....	28	QL-60 QY 30 DY.....	43
		REYATAZ 200MG CAP.....	28	RITALIN LA 40MG CAP	
		REYATAZ 300MG CAP.....	28	QL-30 QY 30 DY.....	43
		RHINOCORT AQUA QL-2		RITUXAN VIAL.....	22
		BOTTLES 30 DY.....	71	<i>rivastigmine cap QL-60 QY</i>	
		<i>ribasphere cap 200mg</i>	29	<i>30 DY</i>	13
		<i>ribasphere tab 200mg</i>	29	<i>romycin oint</i>	65
		<i>ribavirin cap 200mg</i>	29	<i>ropinirole tab</i>	24
		<i>ribavirin tab 200mg</i>	29	ROTARIX SUSPENSION.....	62
		RIDAURA CAP.....	61	ROTATEQ SUSPENSION.....	62
		<i>rifampin 600mg vial</i>	20	<i>roxicet 325;5mg tab QL-360</i>	
		<i>rifampin cap</i>	20	<i>QY 30 DY</i>	4
		RIFATER TAB.....	20	<i>roxicet 325mg/5ml;5mg/5ml</i>	
		RILUTEK TAB.....	43	<i>oral soln QL-1800 QY 30 DY</i>	4
		<i>rimantadine tab</i>	29		
		<i>ringers inj iv</i>	74	S	
		RIOMET SOLN ORAL.....	31	SABRIL PACKET.....	11
		RISPERDAL CONSTA QL-2		SABRIL TAB.....	12
		INJ 28 DY.....	24	SAIZEN CLICK EASY PEN.....	54
		<i>risperidone 0.25mg tab QL-90</i>		SAIZEN VIAL.....	54
		<i>QY 30 DY</i>	25	SAMSCA 15MG TAB QL-30	
		<i>risperidone 0.5mg tab QL-90</i>		QY 30 DY.....	38
		<i>QY 30 DY</i>	25	SAMSCA 30MG TAB QL-60	
		<i>risperidone 1mg tab QL-60</i>		QY 30 DY.....	38
		<i>QY 30 DY</i>	25	SANCTURA XR CAP QL-30	
		<i>risperidone 2mg tab QL-60</i>		QY 30 DY.....	51
		<i>QY 30 DY</i>	25	SANCUSO PTCH QL-4	
		<i>risperidone 3mg tab QL-90</i>		PTCH 28 DY.....	17
		<i>QY 30 DY</i>	25	SANDIMMUNE CAP.....	60
		<i>risperidone 4mg tab QL-120</i>		SANDIMMUNE SOLN	
		<i>QY 30 DY</i>	25	ORAL.....	60
		<i>risperidone odt 0.25mg QL-90</i>			
		<i>QY 30 DY</i>	25		

Advantra Freedom (PPO) and Advantra Advantage (HMO)

Formulary Index

Drug Name	Page	Drug Name	Page	Drug Name	Page
S		SEROSTIM VIAL.....	54	SPRYCEL 70MG TAB QL-60	
SANDOSTATIN LAR		<i>sertraline conc oral</i>	14	QY 30 DY	22
DEPOT KIT.....	58	<i>sertraline tab</i>	14	SPRYCEL 80MG TAB QL-60	
SANTYL OINT.....	47	SILENOR TABS QL-30 QY		QY 30 DY	22
SAPHRIS SUBL QL-60 QY		30 DY	71	<i>sronyx tab QL-28 QY 28 DY</i> ...	57
30 DY	25	<i>silver sulfadiazine cream</i>	47	<i>ssd cream</i>	47
<i>scalacort lotion</i>	47	SIMPONI SYRINGE QL-1		<i>stagesic cap QL-240 QY 30</i>	
SEASONIQUE TAB QL-91		SYR 30 DY	61	<i>DY</i>	4
QY 90 DY	57	<i>simvastatin tab 10mg</i>	39	STALEVO TAB.....	24
