MASSACHUSETTS

Welcome

SMHG Seekonk

Welcome to your custom E-Kit for the HMO plan for Seekonk. Please see the attached detailed plan information. As well as added benefits that are offered through your health plan. Thank you!

Member Central | Find a Doctor | Contact Us

Visit: http://saleskits.bluecrossma.com/2016/SMHG_Seekonk

Contents

Pharmacy Information

More Information

Plan details: (click to view documents)

159871BS SMHG NBNEV 3-24-16 FINAL 5 10k moop		SBC

Get more details on your plan (click to view documents)

fitness reimbursment $150	View Document
weight loss $150	View Document
2016 Pharmacy Program Formulary	View Document
Mail Service Pharmacy Brochure & Form	View Document
$9 Generic Medications List	View Document

HEALTH PLAN NCQA ACCREDITATION EXCELLENT

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This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at http://semhg.org/ or by calling **1-800-932-8323**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$5,000** member / **$10,000** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. See www.bluecrossma.com/findadoctor or call **1-800-821-1388** for a list of network providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** (or provider's charge if it is less than the **allowed amount**) for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000 (and it is less than the provider's charge), your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts. (If you are eligible to elect a Health Reimbursement Account (HRA), Flexible Spending Account (FSA) or you have elected a Health Savings Account (HSA), you may have access to additional funds to help cover certain **out-of-pocket** expenses such as **copayments**, **coinsurance**, **deductibles** and costs related to services not otherwise covered.)

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		In-Network	Out-of-Network	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 / visit	Not covered	--- none ---
	Specialist visit	$25 / visit	Not covered	--- none ---
	Other practitioner office visit	$25 / chiropractor visit	Not covered	--- none ---
	Preventive care/screening/immunization	No charge	Not covered	GYN exam limited to one exam per calendar year
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	--- none ---
	Imaging (CT/PET scans, MRIs)	$75	Not covered	Copayment applies per category of test / day; copayment limited to $375 per calendar year for services in Connecticut; pre-authorization required for certain services

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		In-Network	Out-of-Network	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bluecrossma.com/medications.	Generic drugs	$15 / retail supply or $30 / mail service supply	Not covered	Up to 30-day retail (90-day mail service) supply; cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain drugs
	Preferred brand drugs	$30 / retail supply or $60 / mail service supply	Not covered	Up to 30-day retail (90-day mail service) supply; cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain drugs
	Non-preferred brand drugs	$50 / retail supply or $150 / mail service supply	Not covered	Up to 30-day retail (90-day mail service) supply; cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain drugs
	Specialty drugs	Applicable cost share (generic, preferred, non-preferred)	Not covered	When obtained from a designated specialty pharmacy; pre-authorization required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 / admission	Not covered	Pre-authorization required for certain services
	Physician/surgeon fees	No charge	Not covered	Pre-authorization required for certain services
If you need immediate medical attention	Emergency room services	$100 / visit	$100 / visit	Copayment waived if admitted or for observation stay
	Emergency medical transportation	No charge	No charge	--- none ---
	Urgent care	$25 / visit	$25 / visit	Out-of-network coverage limited to out of service area
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 / admission	Not covered	Copayment limited to $500 for services within 30 days for the same or related illness; pre-authorization required
	Physician/surgeon fee	No charge	Not covered	Pre-authorization required

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		In-Network	Out-of-Network	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 / visit	Not covered	Pre-authorization required for certain services
	Mental/Behavioral health inpatient services	$500 / admission	Not covered	Copayment limited to $500 for services within 30 days for the same or related illness; pre-authorization required
	Substance use disorder outpatient services	$25 / visit	Not covered	Pre-authorization required for certain services
	Substance use disorder inpatient services	$500 / admission	Not covered	Copayment limited to $500 for services within 30 days for the same or related illness; pre-authorization required for certain services
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	--- none ---
	Delivery and all inpatient services	$500 / admission and no charge for delivery	Not covered	Copayment limited to $500 for services within 30 days for the same or related illness
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Pre-authorization required
	Rehabilitation services	$25 / visit	Not covered	Limited to 60 visits per calendar year (other than for autism, home health care, and speech therapy); pre-authorization required for certain services
	Habilitation services	$25 / visit	Not covered	Rehabilitation therapy coverage limits apply; cost share and coverage limits waived for early intervention services for eligible children; pre-authorization required for certain services
	Skilled nursing care	No charge	Not covered	Limited to 100 days per calendar year; pre-authorization required
	Durable medical equipment	20% coinsurance	Not covered	Cost share waived for one breast pump per birth
	Hospice service	No charge	Not covered	Pre-authorization required for certain services

Common Medical Event	Services You May Need	Your cost if you use		Limitations & Exceptions
		In-Network	Out-of-Network	
If your child needs dental or eye care	Eye exam	No charge	Not covered	Limited to one exam every 24 months
	Glasses	Not covered	Not covered	--- none ---
	Dental check-up	No charge	Not covered	Limited to members under age 12 (every 6 months) and under age 18 with a cleft palate / cleft lip condition

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture • Children's glasses • Cosmetic surgery	• Dental care (adult) • Long-term care • Non-emergency care when traveling outside the U.S.	• Private-duty nursing

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Bariatric surgery • Chiropractic care • Hearing aids ($2,000 per ear every 36 months for members age 21 or younger)	• Infertility treatment • Routine eye care - adult (one exam every 24 months) • Routine foot care (only for patients with systemic circulatory disease)	• Weight loss programs ($150 per calendar year per policy)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact your plan sponsor. Note: A plan sponsor is usually the member's employer or organization that provides group health coverage to the member. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Member Service number listed on your ID card or contact your plan sponsor. Note: A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Assistance

To obtain language assistance, please call the toll-free Member Service number on your ID card.

SPANISH (Español): Para obtener asistencia en español, llame al número gratuito de Servicio de Atención al Miembro que figura en su tarjeta de identificación.

TAGALOG (Tagalog): Kung kailangan ninyo ng tulong sa Tagalog tumawag sa libreng numero ng telepono ng Serbisyo sa Miyembro na nakasulat sa inyong ID card.

CHINESE (中文): 如果您需要中文語言幫助，請撥打會員卡上的客戶服務免費電話號碼

NAVAJO (Dine): Dinek'ehjí shika' a'dowoł ninizingo, kwojí hodiiłné t'áá jííkeh béésh bee' hane'jı̨ T'áá doolé'é bina'íshdiłkidgo yeeháká'adoojah éí binumber bee néého'dolzin biniiyé naanitinígíí bikáá' doo.

Disclaimer:

This document contains only a partial description of the benefits, limitations, exclusions and other provisions of this health care plan. It is not a policy. It is a general overview only. It does not provide all the details of this coverage, including benefits, exclusions and policy limitations. In the event there are discrepancies between this document and the policy, the terms and conditions of the policy will govern.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,870
- **Patient pays** $670

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$520
Coinsurance	$0
Limits or exclusions	$150
Total	**$670**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,770
- **Patient pays** $2,630

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$2,550
Coinsurance	$0
Limits or exclusions	$80
Total	**$2,630**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums.**
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call **1-800-932-8323** or visit us at www.bluecrossma.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.bluecrossma.com/sbcglossary or call **1-800-932-8323** to request a copy.

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MCC Compliance

This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect as of January 1, 2014, as part of the Massachusetts Health Care Reform Law.

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55-0647 (6/14) 150M

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Your Pharmacy Program

Pharmacy Program Overview

Our pharmacy program is designed to provide you and your doctor with access to a wide variety of safe, clinically effective medications. We have carefully developed a substantial formulary that includes many medications at affordable cost share levels.

Effective January 1, 2016

About This Guide

This guide is up-to-date as of January 1, 2016, and is subject to change. Keep this guide handy, and use it as a reference whenever you need coverage information about a specific medication. To get the most current coverage information about a specific medication, visit our website at **www.bluecrossma.com/medications.**

- **Top Covered Medications**—includes many commonly prescribed covered medications and your cost share tier that applies
- **Over-the-Counter Medications**—includes a list of over-the-counter medications that are covered when prescribed for you by your doctor
- **Quality Care Dosing**—includes a list of medications subject to Quality Care Dosing limits
- **Prior Authorization**—includes a list of medications that require Prior Authorization
- **Specialty Pharmacy Medications**—includes a list of medications that are available through pharmacies in the Specialty Pharmacy Network
- **Step Therapy**—includes a list of medications subject to Step Therapy
- **Medication Resource List Index**—includes all prescription medications listed in this booklet, along with the page(s) on which they can be found.

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Overview

Online Resources

From our main website, **www.bluecrossma.com,** to the **www.express-scripts.com** website, we offer a variety of online resources to help you manage your medications.

- **Search for Medication Information**. To learn whether your medications will be covered, you can visit **www.bluecrossma.com/medications,** and use the **Medication Look Up** feature. You can use this tool before you enroll. (The medication information represents our standard pharmacy coverage; your individual coverage may vary.) Our 2016 formulary changes will not be reflected in this tool until January 1, 2016.
- **Member Central.** Want more detailed information about your health care coverage, claims, or deductibles? You can log on to Member Central by going to our website, **www.bluecrossma.com/member-central.** To register, click **Create an Account,** on the upper right-hand side of the page.

  —If you're already registered, just log in with your user name and password.
- **Express Scripts Online.** Once registered with Member Central, you can also get immediate, online access to information about your specific pharmacy benefit by visiting Express Scripts Inc., (ESI), our pharmacy management partner, at **www.express-scripts.com.** Once there, you'll have access to:

  —Price a Drug

  —Find a Pharmacy

  —Mail Service features (which allow you to order refills and renew prescriptions)

Mail Service Pharmacy

With the Mail Service Pharmacy (administered by ESI), you can enjoy the convenience of having certain prescriptions delivered to you. Depending on your specific coverage, you can use the Mail Service Pharmacy to order up to a 90-day supply of certain long-term maintenance medications (like those used to treat high blood pressure), for less than you may normally pay at a retail pharmacy.

It's convenient, cost-effective, and all information is handled in accordance with our confidentiality policy.

If you would like to use the Mail Service Pharmacy, you can download an order form and find additional information on our website. Go to **www.bluecrossma.com/pharmacy** and choose Mail Service Pharmacy from the menu on the left-hand side. If you'd like our **Mail Service Pharmacy** brochure mailed to you, please call **1-800-262-BLUE (2583)**.

Overview

Your Pharmacy Cost Share

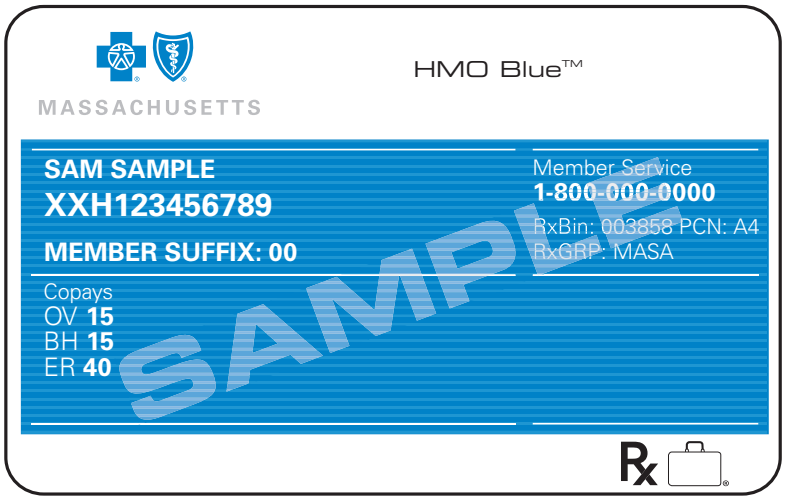
Our pharmacy program formulary is based on a tiered cost share structure. When you fill a prescription, the amount you pay the pharmacy (your prescription cost share) is determined by the tier your medication is on. Medications are placed on tiers according to a variety of factors, including what they are used for, their cost, and whether equivalent or alternative medications are available. The pharmacy will advise you of the amount you owe. Usually, you will pay the least amount of cost share for Tier 1 medications and the most for Tier 3 medications in a three-tier cost share benefit structure. In a four-tier cost share benefit structure, usually, you will pay the least amount of cost share for Tier 1 medications and the most for Tier 4 medications..

Your cost share may include your copayment, co-insurance, and deductibles. For more about your specific prescription benefits, review the information in your benefit literature, which you should have received when you enrolled in your plan, or call the Member Service number listed on the front of your ID card, Monday through Friday, 8:00 a.m. to 9:00 p.m. ET.

Covered compounded medications that require a prescription will be processed at your highest pharmacy benefit tier, regardless of the ingredients in the medication. Compounded medications are medications that are made to order by a pharmacist when existing, commercially available medications do not meet your specific needs as determined by your provider. Some compounded medications may need prior authorization, have Quality Care Dosing guidelines, or require a formulary exception.

Your ID Card

Your ID card contains important information about your pharmacy benefits. Be sure to bring the card with you and give it to your pharmacist when you fill a prescription. A sample ID card is shown below.



Top Covered Medications

Our pharmacy formulary includes over 4,000 covered prescription medications. The following sample list includes covered medications most commonly prescribed for our members.

This list is up-to-date as of January 1, 2016, and is subject to change at any time. You can find the most up-to-date formulary information about a specific prescription medication on our website at **www.bluecrossma.com/medications.**

Please note that this is only a sample of top prescribed medications based on our standard three-tier formulary.

For more information about your specific prescription benefits, review the information in your benefit literature, which you should have received when you enrolled in your plan, or call the Member Service number listed on the front of your ID card.

