Blue MedicareRx℠ Value Plus (PDP) 2018 Formulary

(List of Covered Drugs)

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

This formulary was updated on 09/01/2017. For more recent information or other questions, please contact Blue MedicareRx Value Plus, at 1-888-620-1747 or, for TTY/TDD users, 711, 24 hours a day, 7 days a week, or visit www.RxMedicarePlans.com.

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

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

This document includes a list of the drugs (formulary) for our plan which is current as of January 1, 2018. For an updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2019, and from time to time during the year.

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What is the Blue MedicareRx Value Plus Formulary?

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

Can the Formulary (drug list) change?

Generally, if you are taking a drug on our 2018 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2018 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, 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 January 1, 2018. To get updated information about the drugs covered by Blue MedicareRx Value Plus, please contact us. Our contact information appears on the front and back cover pages.

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

How do I use the Formulary?

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

Medical Condition

The formulary begins on page 7. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, "Cardiovascular". If you know what your drug is used for, look for the category name in the list that begins on page number 7. 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 52. The Index provides an alphabetical list of all of the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

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

Are there any restrictions on my coverage?

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

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

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

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

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 7. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We have posted online documents that explain our prior authorization and step therapy restrictions. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask Blue MedicareRx Value Plus to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, "How do I request an exception to the Blue MedicareRx Value Plus formulary?" on page 3 for information about how to request an exception.

What if my drug is not on the Formulary?

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

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

> You can ask Customer Care for a list of similar drugs that are covered by Blue MedicareRx Value Plus. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by our plan.
>
> You can ask Blue MedicareRx Value Plus to make an exception and cover your drug. See below for information about how to request an exception.

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

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

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

> You can ask us to cover a drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level, and you would not be able to ask us to provide the drug at a lower cost-sharing level.
>
> You can ask us to cover a formulary drug at a lower cost-sharing level if the drug is a tier 2 or tier 4. If approved this would lower the amount you must pay for your drug.
>
> You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, Blue MedicareRx Value Plus limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

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

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

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

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

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

If you are a resident of a long-term care facility, we will allow you to refill your prescription until we have provided you with a 98-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.

If you change your level of care, such as a move from a hospital to a home setting, and you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover up to a temporary 30-day supply (or 31-day supply if you are a long-term care resident) when you go to a network pharmacy. After your first 30-day supply, you are required to use the plan's exception process.

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

For more information

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

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

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

Blue MedicareRx Value Plus Formulary

The formulary that begins on page 7 provides coverage information about the drugs covered by Blue MedicareRx Value Plus. If you have trouble finding your drug in the list, turn to the Index that begins on page 52.

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

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

- **B/D** stands for drugs covered under Medicare Part B or D.
- **QL** stands for Quantity Limits.
- **PA** stands for Prior Authorization.
- **ST** stands for Step Therapy.
- **LA** stands for Limited Access. This prescription may be available only at certain pharmacies. For more information consult your Pharmacy Directory or call Customer Care at 1-888-620-1747, 24 hours a day, 7 days a week. TTY/TDD users should call 711.
- **NMO** stands for No Mail Order. This prescription drug is not available through mail order service.

Explanation of Tiers and Copayments/Coinsurance:

Blue MedicareRx Value Plus Initial Coverage Stage

Tier Label	Retail Cost-Sharing or Out-of-Network (OON) Cost-Sharing* 30-day supply/ Long-term Care (LTC)** 31-day supply		Mail Order Cost-Sharing 90-day supply
	Preferred Retail Cost-Sharing	Standard Retail Cost-Sharing/ OON/LTC	
Tier 1: Preferred Generic Certain **generic drugs** that are available at the lowest copayment	$2	$7	$2
Tier 2: Generic Higher cost **generic drugs** available at a higher copayment than Tier 1 generic drugs	$7	$19	$14
Tier 3: Preferred Brand Many common **brand name drugs** and some higher cost **generic drugs**, many of which may have lower cost options available on Tier 1 or Tier 2***	$35	$45	$70
Tier 4: Non-Preferred Drug Higher cost **generic** and non-preferred **drugs,** many of which may have lower cost options available on Tier 1, Tier 2, and Tier 3***	40%	50%	40%
Tier 5: Specialty Tier Unique and/or very high-cost drugs of which you pay a percentage of the total drug cost***	28%	28%	Not Applicable†

* In addition to your copayment, at an out-of-network pharmacy you will pay the difference between the actual charge and what you would have paid at a network pharmacy. Amounts you pay may vary at out-of-network pharmacies.

** Standard Retail Cost-Sharing applies to all Out-of-Network (OON) and Long-term Care (LTC) Cost-Sharing.

*** You pay the full cost of drugs on Tier 3, Tier 4 and Tier 5 until you have reached the yearly deductible.

† Specialty Tier drugs are not available for a 90-day retail or mail order supply.

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

If you have used mail order services with your current plan before, or if you opt in now, our pharmacy will automatically fill and ship new prescriptions received directly from your doctors or other prescribers. You may opt out of automatic deliveries of new prescriptions at any time by contacting us. If you never had mail order delivery and/or decide to stop automatic fills of new prescriptions, we will contact you each time we get a new prescription from a provider, to see if you want the medication filled and shipped at that time. This will give you an opportunity to make sure that the correct drug (including strength, amount, and form) will be delivered, and, if necessary, allow you to cancel or delay the order before you are billed and it is shipped.

For refills of your mail order prescriptions, you have the option to sign up for an automatic refill program. Under this program, we will start to process your next refill automatically when our records show that you should be close to running out of your drug. We will contact you prior to shipping each refill to make sure you are in need of more medication. You can cancel scheduled refills if you have enough of your medication or if your medication has changed. If you choose not to use the auto-refill program, please contact us 15 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time. To opt out of the automatic refill program, please contact us by calling Customer Care.

Typically, you should expect to receive your prescription drugs within 10 calendar days from the time that the mail order pharmacy receives the order. If you do not receive your prescription drug(s) within this time, please contact us at 1-888-620-1747. TTY/TDD users should call 711.