<i>selegiline cap</i>	24	<i>simvastatin tab 20mg</i>	40	<i>stavudine cap</i>	27
<i>selegiline tab</i>	24	<i>simvastatin tab 40mg</i>	40	<i>stavudine soln oral</i>	27
<i>selfemra cap</i>	14	<i>simvastatin tab 5mg</i>	40	STELARA SYR QL-5 INJ	
SELZENTRY 150MG TAB		<i>simvastatin tab 80mg</i>	40	365 DY	61
QL-60 QY 30 DY	28	SINGULAIR QL-30 QY 30		STROMECTOL TAB.....	22
SELZENTRY 300MG TAB		DY.....	69	SUBOXONE FILM, SUBL	
QL-120 QY 30 DY	28	SKELID TAB	63	QL-90 QY 30 DY	16
SEMPREX-D CAP.....	69	<i>sodium chloride irrigation</i>	47	<i>sucrafate tab</i>	50
SENSIPAR 30MG TAB		<i>sodium chloride iv</i>	74	<i>sulfacetamide/predn sod</i>	
QL-60 QY 30 DY	58	<i>sodium fluoride 1mg tab</i>	74	<i>phosp drops</i>	66
SENSIPAR 60MG TAB		<i>sodium polystyrene sulfonate</i>		<i>sulfadiazine tab</i>	10
QL-60 QY 30 DY	58	<i>powder</i>	16	<i>sulfamethoxazole/trimethoprim</i>	
SENSIPAR 90MG TAB QL-		<i>sodium sulfacet lotion</i>	47	<i>ds tab</i>	10
120 QY 30 DY	58	<i>sodium sulfacet ophth drops</i> ...	65	<i>sulfamethoxazole/trimethoprim</i>	
SEREVENT DISKUS QL-1		SOLARAZE GEL QL-100		<i>suspension</i>	10
DISKUS 30 DY.....	70	GM 30 DY.....	47	<i>sulfamethoxazole/trimethoprim</i>	
SEROMYCIN CAP.....	20	<i>solia tab QL-28 QY 28 DY</i>	57	<i>tab</i>	10
SEROQUEL 100MG TAB		SOMATULINE DEPOT QL-1		<i>sulfamethoxazole/trimethoprim</i>	
QL-90 QY 30 DY	25	INJ 28 DY	59	<i>vial</i>	10
SEROQUEL 200MG TAB		SOMAVERT VIAL.....	59	SULFAMYLON CREAM.....	47
QL-90 QY 30 DY	25	SORIATANE CAP QL-60 QY		SULFAMYLON PACKET.....	47
SEROQUEL 25MG TAB		30 DY	47	<i>sulfasalazine tab</i>	63
QL-90 QY 30 DY	25	<i>sorine tab</i>	35	<i>sulfazine ec tab</i>	63
SEROQUEL 300MG TAB		<i>sotalol tab</i>	35	<i>sulindac tab</i>	5
QL-90 QY 30 DY	25	<i>sotret cap</i>	47	<i>sumatriptan inj QL-8 INJ 30</i>	
SEROQUEL 400MG TAB		SPIRIVA HANDIHALER		<i>DY</i>	19
QL-60 QY 30 DY	25	CAP QL-30 QY 30 DY	69	<i>sumatriptan spray QL-8</i>	
SEROQUEL 50MG TAB		<i>spironolactone /hctz tab</i>	41	SPRAY UNITS 30 DY.....	19
QL-90 QY 30 DY	25	<i>spironolactone tab</i>	41	<i>sumatriptan tab QL-9 QY 30</i>	
SEROQUEL XR 150MG		SPORANOX SOLN ORAL....	18	<i>DY</i>	19
TAB QL-30 QY 30 DY	25	<i>sprintec 28 tab QL-28 QY 28</i>		SUPRAX SUSPENSION	8
SEROQUEL XR 200MG		<i>DY</i>	57	SUPREP BOWL PREP QL-1	
TAB QL-30 QY 30 DY	25	SPRYCEL 100MG TAB		KIT QY 30 DY.....	50