The following covered medication list is based on our standard formulary. The tier that is assigned to the drug is the tier used in a three-tier cost share benefit structure. For members with a two-tier or four-tier cost share benefit structure, please log on to the Blue Cross and Blue Shield web site at **www.bluecrossma.com/medications** and use the Medication Lookup feature.

Top Covered Medications

Abilify (ST)	Tier 3
Acetaminophen/Codeine	Tier 1
Acyclovir	Tier 1
Adapalene	Tier 1
Advair Diskus (ST) (QCD)	Tier 3
Albuterol Sulfate	Tier 1
Alendronate (QCD)	Tier 1
Allopurinol	Tier 1
Alprazolam	Tier 1
Altavera	Tier 1
Alyacen	Tier 1
Amitriptylene	Tier 1
Amlodipine (QCD)	Tier 1
Amlodipine/Benazepril	Tier 1
Amoxicillin	Tier 1
Amoxicillin TR/Potassium Calvulanate	Tier 1
Amphetamine Salt Combination	Tier 1
Amphetamine/Dextroamphetamine ER (QCD)	Tier 2
Anastrozole	Tier 1
Androgel	Tier 2
Apri	Tier 1
Aripiprazole	Tier 1
Armour Thyroid	Tier 3
Asacol HD	Tier 2
Atenolol	Tier 1
Atorvastatin (QCD)	Tier 1
Aviane	Tier 1
Azelastine Nasal Spray (QCD)	Tier 1
Azithromycin	Tier 1
Baclofen	Tier 1
BD Ultra-Fine Pen Needle	Tier 2
Benicar (ST)	Tier 2
Benzonatate	Tier 1
Betamethasone	Tier 1
Budesonide	Tier 1
Buprenorphine/Naloxone (PA) (QCD)	Tier 2
Bupropion	Tier 1
Bupropion SR (QCD)	Tier 1
Bupropion XL (QCD)	Tier 1
Buspirone	Tier 1
Butalbital/Acetaminophen/Caffeine	Tier 1
Camila	Tier 1
Carisoprodol	Tier 1
Cartia XT	Tier 1
Carvedilol	Tier 1
Cefadroxil	Tier 1
Cefdinir	Tier 1
Cefuroxime	Tier 1
Celecoxib (ST) (QCD)	Tier 1
Cephalexin	Tier 1
Chantix	Tier 2
Chlorhexidine Gluconate	Tier 1
Chlorthalidne	Tier 1
Cialis	Tier 3
Ciprodex	Tier 2
Ciprofloxacin	Tier 1
Citalopram (QCD)	Tier 1
Clindamycin HCL	Tier 1
Clindamycin Phosphate	Tier 1
Clindamycin/Benzoyl Peroxide	Tier 1
Clobetasol	Tier 1
Clonazepam	Tier 1
Clonidine	Tier 1
Clopidogrel	Tier 1
Clotrimazole/Betamethasone	Tier 1
Colcrys	Tier 2
Crestor (ST) (QCD)	Tier 2
Cryselle	Tier 1
Cyanocobalamin Injection	Tier 1
Cyclobenzaprine	Tier 1

* (non-covered medication) Quality Care Dosing limits apply for members with approved formulary exceptions
** (new to market drug; non-covered while under review) quantity limits apply to members with approved formulary exceptions
(MBO) medical benefit only
(PA) prior authorization required
(PA17) prior authorization required for members who are 17 years of age or older
(PA30) prior authorization required for members age 30 and older
(QCD) Quality Care Dosing limits apply
(SP) medication is part of the specialty pharmacy benefit
(SPO) pharmacy benefit only
(ST) step therapy required

Top Covered Medications

Desogestrel/Ethinyl Estradiol	Tier 1
Desonide	Tier 1
Dexamethasone	Tier 1
Dexmethylphenidate ER (QCD)	Tier 1
Diazepam	Tier 1
Diclofenac Sodium	Tier 1
Dicyclomine	Tier 1
Diltiazem ER	Tier 1
Divalproex Sodium	Tier 1
Divalproex Sodium ER	Tier 1
Donepezil	Tier 1
Dorzolamide/Timolol	Tier 1
Doxazosin	Tier 1
Doxycycline Hyclate	Tier 1
Doxycycline Monohydrate	Tier 1
Dulera (ST) (QCD)	Tier 2
Duloxetine (QCD)	Tier 1
Econazole Nitrate	Tier 1
Enalapril	Tier 1
Enbrel (PA) (QCD)	Tier 2
Enoxaparin Sodium (QCD)	Tier 1
Enpresse	Tier 1
Epipen (QCD)	Tier 2
Epi-Pen Jr (QCD)	Tier 2
Erythromycin	Tier 1
Escitalopram (QCD)	Tier 1
Esomeprazole (PA) (QCD)	Tier 2
Estrace Cream	Tier 2
Estradiol	Tier 1
Eszopiclone (QCD)	Tier 1
Fenofibrate	Tier 1
Fentanyl (PA) (QCD)	Tier 1
Finasteride	Tier 1
Flovent HFA (QCD)	Tier 2
Fluconazole	Tier 1
Fluocinonide	Tier 1
Fluoride	Tier 1
Fluoxetine (QCD)	Tier 1
Folic Acid	Tier 1
Furosemide	Tier 1
Gabapentin	Tier 1
Gemfibrozil	Tier 1
Gildess FE	Tier 1
Glimepiride	Tier 1
Glipizide	Tier 1
Glipizide ER	Tier 1
Glipizide XL	Tier 1
Glyburide	Tier 1
Guanfacine	Tier 1
Guanfacine ER	Tier 1
Humalog (QCD)	Tier 2
Humalog Kwikpen (QCD)	Tier 2
Humira (PA) (QCD)	Tier 2
Hydrochlorothiazide	Tier 1
Hydrocodone/Acetaminophen	Tier 1
Hydrocortisone	Tier 1
Hydromorphone (PA)	Tier 1
Hydroxychloroquine	Tier 1
Hydroxyzine	Tier 1
Hydroxyzine Pamoate	Tier 1
Ibuprofen	Tier 1
Indomethacin	Tier 1
Insulin Syringes	Tier 2
Invokana (ST)	Tier 2
Iophen C NR	Tier 1
Irbesartan	Tier 1
Isosorbide Mononitrate ER	Tier 1
Januvia (ST)	Tier 2
Junel	Tier 1
Junel FE	Tier 1

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(MBO) medical benefit only
(PA) prior authorization required
(PA17) prior authorization required for members who are 17 years of age or older
(PA30) prior authorization required for members age 30 and older
(QCD) Quality Care Dosing limits apply
(SP) medication is part of the specialty pharmacy benefit
(SPO) pharmacy benefit only
(ST) step therapy required

Top Covered Medications

Kelnor	Tier 1
Ketoconazole	Tier 1
Ketorolac Tromethamine	Tier 1
Klor Con	Tier 1
Labetalol	Tier 1
Lamotrigine	Tier 1
Lansoprazole (PA) (QCD)	Tier 2
Lantus (QCD)	Tier 2
Lantus Solostar (QCD)	Tier 2
Latanoprost	Tier 1
Levetiracetam	Tier 1
Levofloxacin	Tier 1
Levonorgestrel/Ethinyl Estradiol	Tier 1
Levothyroxine	Tier 1
Levoxyl	Tier 1
Lidocaine Patch (QCD)	Tier 1
Liothyronine	Tier 1
Lisinopril	Tier 1
Lisinopril HCTZ	Tier 1
Lithium Carbonate	Tier 1
Lithium Carbonate ER	Tier 1
Lo Loestrin FE	Tier 3
Lorazepam	Tier 1
Loryna	Tier 1
Losartan	Tier 1
Losartan HCTZ	Tier 1
Lovastatin	Tier 1
Ludent Fluoride	Tier 1
Lutera	Tier 1
Lyrica (PA)	Tier 3
Medroxyprogesterone	Tier 1
Meloxicam (QCD)	Tier 1
Metformin	Tier 1
Metformin ER	Tier 1
Methimazole	Tier 1
Methocarbamol	Tier 1
Methotrexate	Tier 1
Methylphenidate	Tier 1
Methylphenidate CD (QCD)	Tier 1
Methylphenidate ER (QCD)	Tier 1
Methylprednisolone	Tier 1
Metoprolol Succinate	Tier 1
Metoprolol Tartrate	Tier 1
Metronidazole	Tier 1
Microgestin FE	Tier 1
Minastrin FE	Tier 1
Minocycline	Tier 1
Mirtazapine	Tier 1
Modafinil (PA)	Tier 1
Mometasone Furoate	Tier 1
Montelukast	Tier 1
Morphine Sulfate ER (PA) (QCD)	Tier 1
Multivitamin/Fluoride	Tier 1
Mupirocin	Tier 1
Nabumetone	Tier 1
Nadolol	Tier 1
Naproxen	Tier 1
Necon	Tier 1
Nifedipine ER	Tier 1
Nitrofurantoin Mono/Macro	Tier 1
Nitrostat	Tier 2
Norethindrone	Tier 1
Norgestimate/Ethinyl Estradiol	Tier 1
Nortrel	Tier 1
Nortriptyline	Tier 1
Nuvaring	Tier 1
Nystatin	Tier 1
Ocella	Tier 1
Ofloxacin	Tier 1
Olanzapine	Tier 1

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(ST) step therapy required

Top Covered Medications

Omeprazole (QCD)	Tier 1
Ondansetron (QCD)	Tier 1
Ondasetron ODT (QCD)	Tier 1
Orsythia	Tier 1
Ortho Tri-Cyclen Lo	Tier 3
Oxcarbazepine	Tier 1
Oxybutynin ER	Tier 1
Oxycodone	Tier 1
Oxycodone/Acetaminophen	Tier 1
OxyContin (PA) (QCD)	Tier 1
Pantoprazole (QCD)	Tier 1
Paroxetine	Tier 1
Paroxetine CR (QCD)	Tier 1
Penicillin V Potassium	Tier 1
Phenazopyridine	Tier 1
Pioglitazone (QCD)	Tier 1
Polymyxin B Sulfate/Trimethoprim	Tier 1
Potassium Chloride	Tier 1
Pramipexole	Tier 1
Pravastatin (QCD)	Tier 1
Prednisolone	Tier 1
Prednisolone Sodium Phosphate	Tier 1
Prednisone	Tier 1
Premarin	Tier 2
Prenatal Plus	Tier 1
Proair HFA (QCD)	Tier 2
Progesterone	Tier 1
Promethazine	Tier 1
Propranolol	Tier 1
Propranolol ER	Tier 1
Pulmicort Flexhaler (QCD)	Tier 2
Quetiapine	Tier 1
Quinapril	Tier 1
QVAR (QCD)	Tier 2
Ramipril	Tier 1
Ranitidine	Tier 1
Reclipsen	Tier 1
Restasis (PA) (QCD)	Tier 3
Risperidone	Tier 1
Rizatriptan (QCD)	Tier 1
Ropinirole	Tier 1
Sertraline (QCD)	Tier 1
Simvastatin	Tier 1
Sodium Sulfacetamide/Sulfur	Tier 1
Spiriva (QCD)	Tier 2
Spironolactone	Tier 1
Sprintec	Tier 1
Strattera (PA) (QCD)	Tier 3
Suboxone (PA) (QCD)	Tier 2
Sulfamethoxazole/Trimethoprim	Tier 1
Sumatriptan (QCD)	Tier 1
Symbicort (ST) (QCD)	Tier 2
Synthroid	Tier 3
Tamoxifen	Tier 1
Tamsulosin	Tier 1
Temazepam	Tier 1
Terazosin	Tier 1
Terbinafine	Tier 1
Testosterone Cypionate	Tier 1
Timolol	Tier 1
Tizanidine	Tier 1
Tobramycin/Dexamethasone	Tier 1
Topiramate	Tier 1
Tramadol	Tier 1
Trazodone	Tier 1
Tretinoin (PA)	Tier 1
Triamcinolone	Tier 1
Tri-Linyah	Tier 1
Trinaterene HCTZ	Tier 1
Trinessa	Tier 1

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Top Covered Medications

Tri-Previfem	Tier 1
Tri-Sprintec	Tier 1
Vagifem	Tier 2
Valacyclovir	Tier 1
Valsartan	Tier 1
Valsartan HCTZ	Tier 1
Venlafaxine	Tier 1
Venlafaxine ER (QCD)	Tier 1
Verapamil ER	Tier 1
Viagra	Tier 3
Viorele	Tier 1
Vitamin D2	Tier 1
Voltaren Solution	Tier 2
Warfarin	Tier 1
Xarelto	Tier 2
Zetia (ST) (QCD)	Tier 3
Zolmitriptan (QCD)	Tier 1
Zolmitriptan ODT (QCD)	Tier 1
Zolpidem (QCD)	Tier 1
Zolpidem ER (QCD)	Tier 1

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Over-the-Counter Medications

For non-grandfathered health plans under the Affordable Care Act, the following list includes over-the-counter medications that are covered with no cost share when they are prescribed for you by your doctor. This list is up to date as of January 1, 2016, and is subject to change at any time.

- **Generic Aspirin (81mg)** is covered for females of all ages and males age 45–79.
- **Generic Folic Acid** is covered for females up to age 50.
- **Generic Iron** is covered for infants up to 12 months old.
- **Generic Smoking Cessation** is covered for up to two 90-day supplies per calendar year.
- **Generic Vitamin D** is covered for females of child bearing age and males age 65 and older.
- **Generic women's contraceptives** (e.g. female condoms, sponges, and spermicide) are covered.