SEROQUEL XR 300MG		QL-30 QY 30 DY	22	SURMONTIL CAP	15
TAB QL-60 QY 30 DY	25	SPRYCEL 140MG TAB		SUSTIVA CAP	27
SEROQUEL XR 400MG		QL-30 QY 30 DY	22	SUSTIVA TAB	27
TAB QL-60 QY 30 DY	25	SPRYCEL 20MG TAB QL-60		SUTENT CAP QL-30 QY 30	
SEROQUEL XR 50MG TAB		QY 30 DY	22	<i>DY</i>	22
QL-60 QY 30 DY	25	SPRYCEL 50MG TAB QL-60		SYMBICORT AERO QL-1	
		QY 30 DY	22	INHALER 30 DY.....	68

Advantra Freedom (PPO) and Advantra Advantage (HMO) Formulary Index

Drug Name	Page	Drug Name	Page	Drug Name	Page
S					
SYMBYAX CAP QL-30 QY 30 DY	14	<i>terbinafine tab QL-30 QY 30 DY</i>	18	TOBRADEX ST SUSP	67
SYMLIN 600MCG/ML VIAL QL-4 VIALS 30 DY	31	<i>terbutaline sulfate tab</i>	70	<i>tobramycin /dexamethasone susp</i>	67
SYMLINPEN 120 1000MCG/ML QL-4 PENS 30 DY	31	<i>terconazole cream</i>	52	<i>tobramycin sulfate 0.3% ophth drops</i>	65
SYMLINPEN 60 1000MCG/ML QL-8 PENS 30 DY	31	<i>terconazole vaginal supp</i>	52	<i>tobramycin sulfate 10mg/ml vial</i>	6
SYNAREL AERO	59	<i>testosterone cypionate vial</i>	54	<i>tobramycin sulfate 80mg/2ml vial</i>	6
SYNTHROID TAB	58	<i>testosterone enanthate vial</i>	54	TOBRAMYCIN/SODIUM CHLORIDE IV	6
SYPRINE CAP	16	TESTRED CAP	54	<i>tobrasol 0.3% ophth drops</i>	65
T		TETANUS TOXOID ADSORBED VIAL	62	TOBREX 0.3% OPHTH OINT	65
TABLOID TAB	21	TETANUS/DIPHThERIA TOXOIDS-ADSORBED VIAL	62	OINT	65
<i>tacrolimus 0.5mg cap</i>	60	<i>tetracycline cap</i>	10	<i>tolazamide tab</i>	31
<i>tacrolimus 1mg cap</i>	60	TEV-TROPIN VIAL.....	54	<i>tolbutamide tab</i>	31
<i>tacrolimus 5mg cap</i>	60	TEXACORT SOLN NON- ORAL.....	47	<i>tolmetin cap</i>	5
TAMIFLU CAP 30MG & 45MG	29	THALITONE TAB	38	<i>tolmetin tab</i>	5
TAMIFLU CAP 75MG QL-56 QY 365 DY	29	THALOMID CAP QL-28 QY 28 DY	20	<i>topiramate 100mg tab QL-90 QY 30 DY</i>	12
TAMIFLU SUSPENSION	29	THEO-24 100MG CAP QL-30 QY 30 DY	70	<i>topiramate 200mg tab</i>	12
<i>tamoxifen citrate tab</i>	21	THEO-24 200MG CAP QL-30 QY 30 DY	70	<i>topiramate 25mg tab</i>	12
<i>tamsulosin cap QL-60 QY 30 DY</i>	52	THEO-24 300MG CAP QL-60 QY 30 DY	70	<i>topiramate 50mg tab QL-90 QY 30 DY</i>	12
TARCEVA TAB QL-30 QY 30 DY	22	THEO-24 400MG CAP QL-30 QY 30 DY	70	<i>topiramate cap, sprinkle</i>	12
TARGRETIN CAP	22	<i>theochron tab</i>	70	<i>torseamide tab</i>	38
TARGRETIN GEL QL-60 GM 30 DY	47	<i>theophylline er tab, sr</i>	70	TPN ELECTROLYTE FTV ...	74