Quality Care Dosing

Our Quality Care Dosing program helps to ensure that the quantity and dose of medications you receive comply with Food and Drug Administration (FDA) recommendations, as well as manufacturer and clinical information. When you fill a prescription for one of the following medications, it is checked electronically in two ways:

- **Dose Consolidation**—Checks to see whether you're taking two or more pills a day that can be replaced with one pill providing the same daily dosage.
- **Recommended Monthly Dosing Level**—Checks to see that your monthly dosage is consistent with the manufacturer's and FDA's monthly dosing recommendations and clinical information.

We will get your doctor's approval before making any changes to your prescribed medications.

For the most up-to-date list of medications subject to Quality Care Dosing, along with associated dosing limits, please visit our website at **www.bluecrossma.com/pharmacy**, click on **Pharmacy Management Program**, and proceed to the **Quality Care Dosing** section.

Please note: Your doctor may request an exception from the guidelines for medications that are subject to Quality Care Dosing (when medically necessary).

This list of medications that are in our Quality Care Dosing program is up-to-date as of January 1, 2016, and may change from time to time.

Quality Care Dosing

Abstral * (PA)
AcipHex * (PA)
Actiq * (PA)
Actonel (ST)
ACTOplus Met (ST)
ACTOplus Met XR (ST)
Actos (ST)
Acular PF
Acular *
Acular LS *
Adderall XR
Advair Diskus (ST)
Advair HFA (ST)
Advicor (ST)
Aerobid *
Aerobid-M *
Aerospan *
Akynzeo *
Alendronate Sodium
Alora *
Alosetron
Alrex *
Alsuma *
Altoprev (ST)
Alupent inhaler
Alvesco *
Ambien *
Ambien CR *
Amerge
Amitiza
Amlodipine
Amlodipine-Atorvastatin
Ampyra (PA) (SP)
Anzemet *
Aplenzin ER *
Aptenzio XR *
Aranesp * (PA) (SP) (SPO)
Arava *
Arcapta Neohaler *
Arnuity Ellipta *
Arixtra *
Asmanex Twisthaler *
Astelin
Astepro *
Atelvia DR * (ST)
Atorvastatin
Atrovent (nasal spray)
Atrovent HFA
Auvi-Q *
Avandamet (ST)
Avandia (ST)
Avinza *
Avonex (SP) (SPO)
Axert *
Azelastine (nasal spray)
Azmacort *
Beconase AQ *
Belsomra *
Belviq (PA)
Betaseron (SP) (SPO)
Binosto * (PA)
Boniva tablets * (ST)
Breo Ellipta * (ST)
Brintellix *
Brisdelle *
Budeprion SR
Budeprion XL
Budesonide (nebules)
Budesonide (nasal spray)
Bunavail (PA)

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Quality Care Dosing

Buprenorphine (PA)
Buprenorphine-Naloxone (PA)
Buprenex (PA)
Bupropion SR
Bupropion XL
Butorphanol NS
Butrans *
Bydureon
Byetta
Cabergoline
Caduet * (ST)
Cardura *
Cardura XL *
Catapres TTS
Celebrex (ST)
Celecoxib (ST)
Celexa *
Cesamet *
Cholbam
Ciclodin solution/kit
Ciclopirox nail lacquer
Citalopram
Climara
Climara Pro
Clonidine patch
CNL 8 nail kit *
Combivent
Combivent Respimat
Concerta
Contrave (PA)
Copaxone (SP) (SPO)
Cosentyx * (PA)
Crestor (ST)
Crolom ophthalmic
Cromolyn ophthalmic
Cymbalta
Daklinza ** (PA) (SP)
Desvenlafaxine ER *
Dexilant * (PA)
Dexmethylphenidate ER
Dexmethylphenidate XR
Dextroamphetamine/Amphetamine ER
Diflucan (150 mg only)
Dihydroergotamine (nasal spray)
Doxazosin
Dulera (ST)
Duloxetine
Duloxetine DR
Duragesic * (PA)
Dymista *
Edluar *
Effexor XR *
Embeda *
Emend
Enbrel (PA) (SP) (SPO)
Enoxaparin
Epinephrine injection
Epi-Pen Auto-Injector
Epogen * (PA) (SP) (SPO)
Escitalopram
Esomeprazole (PA)
Esomeprazole Strontium * (PA) (QCD)
Estraderm
Estradiol patch
Estrasorb *
Estrogel *
Eszopiclone
Evamist *
Evzio
Exalgo *

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Quality Care Dosing

Extavia (SP) (SPO)
Famciclovir
Famvir *
Farydak (PA)
Farxiga * (ST)
Fentanyl oral/mucosal (PA)
Fentanyl patch (PA)
Fentora * (PA)
Fetzima *
Flovent/HFA
Fluconazole (150 mg only)
Flunisolide
Fluoxetine
Fluoxetine DR
Fluticasone
Fluvastatin XR
Fluvastatin
Fluvoxamine
Fluvoxamine CR
Focalin XR *
Fondaparinux
Foradil
Forfivo XL *
Forteo (PA) (SP) (SPO)
Fosamax * (ST)
Fosamax Plus D (ST)
Fragmin *
Frova *
Fulyzaq (PA)
Gatifloxacin
Gilenya (SP)
Glatopa
Glucose testing strips (all)
Glyxambi *
Granisetron
Granisol
Granix
Grastek (PA)
Harvoni (PA) (SP)
Hetlioz (PA)
Humira (PA) (SP) (SPO)
Hydromorphone ER (PA)
Hysingla ER * (PA)
Hytrin *
Ibandronate
Ibrance (PA) (SP)
Imitrex
Incruse Ellipta * (ST)
Infergen (PA) (SP) (SPO)
Invokana (ST)
Insulins (all)
Intermezzo *
Ipratropium NS
Irenka DR *
Itraconazole
Jardiance (ST)
Kadian * (PA)
Kerydin *
Ketorolac ophthalmic
Khedezla *
Kytril *
Lamisil *
Lansoprazole (PA)
Lansoprazole/Amoxicillin/Clarithromycin
Lazanda * (PA)
Leflunomide
Lescol * (ST)
Lescol XL * (ST)
Lexapro
Lidocaine Patch

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Quality Care Dosing

Lidoderm
Linzess
Lipitor * (ST)
Liptruzet **
Livalo * (ST)
Lotronex
Lovastatin
Lovenox *
Lunesta
Luvox CR *
Lysteda *
Maxair Autohaler *
Maxalt *
Maxalt-MLT *
Meloxicam
Menostar *
Metadate CD
Methylphenidate CD
Methylphenidate ER
Mevacor * (ST)
Migranal
Minivelle
Mirtazapine
Mirtazapine Rapid Dissolve
Mobic *
Morphine Sulfate ER (PA)
Movantik
Moxeza *
MS Contin (PA)
Naratriptan
Nasonex *
NebuPent
Neulasta (SP)
Neupogen (SP)
Nexium * (PA)
Norvasc *
Olanzepine-Fluoxetine
Olopatadine Nasal
Omeprazole
Omeprazole-Sod. Bicarbonate * (PA)
Omnaris *
Omontys (PA) (SP)
Ondansetron
Ondansetron ODT
Onmel *
Onsolis * (PA)
Opana ER * (PA)
Oralair (PA)
Oramorph SR * (PA)
Otezla (PA)
Oxycodone ER (PA)
OxyContin (PA)
Oxymorphone ER (PA)
Pantoprazole
Paroxetine
Paroxetine CR
Patanase *
Paxil *
Paxil CR *
Pediapirox-4
Pegasys (SP) (SPO)
PEG-Intron (SP) (SPO)
Penlac *
Pexeva *
Pioglitazone (ST)
Pioglitazone-Glimepiride (ST)
Pioglitazone-Metformin (ST)
Plegridy * (SP)
Praluent ** (SP)
Pravachol * (ST)

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Quality Care Dosing

Pravastatin
Prevacid * (PA)
PrevPac *
Prilosec * (PA)
Pristiq *
ProAir HFA
ProAir Respiclick
Procrit (PA) (SP) (SPO)
Protonix * (PA)
Proventil HFA *
Prozac *
Prozac Weekly *
Pulmicort Flexhaler
Pulmicort Respules
QNASL *
Qualaquin
Qutenza (SP)
QVAR
Rabeprazole (PA)
Ragwitek (PA)
Rapaflux
Rebif (SP) (SPO)
Relpax *
Remeron *
Remeron Soltab *
Repatha ** (SP)
Restasis (PA)
Rhinocort Aqua *
Risedronate
Ritalin LA *
Rizatriptan
Rozerem
Sancuso *
Sarafem *
Saxenda (PA)
Selferma
Serevent Diskus
Sertraline
Silenor *
Simcor * (ST)
Simponi (PA) (SP) (SPO)
Simvastatin
Sonata
Spiriva
Sporanox *
Stiolto Respimat
Strattera (PA17)
Striverdi Respimat
Suboxone (PA)
Subsys * (PA)
Subutex (PA)
Sumatriptan
Sumavel Dosepro *
Symbicort (ST)
Symbyax
Synjardy **
Tanzeum
Technivie ** (PA) (SP)
Terazosin
Terbinafine
Terbinex *
Tivorbex *
Toujeo Solostar *
Tranexamic Acid
Treximet *
Trulicity (ST)
Tudorza
Valacylovir
Valtrex
Venlafaxine ER capsule

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Quality Care Dosing

Venlafaxine ER tablet
Ventolin HFA *
Veramyst *
Victoza (ST)
Viekira PAK * (PA) (SP)
Vigamox *
Viibryd *
Vivelle
Vivelle-Dot
Vytorin * (ST)
Vyvanse *
Wellbutrin SR *
Wellbutrin XL *
Xartemis XR * (PA)
Xifaxan
Xigduo * (ST)
Xopenex HFA *
Zaleplon
Zarxio
Zegerid * (PA)
Zetia (ST)
Zetonna *
Zocor * (ST)
Zofran *
Zofran ODT *
Zohydro ER * (PA)
Zolmitriptan
Zolmitriptan ODT
Zoloft *
Zolpidem
Zolpidem ER
Zolpimist *
Zomig *
Zomig ZMT *
Zubsolv **
Zuplenz *
Zydelig (SP)
Zymar *
Zymaxid *

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Prior Authorization

Your doctor is required to obtain prior authorization before prescribing specific medications. This ensures that your doctor has determined that this medication is necessary to treat you, based on specific medical standards.

For the most up-to-date list of medications that require prior authorization, please visit our website, **www.bluecrossma.com/pharmacy,** click on **Pharmacy Management Program,** and proceed to **Prior Authorization.**

Another part of our prior authorization program is step therapy. Please refer to page 22 for a list of medications that require step therapy.

This list of medications that require prior authorization is up-to-date as of January 1, 2016, and may change from time to time.

Prior Authorization

Abstral * (QCD)
AcipHex * (QCD)
Actemra (SP)
Acthar (SP)
Actiq * (QCD)
Adcirca (SP)
Amevive (MBO)
Amphetamines (e.g Amphetamine, Methamphetamine, Liquadd, Procentra)
Ampyra (QCD) (SP)
Aralast (MBO)
Aralast NP (MBO)
Aranesp * (QCD) (SP) (SPO)
Avinza * (QCD)
Belviq
Binosto *
Boniva syringe * (SP)
Botox (SP)
Bunavail (QCD)
Buprenorphine (QCD)
Buprenorphine-Naloxone (QCD)
Buprenex
Butrans * (QCD)
Ceredase (MBO)
Cerezyme (MBO)
Cimzia (SP) (SPO)
Cinryze (MBO)
Contrave (QCD)
Cosentyx *
Daklinza ** (QCD) (SP)
Desoxyn (PA17)
Dexilant * (QCD)
Dextroamphetamines (e.g. Dexedrine) (PA17)
Dificid *
Diskets
Dolophine
Duragesic * (QCD)
Dysport
Egrifta (SP)
Elidel
Embeda * (QCD)
Enbrel (QCD) (SP) (SPO)
Enteral formula
Entyvio (SP)
Epogen * (QCD) (SP) (SPO)
Erbitux (MBO)
Esomeprazole (QCD)
Esomeprazole Strontium * (QCD)
Euflexxa * (SPO)
Exalgo * (QCD)
Eylea (MBO)
Factor VIII, VIIIa, IX, XIII (MBO)
Farydak (SP)
Fentanyl patch (QCD)
Fentanyl oral/mucosal (QCD)
Fentora * (QCD)
First-lansoprazole
First-omeprazole
Forteo (QCD) (SP) (SPO)
Fulyzaq (QCD)
Gel-One * (SPO)
Genotropin * (SP) (SPO)
Geref
Grastek (QCD)
Harvoni (QCD)
Hetlioz (QCD)
Humatrope (SP) (SPO)
Humira (QCD) (SP) (SPO)
Hyalgan * (SPO)
Hysingla ER * (QCD)