TASIGNA CAP QL-120 QY 30 DY	22	<i>thermazene cream</i>	47	TRACLEER TAB QL-60 QY 30 DY	71
TASMAR TAB	24	<i>thioridazine tab</i>	26	<i>tramadol tab</i>	4
TAXOTERE VIAL	21	<i>thiotepa vial</i>	20	<i>tramadol/apap tab QL-240 QY 30 DY</i>	4
TAZORAC CREAM QL-30 GM 30 DY	47	<i>thiothixene cap</i>	26	<i>trandolapril tab</i>	41
TAZORAC GEL QL-30 GM 30 DY	47	THYROLAR TAB	58	<i>tranylcpromine sulfate tab</i>	14
<i>taztia xt cap</i>	37	<i>ticlopidine tab</i>	34	<i>travasol iv</i>	74
TEFLARO VIAL.....	8	TIKOSYN CAP	35	TRAVATAN Z QL-5ML 30 DY	67
TEGRETOL CHEW	13	TIMENTIN IV	9	<i>trazodone tab</i>	14
TEGRETOL SUSPENSION....	13	TIMENTIN VIAL	9	TRECTOR TAB	20
TEGRETOL TAB	13	<i>timolol drops</i>	67	TRELSTAR DEPOT 3.75MG SUSR QL-1 VIAL 30 DY	59
TEGRETOL-XR TAB	13	<i>timolol drops gel</i>	67	TRELSTAR LA 11.25MG SUSR QL-1 VIAL 90 DY	59
<i>terazosin cap</i>	52	<i>timolol tab</i>	36	TRELSTAR MIXJECT 22.5MG QL-1 VIAL 180 DY .	59
		TIROSINT CAP QL-30 QY 30 DY	58	<i>tretinoin 10mg cap</i>	22
		<i>tizanidine tab</i>	72	<i>tretinoin cream</i>	47
		TOBI VIAL, NEB QL-56 VIALS 28 DY	71	<i>tretinoin gel</i>	47
		TOBRADEX OINT	66		

Advantra Freedom (PPO) and Advantra Advantage (HMO) Formulary Index

Drug Name	Page	Drug Name	Page	Drug Name	Page
T		TWINJECT QL-2 INJ 30 DY		VANOS CREAM.....	48
<i>triamcinolone acetone cream</i>	47	.....	70	VAQTA VIAL.....	62
<i>triamcinolone acetone absorb base oint</i>	48	TWINRIX VIAL	62	VARIVAX VIAL	62
<i>triamcinolone acetone lotion</i>	48	TWYNSTA TAB QL-30 QY 30 DY	41	VECTICAL OINT	48
<i>triamcinolone acetone ointment</i>	48	TYGACIL VIAL	6	VELCADE VIAL.....	21
<i>triamcinolone in orabase</i>	43	TYKERB TAB QL-180 QY 30 DY	21	<i>velivet tab QL-28 QY 28 DY</i> ...	58
<i>triamterene/hctz cap</i>	38	TYPHIM VI VIAL.....	62	<i>venlafaxine er 150mg cap</i>	
<i>triamterene/hctz tab</i>	38	TYSABRI VIAL.....	61	<i>QL-90 QY 30 DY</i>	15
TRICOR TAB QL-30 QY 30 DY.....	40	TYZEKA TAB QL-30 QY 30 DY.....	29	<i>venlafaxine er 150MG TAB</i>	
<i>triderm cream</i>	48	TYZINE DROPS.....	71	<i>QL-90 QY 30 DY</i>	15
<i>trifluoperazine tab</i>	26	TYZINE PEDIATRIC NASAL DROPS	71	<i>venlafaxine er 225MG TAB</i>	
<i>trifluridine drops</i>	65	U		<i>QL-30 QY 30 DY</i>	15
TRIGLIDE TAB QL-30 QY 30 DY	40	ULESFIA LOTION	23	<i>venlafaxine er 37.5mg cap</i>	