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Prior Authorization

Ibandronate injection/syringe
Ibrance (QCD) (SP)
Ilaris (SP) (SPO)
Increlix
Incivek (SP) (SPO)
Interferons (alpha, gamma)
Iplex
IV Immunoglobulin (MBO)
Kadian * (QCD)
Kalydeco
Kineret (SP) (SPO)
Lansoprazole (QCD)
Lazanda * (QCD)
Lenvima (SP)
Leukine (SP)
Lucentis (MBO)
Lynparza (SP)
Lyrica
Macugen (MBO)
Makena (SP)
Mekinist
Methadone
Methadose
Modafinil
Monovisc * (SPO)
Morphine Sulfate CR (QCD)
Morphine Sulfate ER (QCD)
MS Contin (QCD)
Myalept (SP)
Nexium * (QCD)
Norditropin * (SP) (SPO)
Nucynta ER *
Nutritional Supplements
Nutropin * (SP) (SPO)
Nuvigil * (PA17)
Olysio (SP)
Omeprazole-Sod. Bicarbonate * (QCD)
Omnitrope (SP) (SPO)
Omontys (SP) (SPO)
Onsolis * (QCD)
Opana ER * (QCD)
Opdivo (SP)
Oralair (QCD)
Oramorph SR * (QCD)
Orencia (SP)
Orthovisc * (SPO)
Otezla (QCD) (SP)
Oxycodone ER (QCD)
Oxycontin (QCD)
Oxymorphone ER (QCD)
Preservative-Free Morphine (MBO)
Prevacid * (QCD)
Prilosec * (QCD)
Procrit (QCD) (SP) (SPO)
Prolastin (MBO)
Prolastin C (MBO)
Proleukin (SP)
Prolia (SP) (SPO)
Protonix * (QCD)
Protopic
Protropin (SPO)
Provigil (PA17)
Rabeprazole (QCD)
Ragwitek (QCD)
Raptiva
Reclast (MBO)
Regranex
Remicade (SP)
Respiratory SyncytialVirus IG/Synagis (SP)
Restasis (QCD)

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Prior Authorization

Revatio * (SP)
Rituxan (SP)
Saizen * (SP) (SPO)
Saxenda (QCD)
Serostim
Sildenafil (SP)
Simponi (QCD) (SP) (SPO)
Sovaldi (SP)
Stelara * (SP) (SPO)
Strattera (PA17) (QCD)
Suboxone (QCD)
Subsys * (QCD)
Supartz * (SPO)
Synvisc * (SPO)
Synvisc One * (SPO)
Tafinlar (PA) (SP)
Technivie ** (QCD) (SP)
Tev-Tropin * (SP) (SPO)
Topical Retinoic Acid Derivatives (e.g. Retin-A) (PA30)
TPN (total parenteral nutrition) (MBO)
Tysabri (MBO)
Vectibix (MBO)
Victrelis (SP)
Viekira PAK * (QCD)
Xalkori (SP)
Xartemis XR * (QCD)
Xeljanz * (SP)
Xenazine
Xeomin
Xgeva (SP) (SPO)
Xiaflex (MBO)
Xolair (MBO)
Zegerid * (QCD)
Zelboraf (SP)
Zohydro ER * (QCD)
Zomactin * (SP) (SPO)
Zometa (MBO)
Zorbtive (SPO)
Zubsolv (QCD)
Zydelig (SP)
Zykadia (SP)

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Specialty Pharmacy Medications

Blue Cross Blue Shield of Massachusetts has set up a network of retail specialty pharmacies to dispense certain medications classified as specialty. The following is a list of medications that can only be purchased from one of the pharmacies in this network in order for coverage to be available.

This list is up-to-date as of January 1, 2016. You can find the latest information about your medications and look up pharmacy contact information by visiting **www.bluecrossma.com/pharmacy.**

Network Pharmacy Information

AcariaHealth
1-866-892-1202
www.acariahealth.com

Accredo Health Group, Inc. /CuraScript
1-877-988-0058
www.accredo.com

CVS Caremark, Inc.
1-866-846-3096
www.caremark.com

OncoMed, the Oncology Pharmacy
1-877-662-6633
www.oncomed.net

Walgreens Specialty Pharmacy
1-800-649-2872 / Fax: 866-935-0719
www.walgreens.com/specialty

Network Pharmacy Information for Medications Most Commonly Used for Fertility

BriovaRx
1-800-850-9122
www.briovarx.com

Freedom Fertility Pharmacy
1-866-297-9452
www.freedomfertility.com

Metro Drugs
1-888-258-0106
www.metrodrugs.com

Village Fertility Pharmacy
1-877-334-1610
www.villagefertilitypharmacy.com

Walgreens
1-800-424-9002
www.walgreens.com/pharmacy/specialpharmacy.jsp

Specialty Pharmacy

Injectable Medications

Abraxane
Actemra (PA)
Acthar (PA)
Actimmune (PA) (SPO)
Adriamycin PFS
Adrucil
Alferon N (PA)
Alkeran
Apokyn
Aranesp * (PA) (QCD) (SPO)
Arcalyst Injection (SPO)
Aredia
Arzerra
Aveed
Avonex (QCD) (SPO)
Beleodaq
Betaseron (QCD) (SPO)
BiCNu
Bivigam (PA)
Bleomycin Sulfate
Blincyto
Boniva Injection * (PA)
Botox (PA)
Busulfex
Calcium Folanate
Camptosar
Carboplatin
Carimune (PA)
Cerubidine
Cimzia (PA) (SPO)
Cisplatin
Cladribine
Copaxone (QCD) (SPO)
Cosentyx * (PA) (SPO)
Cosmegen
Cyclophosphamide
Cyramza
Cytarabine
Cytogam (PA)
Cytoxan
Dacarbazine
Dactinomycin
Daunorubicin HCL
DaunoXome
DDAVP *
Depocyt
Desmopressin Acetate
Dexrazoxane
Docefrez
Docetaxel
Doxil
Doxorubicin HCl
DTIC-Dome
Duopa
Dysport (PA)
Egrifta (PA)
Eligard
Ellence
Eloxatin
Elspar
Enbrel (PA) (QCD) (SPO)
Entyvio (PA)
Epirubicin
Epogen * (PA) (QCD) (SPO)
Ethyol
Etopophos
Etoposide
Extavia * (QCD) (SPO)
Faslodex

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Specialty Pharmacy

Firazyr
Firmagon
Flebogamma (PA)
Floxuridine
Fludara
Fludarabine phosphate
Fluorouracil
Forteo (PA) (QCD) (SPO)
FUDR
Fusilev I.V.
Fuzeon (SPO)
Gammagard (PA)
Gammagard Liquid (PA)
GamaSTAN (PA)
Gammaked (PA)
Gammaplex (PA)
Gamunex (PA)
Gattex
Gazyva
Gemcitabine
Gemzar
Genotropin * (PA) (SPO)
Glatopa (QCD) (SPO)
Granix
Herceptin
Hizentra (PA)
Humatrope (PA) (SPO)
Humira (PA) (QCD) (SPO)
Hycamtin
HyQvia (PA)
Ibandronate injection/syringe
Idamycin PFS
Idarubicin
Ifex
Ifosfamide
Ifosfamide/Mesna
Ilaris (PA) (SPO)
Increlex (PA) (SPO)
Infergen (PA) (QCD) (SPO)
Intron A (PA) (SPO)
Irinotecan
Istodax
Kenalog
Keytruda
Kineret (PA) (SPO)
Kynamro
Lemtrada * (SPO)
Leucovorin Calcium
Leukine (PA)
Leuprolide Acetate (SPO)
Leustatin
Lipodox
Lipodox-50
Lupaneta Pack
Lupron Depot
Lupron Depot-Ped
Makena (PA)
Marqibo
Mesna
Mesnex
Methotrexate
Mitomycin
Mitoxantrone
Mozobil
Mustargen
Myalept (PA)
Mylotarg
Myobloc (PA)
Naptara
Navelbine

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Specialty Pharmacy

Neosar
Neulasta (QCD)
Neumega
Neupogen (QCD)
Nipent
Norditropin * (PA) (SPO)
Norditropin Flexpro * (PA) (SPO)
Norditropin Nordiflex * (PA) (SPO)
Novantrone
Nplate
Nutropin (PA) (SPO)
Nutropin AQ (PA) (SPO)
Nutropin AQ Nuspin (PA) (SPO)
Octagam (PA)
Octreotide injection (SPO)
Omnitrope * (PA) (SPO)
Oncaspar
Onxol
Opdivo (PA)
Orencia (PA)
Otrexup *
Oxaliplatin
Paclitaxel
Pamidronate
Pamidronate disodium
Pegasys (QCD) (SPO)
Peg-Intron (QCD) (SPO)
Photofrin
Plegridy * (QCD)
Praluent ** (QCD)
Privigen (PA)
Procrit (PA) (QCD) (SPO)
Proleukin (PA)
Prolia (PA) (SPO)
Rebif (QCD) (SPO)
Remicade (PA)
Repatha ** (QCD)
Revatio * (PA)
Rituxan (PA)
Ruconest
Saizen * (PA) (SPO)
Sandostatin (SPO)
Sandostatin-LAR
Serostim (PA) (SPO)
Signafor
Signafor LAR
Simponi (PA) (QCD) (SPO)
Simponi Aria (PA)
Simulect
Somatuline
Somavert (SPO)
Stelara * (PA) (SPO)
Sylatron (PA)
Sylvant
Synagis (PA)
Synribo
Tarabine
Taxol
Taxotere
Teniposide
Tev-Tropin * (PA) (SPO)
TheraCys
Thiotepa
Thyrogen
Toposar
Totect
Trelstar
Trelstar LA
Trelstar Depot
Valstar

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Specialty Pharmacy

Velcade
Vimzim
VinBLAStine
VinCRIStine
Vinorelbine
Vivitrol
Vumon
Xeomin (PA)
Xgeva (PA) (SPO)
Zaltrap
Zanosar
Zinecard
Zoladex
Zomacton * (PA) (SPO)
Zorbtive (PA) (SPO)

Oral Medications

8-Mop
Adcirca (PA)
Adempas
Afinitor
Alkeran
Ampyra (PA) (QCD)
Aubagio
Bethkis
Bosulif
Capecitabine
Carbaglu
Cerdelga **
Cometriq
Copegus (SPO)
Cystagon
Cytoxan
Daklinza ** (PA) (QCD)
Daraprim
Duopa
Erivedge
Esbriet
Etoposide
Exjade
Farydak (PA)
Gilenya (QCD)
Gilotrif
Gleevec
Havroni (PA) (QCD)
Hetlioz (PA)
Hycamtin
Ibrance (PA)
Iclusig
Imbruvica
Incivek (PA)
Inlyta
Iressa
Jadenu
Jakafi
Kalydeco (PA)
Kitabis PAK *
Korlym
Kuvan
Lenvima (PA)
Letairis
Lynparza (PA)
Mekinist
Mesnex
Moderiba
Nexavar
Northera *
Ofev
Oforta
Olysio (PA)
Onsolis * (PA) (QCD)

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Specialty Pharmacy

Opsumit
Orenitram
Orfadin (SPO)
Orkambi **
Otezla (PA) (QCD)
Otezla Starter Pack (PA)
Pomalyst
Procysbi
Promacta
Pulmozyme (SPO)
Raptiva (PA)
Ravicti
Rebetol (SPO)
Revatio * (PA)
Revlimid
Ribapak (SPO)
Ribasphere (SPO)
Ribatab
Ribavirin (SPO)
Rilutek
Riluzole
Sabril
Sildenafil (PA)
Sovaldi (PA)
Sprycel
Stivarga
Sucraid
Sutent
Tafinlar (PA)
Tarceva
Tasigna
Tecfidera
Technivie ** (PA) (QCD)
Temodar
Temozoloamide
Tetrabenazine
Thalomid
TOBI ampules (SPO)
TOBI-Podhaler (SPO)
Tobramycin ampules
Tracleer
Tykerb
Tyvaso
Viekira PAK * (PA) (QCD)
Victrelis (PA)
Votrient
Xalkori (PA)
Xeljanz *
Xeloda
Xenazine
Xtandi (ST)
Xyrem
Zavesca
Zelboraf (PA)
Zolinza
Zydelig (QCD)
Zykadia (PA)
Zytiga

Topical

Cystaran
Panretin (SPO)
Qutenza (QCD)
Valchlor
Zecuity *

Fertility Medications

Bravelle * (SPO)
Cetrotide (SPO)
Clomid
Clomiphene
Endometrin

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Specialty Pharmacy

Follistim AQ * (SPO)

Ganirelix * (SPO)

Gonal F/Gonal F RFF (SPO)

Gonal F Rff Rediject (SPO)

Human Chorionic Gonadotropin (HCG) (SPO)

Leuprolide (SPO)

Lupron Depot

Lupron Depot-Ped

Luveris (SPO)

Menopur (SPO)

Novarel

Ovidrel (SPO)

Pregnyl (SPO)

Repronex (SPO)

Serophene

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Step Therapy

Step therapy is a key part of our prior authorization program that allows us to help your doctor provide you with an appropriate and affordable drug treatment. Before coverage is allowed for certain costly "second-step" medications, we require that you first try an effective, but less expensive, "first-step" medication. Some medications may have multiple steps.

This list is up-to-date as of January 1, 2016, and is subject to change at any time. For the most up-to-date list of medications that require step therapy, please visit our website **www.bluecrossma.com/pharmacy,** click on **Pharmacy Management Program,** and proceed to **Step Therapy.**

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Step Therapy

Atypical Antipsychotic Medications

Abilify

Abilify DiscMelt *

Abilify Maintenna *

Clozaril

Fanapt *

FazaClo *

Geodon

Haldol

Haldol Decanoate

Invega *

Invega Sustenna

Invega Trinza

Latuda *

Loxitane

Rexulti **

Risperdal

Risperdal Consta

Risperdal M-Tab *

Saphris *

Seroquel

Seroquel XR

Symbyax (QCD)

Zyprexa

Zyprexa IM *

Zyprexa Relprevv *

Zyprexa Zydis

Asthma Management

Accolate *

Advair Diskus (QCD)

Advair HFA (QCD)

Anoro Ellipta (QCD)

Breo Ellipta * (QCD)

Dulera (QCD)

Incruse Ellipta * (QCD)

Singulair

Stiolto Respimat (QCD)

Symbicort (QCD)

Zafirlukast

Zyflo *

Zyflo CR *

Cholesterol Treatment

Advicor (QCD)

Altoprev * (QCD)

Caduet * (QCD)

Crestor (QCD)

Juxtapid

Kynamro (SP)

Lescol * (QCD)

Lescol XL * (QCD)

Lipitor * (QCD)

Liptruzet * (QCD)

Livalo * (QCD)

Mevacor * (QCD)

Pravachol * (QCD)

Simcor * (QCD)

Vytorin * (QCD)

Zetia (QCD)

Zocor * (QCD)

Diabetes Management

ACTOplus Met (QCD)

ACTOplus Met XR (QCD)

Actos (QCD)

Avandamet (QCD)

Avandaryl

Avandia (QCD)

Duetact

Farxiga *

Fortamet *

Glucophage *

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Step Therapy

Glucophage XR *
Glumetza *
Glyxambi * (QCD)
Invokana (QCD)
Invokamet (QCD)
Janumet
Janumet XR
Januvia
Jardiance
Jentadueto *
Kazano *
Kombiglyze XR
Nesina *
Onglyza
Oseni *
Pioglitazone (QCD)
Pioglitazone-Glimepiride (QCD)
Pioglitazone-Metformin (QCD)
Prandin *
Prandimet *
Tradjenta *
Trulicity (QCD)
Victoza (QCD)
Xigduo * (QCD)

Glaucoma

Lumigan
Rescula *
Travatan
Travatan Z
Xalatan

Heart/Blood Modifiers/Circulation

Amturnide *
Atacand *
Atacand HCT *
Avalide
Avapro
Azor
Benicar
Benicar HCT
Cozaar *
Diovan
Diovan HCT
Edarbi *
Edarbyclor *
Exforge
Exforge-HCT
Hyzaar *
Micardis *
Micardis HCT *
Tekamlo *
Tekturna *
Tekturna HCT *
Teveten *
Teveten HCT *
Tribenzor
Twynsta *
Valturna *

Osteoporosis Treatment (Oral)

Actonel (QCD)
Atelvia DR * (QCD)
Binosto * (QCD)
Boniva tablets * (QCD)
Fosamax * (QCD)
Fosamax Plus D (QCD)

Pain Relievers (Cox II Inhibitors)

Celebrex (QCD)
Celecoxib (QCD)

Prostate Treatment

Avodart
Jalyn

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Proscar *

Prostate Cancer - Oral

Xtandi

Parkinson's Disease Treatment

Mirapex

Mirapex ER *

Requip *

Requip XL *

Overactive Bladder Treatment

Detrol *

Detrol LA *

Ditropan *

Ditropan XL *

Enablex *

Gelnique *

Oxytrol *

Myrbetriq *

Sanctura *

Sanctura XR *

Toviaz *

Vesicare

Topical Testosterone

Fortesta *

Natesto Nasal *

Testim *

Testosterone gel (Fortesta Authorized product) *

Testosterone gel (Testim Authorized product) *

Testosterone gel (Vogelxo Authorized product) *

Testosterone CIK Kit *

Vogelxo *

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Non-Covered Medication

Your pharmacy program provides coverage for over 4,000 prescription medications. Most medications on our non-covered list have equally safe, effective, covered alternatives for treating the same medical conditions. If a non-covered drug is approved, it will be covered at the highest tier or cost share. Check with your doctor about appropriate alternatives if you currently take any of these medications.

Please note: Your doctor may request coverage for a non-covered medication if no covered alternative is appropriate for treating your condition.

This list of non-covered medications is up-to-date as of January 1, 2016, and may change from time to time. For the most up-to-date list of medications that are not covered and their covered alternatives, please visit our website, **www.bluecrossma.com/medications** and proceed to the **Medications that are not Covered** section.

Non-Covered Medication

Abilify DiscMelt (ST)
Abilify Maintenna (ST)
Absorica
Abstral (PA) (QCD)
Acanya
Accolate (ST)
Accu-Chek diabetic testing supplies (QCD)
AccuNeb
Accupril
Accuretic
Accutane
Aceon
AcipHex (PA) (QCD)
Acticlate
Actigall
Actiq (PA) (QCD)
Activella
Acular (QCD)
Acular LS (QCD)
Acuvail
Aczone
Adalat CC
Adazin
Adderall
Adoxa CK
Adoxa TT
Advanced Allergy Collection Kit
Advocate Redi-Code diabetic testing supplies (QCD)
Aerobid (QCD)
Aerobid-M (QCD)
Aerospan (QCD)
Afrezza
Airet
Akynzeo (QCD)
Alivycin Antipruritic SG gel
Aleveer
Alodox
Aloquin
Alora (QCD)
Alrex (QCD)
Alsuma (QCD)
Altabax
Altace
Altoprev (QCD) (ST)
Aluvea
Alvesco (QCD)
Ambien (QCD)
Ambien CR (QCD)
Amrix
Amturnide (ST)
Anafranil
Analpram Advanced
Analpram-E kit
Angeliq
Antara
Anzemet (QCD)
Apidra
Aplenzin ER (QCD)
Appformin-D
Aptensio XR (QCD)
Aqua Glycolic HC
Aranesp (PA) (QCD) (SP) (SPO)
Arava (QCD)
Arcapta Neohaler (QCD)
Arixtra (QCD)
Arnuity Ellipta (QCD)
Ascensia diabetic testing supplies (QCD)
Asmanex Twisthaler (QCD)
Assure diabetic testing supplies (QCD)
Astepro (QCD)

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Non-Covered Medication

Atacand (ST)
Atacand HCT (ST)
Atelvia DR (QCD) (ST)
Ativan
Atopiclair
Atralin
Atrapro Dermal Spray
Atrapro CP
Atrapro Hydrogel
Atropen
Augmentin XR
Aurstat
Auryxia
Auvi-Q (QCD)
Avelox
Avidoxy
Avidoxy DK
Avinza (PA) (QCD)
Avita
Axert (QCD)
Axid
Azasite
Azmacort (QCD)
B-D diabetic testing supplies (QCD)
Beconase AQ (QCD)
Belsomra (QCD)
BenzaClin kit
Besivance
BG-Star diabetic testing supplies (QCD)
Binosto (QCD) (ST)
Bionect
Boniva syringe (PA) (SP)
Boniva tablets (QCD) (ST)
Bravelle (SP)
Breo Ellipta (QCD) (ST)
Brevicon
Brilinta
Brintellix (QCD)
Brisdelle (QCD)
Bromday
Brovana
Butrans (PA) (QCD)
Bystolic
Caduet (QCD)
Calcitriol Topical
Cambia
Caphosol
Capoten
Careone diabetic testing supplies (QCD)
Caresens N diabetic testing supplies (QCD)
Cardene
Cardene SR
Cardizem CD
Cardizem LA
Cardura XL (QCD)
Cataflam
Ceclor
Ceclor CD
Cedax
Celexa (QCD)
Cem-Urea
Cenestin
Centany
Centany AT
Cesamet (QCD)
Cetraxel
Chenodal
Chibroxin Ocumeter
Cipro-XR
Cleanse and Treat

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Non-Covered Medication

Cleervue-M
Cleocin T
Clever Choice Voice diabetic testing supplies (QCD)
Clindacin ETZ Kit
Clindacin PAC
Clindagel
Clindamax
Clindareach
Clindets
Clobeta + Plus
Clobex
Clodan Kit
CNL 8 nail kit (QCD)
Colazal
CoLyte
Combigan
Combunox
Contour Next diabetic testing supplies (QCD)
Conzip
Coreg
Coreg CR
Corlanor
Cosentyx (PA) (QCD)
Cosopt PF
Cozaar (ST)
CVS Advanced diabetic testing supplies (QCD)
Cymbalta (QCD)
Daliresp
Darvocet N-100
Daypro
Daytrana
DDAVP
Demulen
Depo-Sub Q Provera 104
Derma-Smoothe/FS
Dermacin RX Silpak
Dermasilk RX SDS
Dermacin RX Surgical Pharmpak
Dermapak Plus
Dermasorb-AF
Dermasorb-HC
Dermasorb-TA
Dermasorb-XM
DermOtic
Desogen
Desonil + Plus
DesOwen kit
Desvenlafaxine ER (QCD)
Detrol (ST)
Detrol LA (ST)
Dexedrine (PA)
Dexilant (PA) (QCD)
Dificid (PA)
Dilacor XR
Dilaudid
Dipentum
Dispermox
Ditropan (ST)
Ditropan XL (ST)
Divigel
Duavee
Duexis
Duragesic (PA) (QCD)
Durezol
Dyloject
Dymista (QCD)
Dynabac
Dynacin
Dynacirc
Dynacirc CR

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Non-Covered Medication

Dytan
Easy Max diabetic testing supplies (QCD)
Easy Step diabetic testing supplies (QCD)
Easy Talk diabetic testing supplies (QCD)
Easy Touch diabetic testing supplies (QCD)
Easy-Trak diabetic testing supplies (QCD)
Edarbi (ST)
Edarbiclor (ST)
Edluar (QCD)
Effexor
Effexor XR (QCD)
Elenza
Elestrin
Eletone
Embeda (QCD)
Embrace diabetic testing supplies (QCD)
Emsam
Enablex (ST)
Enjuvia
Epaned
EpiCeram
Epiduo
Epiduo Forte
Episil
Epogen (PA) (SP) (SPO)
Equetro
Ertaczo
Esomeprazole Strontium (QCD) (ST)
Estrace
Estrasorb (QCD)
Estrogel (QCD)
Euflexxa (PA) (SPO)
Evamist (QCD)
Evoclin
ExacTech diabetic testing supplies (QCD)
Exalgo (PA) (QCD)
Extavia
Extina
Factive
Falessa kit
Famvir (QCD)
Fanapt (ST)
Farxiga (ST)
FazaClo (ST)
Femtrace
Fenoglide
Fentora (PA) (QCD)
Fertinex (SP)
Fetzima (QCD)
Fexmid
Fibracor
Fifty50 diabetic testing supplies (QCD)
Finacea Plus
Fioricet
Fiorinal
Fiorinal with Codeine
Flagyl
Flagyl ER
Flagyl IV
Flector
Flonase (QCD)
Fluoroplex
FML Forte
Focalin
Focalin XR (QCD)
Follistim AQ (SP)
Fora V12 diabetic testing supplies (QCD)
Forfivo XL (QCD)
Fortamet (ST)
Fortesta (ST)

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Non-Covered Medication

Fosamax (QCD) (ST)
Fragmin (QCD)
Freestyle diabetic testing supplies (QCD)
Fresh Kote
Frova (QCD)
Ganirelix (SP) (SPO)
Garamide
Gel-One (PA) (SPO)
Gelclair
Gelnique (ST)
GelX
Genotropin (PA) (SP) (SPO)
GE 100 diabetic testing supplies (QCD)
Giazo
Glucocard diabetic testing supplies (QCD)
Glucometer diabetic testing supplies (QCD)
Glucophage
Glucophage XR
Glumetza
Glyxambi (QCD) (ST)
Gmate diabetic testing supplies (QCD)
GoLytely
Halonate
Halotin
Healthpro diabetic testing supplies (QCD)
Helidac
Horizant
HPR
HPR Plus
HPR Plus Hydrogel Kit
Hyalgan (PA) (SPO)
Hydrocortisone-Lidocaine kit
Hylase
Hylatopic
Hylatopic Plus
Hylatopic Plus-Aurstat
Hylira
Hysingla ER (PA) (QCD)
Hytrin (QCD)
Hyzaar (ST)
IB-Stat
IC400 kit
IC800 kit
Ilevro
Imuran
Incruse Ellipta (QCD) (ST)
Inderal LA
Inderal XL
Innohep
InnoPran XL
Intermezzo (QCD)
Intuniv
Invega (ST)
Iquix
Irenka DR (QCD)
Istalol
Jentadueto (ST)
Jublia
Kadian (PA) (QCD)
Kapvay
Kazano (ST)
Keppra XR
Keralyt kit
Kerydin (QCD)
Ketocon + Plus
Khedezla (QCD)
Kitabis PAK (SP)
Klonopin
Kro Premium diabetic testing supplies (QCD)
Kytril (QCD)

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Non-Covered Medication

Lamictal ODT
Lamisil (QCD)
Lamisil Granules (QCD)
Latuda (ST)
Lazanda (PA) (QCD)
Lemtrada (SP) (SPO)
Lescol (QCD) (ST)
Lescol XL (QCD) (ST)
Levaquin
Levemir (QCD)
Levlen
Lexapro (QCD)
Lexxel
Lialda
Lidodextrapine
Lidovex
Lidovir
Lipitor (QCD) (ST)
Lipofen
Liptruzet (QCD) (ST)
Livalo (QCD) (ST)
Livixil PAK
Lodine
Lodine XL
Lofibra
Lopressor
Lorabid
Lorenza
LoSeasonique
Lotensin
Lotensin HCT
Loutrex
Lovaza
Lovenox (QCD)
Lunesta (QCD)
Luvox CR (QCD)
Luzu
Lysteda (QCD)
Lytensopril
MAC Patch
Mavik
Maxair Autohaler (QCD)
Maxalt (QCD)
Maxalt-MLT (QCD)
Maxipime
MB Hydrogel
Medrox Patch
Megace ES
Menostar (QCD)
Metaglip
Metozolv ODT
Metrogel kit
Mevacor (QCD) (ST)
Micardis (ST)
Micardis HCT (ST)
Minocin
Minocin Combo Pack
Mirapex ER (ST)
Mobic (QCD)
Momexin
Monodox
Monopril
Monopril HCT
Monovisc (PA) (SPO)
Morgidox
MoviPrep
Moxatag
Moxeza (QCD)
Myoxin
Myrbetriq