<i>trihexyphenidyl elixir</i>	24	ULORIC TABS QL-30 QY 30 DY	19	<i>QL-30 QY 30 DY</i>	15
<i>trihexyphenidyl tab</i>	24	<i>unithroid tab</i>	58	<i>venlafaxine ir tab</i>	15
TRIHIBIT KIT	62	<i>ursodiol cap 300mg</i>	50	VENTAVIS AMPUL	71
<i>tri-legest fe tab QL-28 QY 28 DY</i>	57	<i>ursodiol tab 250mg</i>	50	VENTOLIN HFA QL-2 INHALERS 30 DY	70
TRILIPIX CAP QL-30 QY 30 DY.....	40	<i>ursodiol tab 500mg</i>	50	<i>verapamil ampul</i>	37
<i>trilyte soln oral QL-1 KIT QY 30 DY</i>	50	V		<i>verapamil hcl er cap,24hr</i>	37
<i>trimethobenzamide cap</i>	17	VAGIFEM TAB	56	<i>verapamil hcl er tab</i>	37
<i>trimethoprim sulf/poly b sulfate drops</i>	65	<i>valacyclovir 1000mg tab</i> <i>QL-30 QY 30 DY</i>	29	<i>verapamil hcl sr cap,24hr</i>	37
<i>trimethoprim tab</i>	6	<i>valacyclovir 500mg tab</i> <i>QL-42 QY 30 DY</i>	29	<i>verapamil hcl tab</i>	37
<i>trinessa tab QL-28 QY 28 DY</i>	57	VALCYTE TAB	27	VEREGEN OINT QL-15 GM 30 DY	48
TRIPEDIA VIAL.....	62	<i>valproate vial</i>	12	VESICARE TAB QL-30 QY 30 DY	51
<i>tri-previfem tab QL-28 QY 28 DY</i>	57	<i>valproic acid cap</i>	12	VEXOL SUSPENSION.....	67
TRISENOX AMPUL.....	21	<i>valproic acid syrup</i>	12	VFEND IV VIAL.....	18
<i>tri-sprintec tab QL-28 QY 28 DY</i>	57	VANOCOCIN 125MG CAP QL-56 QY 14 DY	6	VFEND SUSPENSION.....	18
<i>trivora-28 tab QL-28 QY 28 DY</i>	58	VANOCOCIN 250MG CAP QL-40 QY 10 DY	6	VIBATIV VIAL.....	6
TRIZIVIR TAB	27	VANCOMYCIN DEXTROSE IV	6	VIBRAMYCIN SYRUP.....	10
TROPHAMINE IV	74	<i>vancomycin dextrose iv</i>	6	VIDAZA VIAL.....	21
<i>tropicamide drops</i>	65	<i>vancomycin vial</i>	6	VIDEX PEDIATRIC SOLN ORAL.....	27
<i>tropium tab QL-60 QY 30 DY</i>	51	<i>vandazole gel</i>	52	VIGAMOX DROPS QL-3ML 30 DY	65
TRUVADA TAB.....	27	VANDETANIB TAB 100MG QL-60 QY 30 DY	20	VIIBRYD TAB	15
		VANDETANIB TAB 300MG QL-30 QY 30 DY	20	VIMOVO TAB QL-60 QY 30 DY.....	1
				VIMPAT SOLN ORAL	11
				VIMPAT TAB QL-60 QY 30 DY.....	11

Advantra Freedom (PPO) and Advantra Advantage (HMO)

Formulary Index

Drug Name	Page	Drug Name	Page	Drug Name	Page
V		XOPENEX HFA QL-2		ZOSTAVAX VIAL QL-1 INJ	
VIMPAT VIAL	11	INHALERS 30 DY	71	365 DY	62
VIRACEPT 50MG/GM		XYREM SOLN ORAL QL-		<i>zovia tab QL-28 QY 28 DY</i>	58
POWDER.....	28	540ML 30 DY	43	ZOVIRAX 5% OINT QL-30	
VIRACEPT TAB	28	Y		GM 30 DY.....	29