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Non-Covered Medication

Namzaric
Naprelan
Naprelan CR
Naprosyn
Naprosyn EC
Nasarel (QCD)
Nasonex (QCD)
Natazia
Natesto Nasal (ST)
Neo-Synalar Kit
Neosalus
Neosalus CP
Nesina (ST)
Neuac Kit
Neumaxin
Neupro
Neurontin
Nevanac
Nexiclon XR
Nexium (PA) (QCD)
Niravam
Norditropin (PA) (SP) (SPO)
Norinyl
Noroxin
Nor-Q-D
Northera (SP)
Norvasc (QCD)
Novacort
Nova Max diabetic testing supplies (QCD)
Novolin Insulin products
Novolog Insulin products
NuCort
Nucynta
Nucynta ER (PA)
NuLytely
NutriDox
Nuvessa
Nuvigil (PA)
Ocudox kit
Oleptro ER
Olux
Omeprazole-Sod. Bicarbonate (PA) (QCD)
Omnaris (QCD)
Omnicef
Omnitrope (PA) (SP) (SPO)
Onexton
Onmel (QCD)
Onsolis (PA) (QCD)
Opana
Opana ER (PA) (QCD)
Optase
Oracea
Oramorph SR (PA) (QCD)
Orapred ODT
Oravig
Oroxin
Ortho-Prefest
Orthovisc (PA) (SPO)
Oseni (ST)
Osphena
Otrexup (SP)
Ovcon
Oxecta
Oxytrol (ST)
Pain Relief Patch
Pamelor
Pamine FQ
Pancreaze
Paptase
Patanase (QCD)

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Non-Covered Medication

Paxil (QCD)
Paxil CR (QCD)
PCE
PCE Dispertab
Pediaderm AF
Pediaderm HC
Pediaderm TA
Penlac (QCD)
Pennsaid
Pepcid
Percocet
Pertzye
Pexeva (QCD)
Phoslyra
Picato
Plaquenil
Plegridy (QCD) (SP)
PR-Cream
Pram-HCA
Pramcort
Pramosone E
PrandiMet (ST)
Pravachol (QCD) (ST)
Precision QID diabetic supplies (QCD)
Precision X-Tra diabetic supllies (QCD)
Prepopik
Presera
Prestalia
Prestige diabetic testing supplies (QCD)
Prevacid (PA) (QCD)
Prevacid NapraPAC
PrevPac
Prilosec (PA) (QCD)
Prinivil
Prinzide
Pristiq (QCD)
Procentra (PA)
Procort
Prodigy diabetic testing supplies (QCD)
Prolensa
Promiseb
Promiseb Light
Proquin XR
Protonix (PA) (QCD)
Proventil HFA (QCD)
Proventil inhaler (QCD)
Proventil
Proventil Repetab
Provenza
Prozac (QCD)
Prozac Weekly (QCD)
Purinethol
Pylera
QNASL (QCD)
Quartette
Quillivant XR
Quixin
RadiaPlex Rx
Radigel
Raniclor
Rapaflo
Rasuvio
Rayos
Reciphexamine
Recothrom
Relafen
Relion diabetic testing supplies (QCD)
Relpax (QCD)
Relyyks
Relyyt

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Non-Covered Medication

Remeron (QCD)
Remeron Soltab (QCD)
Renovo
Requip (ST)
Requip XL (ST)
Rescula (ST)
Restoril
Retin-A Micro (PA30)
Rhinocort Aqua (QCD)
Rinnovi
Risperdal M-Tab (ST)
Ritalin
Ritalin LA (QCD)
Ritalin SR
Rosadan
Rosanil
Rybix ODT
Rynatan
Rytary ER
Rythmol
Ryzolt
Saizen (PA) (SP) (SPO)
Salicylic Acid-Ceramide kit
Salkera
Salvax
Salvax Duo
Salvax Duo Plus
Sanctura (ST)
Sanctura XR (ST)
Sancuso (QCD)
Saphris (ST)
Sarafem (QCD)
Savaysa
Scalacort
Scar
Seasonique
Senophylline
Silenor (QCD)
Silvera
Silvrstat
Simbrinza
Simcor (QCD) (ST)
Sinelee
Sinemet
Sitavig
Skelid
Sklice
Smart Sense diabetic testing supplies (QCD)
Sof-Tact diabetic supplies (QCD)
Solaice
Solaraze
Solodyn
Soltamox
Solus V2 diabetic testing supplies (QCD)
Soma
Sonata (QCD)
Soolantra
Spectracef
Sporanox (QCD)
Sprix
Stavzor
Stelara (PA) (SPO)
Striant
Subsys (PA) (QCD)
Sular
Sumadan
Sumavel Dosepro (QCD)
Sumaxin
Sumaxin CP
Sumaxin TS

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Non-Covered Medication

Supartz (PA) (SPO)
Suprep
Synalar Combo-Pack
Synalar TS
Synvexia TC
Synvisc (PA) (SPO)
Synvisc-One (PA) (SPO)
Tagamet
Tekamlo (ST)
Tekturna (ST)
Tekturna HCT (ST)
Tenormin
Tequin
Terbinex (QCD)
Tersi
Test N'Go diabetic testing supplies (QCD)
Testim (ST)
Testone Kit
Testosterone gel (Fortesta Authorized product) (ST)
Testosterone gel (Testim Authorized product) (ST)
Testosterone gel (Vogelxo Authorized product) (ST)
Testosterone CIK Kit (ST)
Tetrix
Teveten (ST)
Teveten HCT (ST)
Tev-Tropin (PA) (SP) (SPO)
Therapentin
Theraproxen
Tiamate
Tiazac
Tindamax
Tirosint
Tivorbex (QCD)
TL-Triseb
TobraDex ST
Tofranil
Tornalate
Toujeo Solostar (QCD)
Toviaz (ST)
Tradjenta (ST)
Tranxene T-Tab
Tretin-X (PA)
Treximet (QCD)
Trezix
Tricor
Triglide
Tri-Levlen
Trilipix
Trinalin
Tri-Norinyl
TriOxin
Tritec
Tropazone
True Metrix diabetic supplies (QCD)
TrueTest diabetic supplies (QCD)
TrueTrack diabetic supplies (QCD)
Twynsta (ST)
Ultracet
Ultram/ER
Ultrasal ER
Ultravate PAC
Ultravate X
Ultressa
Unistrip 1 diabetic testing supples (QCD)
Up & Up diabetic testing supplies (QCD)
Uramaxin
Urea kit
Valium
Valturna (ST)
Vanos

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Non-Covered Medication

Vantin
Vascepa
Vaseretic
Vasolex
Vasotec
Vectical
Vectrin
Velma
Velphoro
Veltin (PA30)
Ventolin HFA (QCD)
Veramyst (QCD)
Veregen
Vexa
Vexol
Viekira PAK (PA) (SP)
Vigamox (QCD)
Viibryd (QCD)
Vimovo
Virasal
Vogelxo (ST)
Voltaren
Voltaren XR
Vusion
Vytorin (QCD) (ST)
Vyvanse (QCD)
Wavesense diabetic testing supplies (QCD)
Welchol
Wellbutrin
Wellbutrin SR (QCD)
Wellbutrin XL (QCD)
Xanax
Xanax XR
X-Clair
Xartemis XR (PA) (QCD)
Xeljanz (SP)
Xenaderm
Xerese
Xibrom
Xifaxan
Xigduo (QCD) (ST)
Xolegel
Xolox
Xopenex HFA (QCD)
Xopenex nebules
Xyralid
Z-Pram
Zanaflex
Zantac
Zebeta
Zecuity (SP)
Zegerid (PA) (QCD)
Zelapar
Zenieva
Zestril
Zetonna (QCD)
Ziana
Zinotic
Zinotic ES
Zipsor
Zithromax
Zmax
Zocor (QCD) (ST)
Zofran (QCD)
Zofran ODT (QCD)
Zohydro ER (PA) (QCD)
Zoloft (QCD)
Zolpimist (QCD)
Zomacton (PA) (SPO)
Zomig (QCD)

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Non-Covered Medication

Zomig ZMT (QCD)

Zontivity

Zovirax

Zuplenz (QCD)

Zyflo (ST)

Zyflo CR (ST)

Zymar (QCD)

Zymaxid

Zypram

Zyprexa IM (ST)

Zyprexa Relprevv (ST)

Zytopic

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New Medication Approval Process

Our Pharmacy and Therapeutics Committee, which is made up of pharmacists and doctors of various specialties, reviews the effectiveness and overall value of new medications approved by the FDA on an ongoing basis. The Committee provides expertise and advice to help us give our members prescription drug options that meet their medical needs and achieve desired treatment goals. Approved medications are added to our formulary as they are approved by our Pharmacy and Therapeutics Committee throughout the year.

While under review, new medications will not be covered by your plan. As with other medications that are not covered, your doctor may request coverage when medically necessary. If a non-covered drug is approved, it will be covered at the highest tier or cost share.

MASSACHUSETTS

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Your Mail Service
Pharmacy Benefit

As a member of Blue Cross Blue Shield of Massachusetts, you can buy certain medications at the Express Scripts mail service pharmacy.

It's a great way to save by purchasing prescriptions on a long-term basis.

Check Out These Benefits!

Savings: The biggest advantage of the mail service pharmacy is that for most long-term maintenance medications you can order up to a 90-day supply. Often times, using mail service results in the lowest possible out-of-pocket costs to you as a member.

Convenience: Your medications will be delivered to your home, postage paid, within 14 days of mailing your new prescription.

Confidentiality: If you have questions, you can call Express Scripts toll-free, 24 hours a day. Registered pharmacists are available to answer your questions about your prescriptions confidentially. Call **1-800-892-5119.**

Special-Needs Services Available: For the convenience of our hearing-impaired members, Express Scripts is TTY-ready, and has installed a separate toll-free number for you to use with your TTY equipment. The number is **1-800-305-5376.**

For our vision-impaired members, upon special request with your order, Express Scripts can provide Braille labels for your medication.

And for our non-English-speaking members, Express Scripts can provide translation services when you call the toll-free line.

Refer to your benefit literature for specific coverage information.

Three Easy Steps To Use Mail Service

For long-term prescriptions, use our mail service pharmacy to save.

1. Ask your doctor to prescribe medications for up to a 90-day supply, plus refills when applicable. (If you're already taking medication on a long-term basis, ask your doctor for a new prescription.)
2. Complete the attached Mail Order Form for each member submitting a prescription. Be sure to answer all of the questions.
3. Seal the form, prescriptions, and the appropriate copayment in the pocket in this brochure (do not send cash). Then simply mail it in. Be sure to write your ID number exactly as it appears on your ID card.

Your order will be quickly processed and sent to you by mail or UPS. Allow 14 days for delivery from the date you mail the order. To prevent delays, do not fill medications that are needed quickly or short-term medications (e.g. antibiotics) via mail service.

Confidential Subscriber/Patient Profile

Please write your ID number, name, and address on the attached form. Then complete the Patient Profile for you and each of your dependents submitting prescriptions, indicating any drug allergies, and health conditions. Express Scripts will use this information to check any potential drug interactions when you have prescriptions filled. If there are no drug allergies, please check "None" in the box provided.

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Instructions

New Prescriptions:

- Have your doctor/provider write the prescription for up to a 90-day supply
- To prevent any delays, make sure that an approved formulary exception (if applicable) for any medications that are non-covered or require prior authorization is on file before you place your order
- Complete all information requested on the attached Mail Order Form
- Select your preference for Safety Caps in the appropriate box
- Ensure that the patient's full name, age, ID number, and address appear on each prescription
- Find out the appropriate copayment necessary for the medication prescribed
- Place prescriptions and copayments in return envelope and mail

Refills:

- Call **1-800-892-5119** or visit **www.express-scripts.com** to refill your order, or
- Place refill slips and copayments in the return envelope and mail it

Make all checks or money orders payable to "Express Scripts". Do not send cash. If paying by credit card, complete the information under "Credit Card Information."

What Do I Do in Emergency Situations?

When you need medication immediately, simply have your prescription filled at a local pharmacy. If you need medication immediately, but will be taking it on an ongoing basis, you can ask your doctor to write two prescriptions:

- You can fill the first prescription at a local participating pharmacy;
- Send the second prescription (up to a 90-day supply), along with your copayment, to Express Scripts immediately.

About Your Prescription

Blue Cross Blue Shield of Massachusetts maintains a list of covered prescription drugs. If you have any questions about whether or not your medications are covered, or subject to Quality Care Dosing, Step Therapy, or Prior Authorization, please visit **www.bluecrossma.com/pharmacy** or call Blue Cross Blue Shield of Massachusetts Member Service at the number on the front of your ID card.

Mail Service Questions

Call Express Scripts customer service 24 hours a day, 7 days a week. Pharmacy consultation is also available around-the-clock.
Toll-free number: **1-800-892-5119** (TTY: **1-800-305-5376**)

Answers to Your Questions

How Do I Determine What Copayment Amount? I Should Include With My Order?

Check your benefit literature, and if you still have specific questions, call the Blue Cross Blue Shield of Massachusetts Member Service phone number listed on the front of your ID card.

Why Did My Order Contain Generic Drugs? When My Prescription Requested a Brand-Name Version?

When authorized by your doctor and permitted by applicable law, Express Scripts will dispense a generic drug. This usually saves you money, so whenever possible, ask your doctor to prescribe generic drugs.

Why Isn't My Drug Available Through the ESI Mail Service?

Certain medications that require immediate administration or are used for short periods of time are inappropriate for mail service. In addition, for certain medications classified as specialty drugs, Blue Cross Blue Shield of Massachusetts has established a relationship with a preferred specialty pharmacy. They offer additional services that are not offered by our mail service pharmacy.

How Do I Order Refills?

Simply call the toll-free number, **1-800-892-5119**, and order your refills over the phone. You can also visit the Express Scripts website to refill your order **(www.express-scripts.com)**. Once you have ordered through mail service, you will receive a refill slip with your prescription.

Enclose the slip and the appropriate copayment amount in the order envelope (which is provided).

Please Note:

Certain controlled substances and several other prescribed medications may be subject to other dispensing limitations and to the professional judgment of the pharmacist. If you have any questions regarding your medication, please call Express Scripts customer service at **1-800-892-5119**.

It's the patient's responsibility to report to Express Scripts any changes in drug allergies, health conditions, chronic diseases, and drug sensitivities.

Prescription information about members and dependents is used by Express Scripts to administer your prescription program. As part of the administration, Express Scripts reports that information to Blue Cross Blue Shield of Massachusetts. Express Scripts also uses the information and prescription data gathered from claims submitted nationwide for reporting and analysis, without identifying individual patients in accordance with applicable laws.

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Express Scripts, an independent company, administers your prescription benefit and its services are being provided on behalf of Blue Cross Blue Shield of Massachusetts. ® Registered Marks of the Blue Cross and Blue Shield Association.

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147610M 32-7040

Express Scripts Pharmacy Prescription Order Form

To order online: sign in at www.StartHomeDelivery.com and follow the prompts.

To order by mail: complete this form and ask your doctor to write your prescription for a 90-day supply or the maximum days supply allowed by your plan.

- Use ALL CAPITAL LETTERS in BLACK INK. Fill in the ovals as shown (●).
- Remember to mail your prescription with this completed form. Your medication will arrive within two weeks from the date we receive your first order.

NOTE: Standard shipping is FREE for online and mail orders.

1041

PATIENT 1 (CARDHOLDER)

ID Card Number

First Name MI Date of Birth (MM/DD/YYYY) / /

Last Name Gender ○ M ○ F

Some medications cannot be delivered to a PO Box. Provide a street address to allow delivery of your order.

Shipping Address 1

Shipping Address 2

City State

Zip Code —

○ Check here for rush shipment. Your order, once received and filled, will be shipped overnight for $21.

Email

Please select one as your preferred telephone number

○ Daytime Phone ( ) —

○ Evening Phone ( ) —

○ Cell Phone ( ) —

Doctor/Prescriber Last Name Doctor/Prescriber Phone Number ( )

PATIENT 2

First Name MI Date of Birth (MM/DD/YYYY) / /

Last Name Gender ○ M ○ F

Email

Doctor/Prescriber Last Name Doctor/Prescriber Phone Number ( ) —

PAYMENT

All individuals included in the family will be charged to this credit card.

○ Apply to this order only ○ Apply to all orders Amount Enclosed

○ Check Card ○ Credit Card ○ Check / Money Order $.

Card # Exp. Date (MM/YY) /

Sign here to authorize card payment X

Detach Here

For all orders after 08/01/2011, use this form.

Fold and tear off this piece before putting in the return envelope.

Detach Here

REMINDER: This section must be removed before mailing.

1042

Patient 1 (Cardholder)		Patient 2
Name: _____	**Date of Birth is required for patient identification.**	Name: _____
I want non-child resistant caps, when available.	Failure to provide complete and accurate information may prevent the pharmacy from detecting drug related problems.	I want non-child resistant caps, when available.
Date of Birth (MM/DD/YYYY) __ __ / __ __ / __ __ __ __		Date of Birth (MM/DD/YYYY) __ __ / __ __ / __ __ __ __

	Patient 1 (Cardholder)		Patient 2
DRUG ALLERGIES	List other Allergies here:	**No Known Allergies**	List other Allergies here:
		Acetaminophen/Tylenol®	
		Amoxicillin	
		Aspirin	
		Cephalosporin (i.e., Keflex®, Cephalexin)	
		Codeine	
		Erythromycin, Biaxin®, Zithromax®	
		NSAIDs (i.e., Ibuprofen, Naproxen)	
		Oxycodone (i.e., OxyContin®, Percocet®)	
		Penicillin	
		Sulfa	
		Tetracycline (i.e., Doxycycline, Minocycline)	
HEALTH CONDITIONS	List other Health Conditions here:	**No Known Health Conditions**	List other Health Conditions here:
		Arthritis (715.9)	
		Asthma (493.9)	
		Chronic Bronchitis or Emphysema (496)	
		Depression (311)	
		Diabetes Type I (250.01)	
		Diabetes Type II (250.00)	
		Epilepsy/Seizures (345.9)	
		GERD (530.81)	
		Glaucoma (365.9)	
		High Cholesterol (272.9)	
		Hormone Replacement Therapy (627.9)	
		Hypertension (401.9)	
		Thyroid: Low (244.9)	
OTC	List other OTC that you take on a regular basis:	**No Over-the-Counter Medications**	List other OTC that you take on a regular basis:
		Acetaminophen/Tylenol®	
		Advil®/Aleve®/Motrin®	
		Aspirin/Excedrin®	
DEVICES	List Medical Devices here:	**No Medical Devices**	List Medical Devices here:
		Medical Devices (i.e., Glucose Testing Device, Insulin Pump, Nebulizer) and specify brand name and model.	
OTHER	List other Prescription Medications here:	**No Other Prescriptions**	List other Prescription Medications here:
		Prescription Medications not filled through Express Scripts Pharmacy.	

FDA approved generic medications will be dispensed when allowed by your doctor, subject to the terms outlined in your plan. I certify that all the information on this form is correct. I permit Express Scripts Inc. to release all information on this form concerning prescription orders to my plan sponsor, administrator or health plan for the purpose of payment, treatment or health care operations.

Signature Required X _____

More than two family members on your plan? On a separate sheet of paper, write the family member(s) name, date of birth, allergies and health conditions along with the name and phone number of their doctor/prescriber.

Please Note: Your order may be filled at any one of our Express Scripts Pharmacies located nationwide.

Pref

Please note

Please note that all prescriptions requiring a formulary exception will not be processed without prior approval. To prevent any delays, make sure that an approved formulary exception (if applicable) is on file before you place your order.

Thank you for using our mail service prescription drug program.

Fold

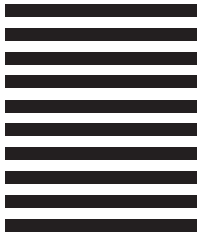
MLRBENP

_____

_____

_____

NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES



BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 3580 ST LOUIS MO

POSTAGE WILL BE PAID BY ADDRESSEE

Home Delivery Service
PO Box 66566
St Louis, MO 63166-9967

Pref

Pref

Pref

Fold

Did You Remember To...

- Complete all applicable information
- Include your ID number on the mail order form
- Enclose the original prescription, mail order form, and appropriate copayment
- Make checks or money orders payable to "Express Scripts", or include credit card information

Detach envelope to mail prescription order form

(Tear here)

Pref

Pref

Pref

Detach envelope to mail presciption order form

(Tear here)

Glue

Pref

Fold

Glue

Inside envelope

Fold

Glue

Glue

Pref

Inside envelope

Glue

MASSACHUSETTS

$9 Medications

Blue Cross Blue Shield of Massachusetts offers our members 90-day supplies of certain generic medications for just $9 when the prescription is filled through the Express Scripts Mail Service Pharmacy. The following list includes those medications that are available for $9. Normal prescription guidelines apply, which in some cases results in prescription supplies for fewer than 90 days. This list is up-to-date as of July 1, 2015, and may be updated from time to time.

If your copayment for a 90-day supply through the mail pharmacy is less than $9, you will pay the lesser amount. $9 price is based only on quantities stated below. The price of the medication may differ if the quantity purchased is different. The $9 price is subject to change, so you should always confirm your cost prior to filling a medication.

Antibiotics, Antifungals, Antivirals

Drug Name/Strength	$9 Quantity
AMOXICILLIN TRIHYDRATE 250MG CAPSULE	90
AMOXICILLIN TRIHYDRATE 500MG CAPSULE	90
CEPHALEXIN MONOHYDRATE 250MG CAPSULE	84
CEPHALEXIN MONOHYDRATE 500MG CAPSULE	90
CIPROFLOXACIN HCL 250MG TABLET	42
CIPROFLOXACIN HCL 500MG TABLET	60
FLUCONAZOLE 150MG TABLET	3
ISONIAZID 300MG TABLET	90
PENICILLIN V POTASSIUM 250MG TABLET	84
SULFAMETHOXAZOLE/TRIMETHOPRIM 400-80MG TABLET	84
SULFAMETHOXAZOLE/TRIMETHOPRIM 800-160MG TABLET	60
TERBINAFINE HCL 250MG TABLET	90

Anticoagulants

Drug Name/Strength	$9 Quantity
WARFARIN SODIUM 10MG TABLET	90
WARFARIN SODIUM 1MG TABLET	90
WARFARIN SODIUM 2.5MG TABLET	90
WARFARIN SODIUM 2MG TABLET	90
WARFARIN SODIUM 3MG TABLET	90
WARFARIN SODIUM 4MG TABLET	90
WARFARIN SODIUM 5MG TABLET	90
WARFARIN SODIUM 6MG TABLET	90
WARFARIN SODIUM 7.5MG TABLET	90

Antiseizure Medications

Drug Name/Strength	$9 Quantity
PRIMIDONE 50 MG TABLET	180

Arthritis, Pain

Drug Name/Strength	$9 Quantity
INDOMETHACIN 25MG CAPSULE	180
MELOXICAM 15MG TABLET	90
MELOXICAM 7.5MG TABLET	90
NAPROXEN 500 MG TABLET	180
NAPROXEN SODIUM 220 MG TABLET	90

Asthma, Respiratory

Drug Name/Strength	$9 Quantity
IPRATROPIUM BROMIDE 0.2MG/ML SOLUTION	225mL

Heart Health & Blood Pressure

Drug Name/Strength	$9 Quantity
ATENOLOL 100MG TABLET	90
ATENOLOL 25MG TABLET	90
ATENOLOL 50MG TABLET	90
ATENOLOL/CHLORTHALIDONE 100-25MG TABLET	90
ATENOLOL/CHLORTHALIDONE 50MG-25MG TABLET	90
BENAZEPRIL HCL 10MG TABLET	90
BENAZEPRIL HCL 20MG TABLET	90
BENAZEPRIL HCL 40MG TABLET	90
BENAZEPRIL HCL 5MG TABLET	90
BENAZEPRIL/HCTZ 10-12.5MG TABLET	90
BENAZEPRIL/HCTZ 20-12.5MG TABLET	90
BENAZEPRIL/HCTZ 20-25MG TABLET	90

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Heart Health & Blood Pressure (cont.)

Drug Name/Strength	$9 Quantity
BENAZEPRIL/HCTZ 5MG/6.25MG TABLET	90
BISOPROL/HYDROCHLOROTHIAZIDE 10-6.25MG TABLET	90
BISOPROL/HYDROCHLOROTHIAZIDE 2.5-6.25MG TABLET	90
BISOPROL/HYDROCHLOROTHIAZIDE 5-6.25MG TABLET	90
BISOPROLOL FUMARATE 10MG TABLET	90
BISOPROLOL FUMARATE 5MG TABLET	90
CARVEDILOL 12.5MG TABLET	180
CARVEDILOL 25MG TABLET	180
CARVEDILOL 3.125MG TABLET	180
CARVEDILOL 6.25MG TABLET	180
CLONIDINE HCL 0.1MG TABLET	90
CLONIDINE HCL 0.2MG TABLET	90
DOXAZOSIN MESYLATE 1MG TABLET	90
DOXAZOSIN MESYLATE 2MG TABLET	90
DOXAZOSIN MESYLATE 4MG TABLET	90
DOXAZOSIN MESYLATE 8MG TABLET	90
ENALAPRIL MALEATE 10MG TABLET	90
ENALAPRIL MALEATE 2.5MG TABLET	90
ENALAPRIL MALEATE 20MG TABLET	90
ENALAPRIL MALEATE 5MG TABLET	90
ENALAPRIL/HYDROCHLOROTHIAZIDE 5-12.5MG TABLET	90
FUROSEMIDE 20MG TABLET	90
FUROSEMIDE 40MG TABLET	90
FUROSEMIDE 80MG TABLET	90
GUANFACINE HCL 1MG TABLET	90
HYDRALAZINE HCL 100 MG TABLET	270
HYDRALAZINE HCL 10MG TABLET	90
HYDRALAZINE HCL 25MG TABLET	90
HYDRALAZINE HCL 50 MG TABLET	270
HYDROCHLOROTHIAZIDE 12.5MG CAPSULE	90
HYDROCHLOROTHIAZIDE 25MG TABLET	90
HYDROCHLOROTHIAZIDE 50MG TABLET	90
ISOSORBIDE MONONITRATE 30MG TAB.SR 24H	90

Heart Health & Blood Pressure (cont.)