VIRAMUNE SUSPENSION ..	27	ZYCLARA 3.75% CREAM		QL-28 PACK 30 DY.....	48
VIRAMUNE TAB	27	YF-VAX VIAL	62	ZYFLO 600MG TAB12 QL-	
VIRAMUNE XR TAB	27	Z		120 QY 30 DY	69
VIREAD TAB	27	ZAFIRLUKAST TAB QL-60 QY 30		ZYLET SUSPENSION	67
VISICOL TAB	50	<i>DI</i>	69	ZYMAR DROPS QL-5ML 30	
VIVAGLOBIN VIAL	60	<i>DI</i>	69	<i>DI</i>	65
VIVELLE-DOT PATCH QL-8		<i>DI</i>	71	ZYMAXID DROPS QL-	
PTCH 28 DY	56	ZAVESCA CAP.....	48	2.5ML 30 DY	65
VIVITROL SUSPENSION	16	<i>DI</i>	52	ZYPREXA 10MG TABS	
VOLTAREN GEL QL-1000		ZAZOLE CREAM	52	QL-30 QY 30 DY	25
GM 30 DY.....	48	ZEMAIRA VIAL.....	71	ZYPREXA 15MG TABS	
<i>voriconazole tab QL-60 QY</i>		ZEMPLAR CAP QL-30 QY		QL-60 QY 30 DY	25
<i>30 DY</i>	18	30 DY	64	ZYPREXA 20MG TABS	
VOTRIENT TAB QL-120 QY		ZENPEP CAP.....	48	QL-60 QY 30 DY	25
30 DY	20	<i>zeosa QL-28.00 QTY 28 DY</i> ...	58	ZYPREXA 2.5MG TABS	
VPRIV VIAL.....	48	<i>zerlor tab QL-150 QY 30 DY</i> ..	4	QL-30 QY 30 DY	25
VYTORIN TAB 10/10MG		ZETIA TAB QL-30 QY 30		ZYPREXA 5MG TABS	
QL-30 QY 30 DY	40	<i>DI</i>	40	QL-30 QY 30 DY	25
VYTORIN TAB 10/20MG		ZIAGEN SOLN ORAL.....	27	ZYPREXA 7.5MG TABS	
QL-30 QY 30 DY	40	ZIAGEN TAB.....	27	QL-30 QY 30 DY	25
VYTORIN TAB 10/40MG		<i>zidovudine cap</i>	27	ZYPREXA RELPREVV	
QL-30 QY 30 DY	40	<i>zidovudine syrup</i>	28	210MG QL-2 INJ 28 DY.....	25
VYTORIN TAB 10/80MG		<i>zidovudine tab</i>	28	ZYPREXA RELPREVV	
QL-30 QY 30 DY	40	ZIRGAN GEL QL-5.00 QY		300MG QL-2 INJ 28 DY.....	26
		30 DY	29	ZYPREXA RELPREVV	
		ZOLINZA CAP QL-120 QY		405MG QL-1 INJ 28 DY.....	26
		30 DY	21	ZYPREXA VIAL	26
W		<i>zolpidem tartrate tab</i>	72	ZYPREXA ZYDIS 10MG	
<i>warfarin tab</i>	33	ZOMETA VIAL.....	64	TBDP QL-30 QY 30 DY	26
WELCHOL 3.75GM PACK		ZOMIG NASAL SPR QL-6		ZYPREXA ZYDIS 15MG	
QL-30 PACK 30 DY.....	40	SPRAY UNITS 30 DY.....	19	TBDP QL-60 QY 30 DY	26
WELCHOL 625MG TAB		ZOMIG TAB QL-6 QY 30		ZYPREXA ZYDIS 20MG	
QL-180 QY 30 DY	40	<i>DI</i>	19	TBDP QL-60 QY 30 DY	26
		ZOMIG ZMT TAB QL-6 QY		ZYPREXA ZYDIS 5MG	
		30 DY	19	TBDP QL-30 QY 30 DY	26
		ZONALON CREAM QL-45		ZYTIGA TAB QL-120.00 QY	
		GM 30 DY.....	48	30 DY	21
		<i>zonisamide cap</i>	12	ZYVOX IV	7
		ZORBTIVE VIAL.....	54	ZYVOX ORAL SUSR QL-	
		ZORTRESS 0.25MG TABS....	60	900ML 14 DY	7
		ZORTRESS 0.5MG TABS.....	60	ZYVOX TAB QL-28 QY 14	
		ZORTRESS 0.75MG TABS....	60	<i>DI</i>	7