Drug Name/Strength	$9 Quantity
ISOSORBIDE MONONITRATE 60MG TAB.SR 24H	90
LISINOPRIL 5MG TABLET	90
LISINOPRIL 10MG TABLET	90
LISINOPRIL 2.5MG TABLET	90
LISINOPRIL 20MG TABLET	90
LISINOPRIL 30MG TABLET	90
LISINOPRIL 40MG TABLET	90
LISINOPRIL/HYDROCHLOROTHIAZIDE 10-12.5MG TABLET	90
LISINOPRIL/HYDROCHLOROTHIAZIDE 20-12.5 MG TABLET	90
LISINOPRIL/HYDROCHLOROTHIAZIDE 20-25MG TABLET	90
METHYLDOPA 250MG TABLET	180
METHYLDOPA 500MG TABLET	90
METOPROLOL TARTRATE 100MG TABLET	180
METOPROLOL TARTRATE 25MG TABLET	180
METOPROLOL TARTRATE 50MG TABLET	180
PRAZOSIN HCL 1MG CAPSULE	90
PRAZOSIN HCL 2MG CAPSULE	90
PROPRANOLOL HCL 10MG TABLET	180
PROPRANOLOL HCL 80MG TABLET	180
RAMIPRIL 1.25 MG CAPSULE	90
RAMIPRIL 10 MG CAPSULE	90
RAMIPRIL 2.5MG CAPSULE	90
RAMIPRIL 5 MG CAPSULE	90
SOTALOL HCL 80MG TABLET	90
SPIRONOLACTONE 25MG TABLET	90
TERAZOSIN HCL 10MG CAPSULE	90
TERAZOSIN HCL 1MG CAPSULE	90
TERAZOSIN HCL 2MG CAPSULE	90
TERAZOSIN HCL 5MG CAPSULE	90
TORSEMIDE 5 MG TABLET	90
TRIAMTERENE/HYDROCHLOROTHIAZID 37.5-25MG TABLET	90
TRIAMTERENE/HYDROCHLOROTHIAZID 75-50MG TABLET	90
VERAPAMIL HCL 120MG TABLET	90
VERAPAMIL HCL 80MG TABLET	90

Cold and Allergy Therapy

Drug Name/Strength	$9 Quantity
BENZONATATE 100MG CAPSULE	42
CETIRIZINE HCL 5 MG TABLET	90
D-METHORPHAN HB/PROMETH HCL 15-6.25/5 SYRUP	360mL
PROMETHAZINE HCL 25MG TABLET	36
PROMETHAZINE HCL 6.25MG/5ML SYRUP	540mL

Diabetes

Drug Name/Strength	$9 Quantity
GLIMEPIRIDE 1MG TABLET	90
GLIMEPIRIDE 2MG TABLET	90
GLIMEPIRIDE 4MG TABLET	90
GLIPIZIDE 10MG TABLET	180
GLIPIZIDE 5MG TABLET	90
GLYBURIDE, MICRONIZED 3MG TABLET	90
GLYBURIDE, MICRONIZED 6MG TABLET	90
METFORMIN HCL 1000MG TABLET	180
METFORMIN HCL 500MG TAB.SR 24H	180
METFORMIN HCL 500MG TABLET	180
METFORMIN HCL 850MG TABLET	180

Heartburn, Ulcer

Drug Name/Strength	$9 Quantity
CIMETIDINE 800MG TABLET	90
FAMOTIDINE 20MG TABLET	180
RANITIDINE HCL 150MG TABLET	180
RANITIDINE HCL 300MG TABLET	90

High Cholesterol

Drug Name/Strength	$9 Quantity
LOVASTATIN 10 MG TABLET	90
LOVASTATIN 20 MG TABLET	90
LOVASTATIN 40 MG TABLET	90

Mental Health/Behavioral Health

Drug Name/Strength	$9 Quantity
CLORAZEPATE DIPOTASSIUM 15 MG TABLET	90
CLORAZEPATE DIPOTASSIUM 3.75 MG TABLET	180

Mental Health/Behavioral Health (cont.)

Drug Name/Strength	$9 Quantity
CLORAZEPATE DIPOTASSIUM 7.5 MG TABLET	90
FLUOXETINE HCL 10MG CAPSULE	90
FLUOXETINE HCL 20MG CAPSULE	90
FLUOXETINE HCL 40MG CAPSULE	90
FLUPHENAZINE HCL 1MG TABLET	90
HALOPERIDOL 0.5MG TABLET	90
HALOPERIDOL 1MG TABLET	90
HALOPERIDOL 2MG TABLET	90
HALOPERIDOL 5MG TABLET	90
IMIPRAMINE HCL 10 MG TABLET	90
IMIPRAMINE HCL 25 MG TABLET	90
IMIPRAMINE HCL 50MG TABLET	90
LITHIUM CARBONATE 300MG CAPSULE	270
MIRTAZAPINE 45 MG TABLET	90
PAROXETINE HCL 10MG TABLET	90
PAROXETINE HCL 20MG TABLET	90
PAROXETINE HCL 30MG TABLET	90
PROCHLORPERAZINE MALEATE 10MG TABLET	90
THIORIDAZINE HCL 25MG TABLET	90
THIORIDAZINE HCL 50MG TABLET	90
THIOTHIXENE 2MG CAPSULE	90
TRAZODONE HCL 100MG TABLET	90
TRAZODONE HCL 150MG TABLET	90
TRAZODONE HCL 50MG TABLET	90

Muscle Relaxants

Drug Name/Strength	$9 Quantity
BACLOFEN 10MG TABLET	90
CYCLOBENZAPRINE HCL 10MG TABLET	90
CYCLOBENZAPRINE HCL 5 MG TABLET	90
ORPHENADRINE CITRATE 100MG TABLET SA	90

Other GI Drugs

Drug Name/Strength	$9 Quantity
LACTULOSE 10G/15ML SOLUTION	711mL
METOCLOPRAMIDE HCL 10MG TABLET	180

Other Medications

Drug Name/Strength	$9 Quantity
ALLOPURINOL 100MG TABLET	90
ALLOPURINOL 300MG TABLET	90
CHLORHEXIDINE GLUCONATE 0.12% MOUTHWASH	1419mL
DEXAMETHASONE 0.5MG TABLET	90
DEXAMETHASONE 0.75MG TABLET	36
DEXAMETHASONE 4MG TABLET	18
OXYBUTYNIN CHLORIDE 5MG TABLET	180
PREDNISONE 10MG TABLET	90
PREDNISONE 2.5MG TABLET	90
PREDNISONE 20MG TABLET	90
PREDNISONE 5MG TABLET	90

Parkinson's Disease

Drug Name/Strength	$9 Quantity
BENZTROPINE MESYLATE 2MG TABLET	90
TRIHEXYPHENIDYL HCL 2MG TABLET	180

Skin Conditions

Drug Name/Strength	$9 Quantity
HYDROCORTISONE 1% CREAM(GM)	85.05gm
HYDROCORTISONE 2.5 % CREAM/APPL	90gm
HYDROCORTISONE 2.5% CREAM(GM)	90gm
LIDOCAINE HCL 20MG/ML SOLUTION	300mL
SELENIUM SULFIDE 2.5% SUSPENSION	360mL

Thyroid Therapy

Drug Name/Strength	$9 Quantity
LEVOTHYROXINE SODIUM 100MCG TABLET	90
LEVOTHYROXINE SODIUM 112MCG TABLET	90
LEVOTHYROXINE SODIUM 125MCG TABLET	90

Thyroid Therapy (cont.)

Drug Name/Strength	$9 Quantity
LEVOTHYROXINE SODIUM 137MCG TABLET	90
LEVOTHYROXINE SODIUM 150MCG TABLET	90
LEVOTHYROXINE SODIUM 175MCG TABLET	90
LEVOTHYROXINE SODIUM 200MCG TABLET	90
LEVOTHYROXINE SODIUM 25MCG TABLET	90
LEVOTHYROXINE SODIUM 50MCG TABLET	90
LEVOTHYROXINE SODIUM 75MCG TABLET	90
LEVOTHYROXINE SODIUM 88MCG TABLET	90

Vitamins and Electrolytes

Drug Name/Strength	$9 Quantity
FOLIC ACID 1MG TABLET	90

Women's health

Drug Name/Strength	$9 Quantity
ESTRADIOL 0.5MG TABLET	90
ESTRADIOL 1MG TABLET	90
ESTRADIOL 2MG TABLET	90
MEDROXYPROGESTERONE ACET 10MG TABLET	30
MEDROXYPROGESTERONE ACET 2.5MG TABLET	90
MEDROXYPROGESTERONE ACET 5MG TABLET	90
MEGESTROL ACETATE 20MG TABLET	90

[1] The $9 or less price applies to a 90-day supply of each generic drug. Cost may vary based on prescription quantity or day supply. A processing fee may apply. The coverage and prices of certain medications are also subject to the specific terms of your plan. In applicable states, sales tax may be added to the cost of your prescriptions. Medications and pricing are subject to change without notice. Drug list is valid until Dec. 31, 2014. Changes are made available to your Plan Sponsor. To price drugs, log on at Express-Scripts.com and select "Price a Medication" under the "Manage Prescriptions" menu. Prepackaged drugs are only available for $9 in the package sizes specified on the list.

[2] Cost of standard shipping is included as part of your prescription benefit plan.

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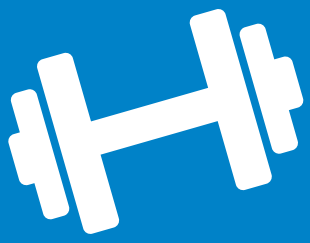
Fitness Reimbursement

Wellness Participation Program



Your Blue Cross Blue Shield of Massachusetts health plan can save you up to $150[1] annually in qualified health club membership fees or for fitness classes taken at a qualified health club.

3 Easy Steps to Getting Reimbursed[2]

1.

Choose

Start by picking a qualified health club.

2.

Complete

Once you pay for the program, fill out the attached form.

3.

Mail

Send the completed form to the address listed at the bottom.

Important Information

- The reimbursement is for each individual (or family) health plan and can only be submitted once each calendar year.
- Keep copies of all your paperwork and proof of payment in case you are denied reimbursement.
  Proof of payment includes the following:
  - Itemized, dated, paid receipts from your health club
  - Bank or credit card statements
  - Paycheck stubs if your club fees are automatically deducted from that account
- Receipts or statements should include the name of the family member enrolled in the club and the individual charges for a full reimbursement of health club fees or fitness classes.
- The dollar amount you receive may be considered taxable income. Consult your tax advisor about how to treat this reimbursement on your taxes.

A qualified health club is:

A full-service health club with a variety of exercise equipment, including:

- Cardiovascular equipment like treadmills and bikes
- Strength-training equipment like free weights and weight machines

To receive the fitness reimbursement for a qualified pay-as-you-go health club, get paid receipts from the club for your records.

What doesn't qualify?

You can't receive the fitness reimbursement for expenses for personal training, lessons, coaching, equipment, clothing, or any of the clubs below:

- Martial arts or yoga centers
- Gymnastics, tennis, aerobic, or pool-only facilities
- Country clubs or social clubs
- Sports teams or leagues

Be sure to talk with your doctor before starting an exercise program.

1. Most plans offer a $150 Fitness Reimbursement, but your employer may have elected a different amount. Please refer to your plan information to confirm.
2. Before starting, check to see if your plan includes the Wellness Participation program. Blue Cross will make a reimbursement decision within 30 calendar days of receiving a completed request for coverage or payment.

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Fitness Reimbursement Form[3]

To verify this reimbursement is within your plan, log in to Member Central at **www.bluecrossma.com/membercentral** or call Member Service at the number on your ID card. Submit this form once per calendar year, no later than March 31 of the following year.

PLEASE PRINT ALL INFORMATION CLEARLY

Subscriber Information (Policyholder)

Identification Number (including first 3 letters)	Subscriber's Last Name	First Name	Middle Initial

Address—Number and Street	City	State	Zip Code

Employer's Name

Member and Claim Information

Member's Last Name	First Name	Middle Initial	Date of Birth: Mo. Day Yr.

Mailing Address—Number and Street (if different from subscriber's)	City	State	Zip Code

Gender
- ☐ Male
- ☐ Female

Claim is for (check one):
- ☐ Subscriber (policyholder)
- ☐ Spouse (of policyholder)
- ☐ Ex-Spouse
- ☐ Dependent (up to age 26)
- ☐ Other (specify) _____

Name, Address, and Phone Number of Qualified Health Club

I am due $_____ for the following reimbursement (check one):

☐ Membership at a qualified health club. My monthly fee is $_____.

☐ Fitness classes at a qualified health club.
My fee per class is $_____.

Health Plan Year

Certification and Authorization (This form must be signed and dated below.)

I authorize the release of any information to Blue Cross Blue Shield of Massachusetts about my health club membership. I certify that the information provided in support of this submission is complete and correct and that I have not previously submitted for these services. I understand that Blue Cross may require additional evidence of health club membership and proof of payment for my membership before reimbursement is provided.

Subscriber's or
Member's Signature: _____ Date: _____

Questions?

To verify this reimbursement is within your plan or for further information, please log in to the Member Central website at **www.bluecrossma.com/membercentral** or call Member Service at the number on the front of your ID card.

Please complete and mail this form to:

Blue Cross Blue Shield of Massachusetts
Local Claims Department
PO Box 986030
Boston, MA 02298

3. Blue Cross will make a reimbursement decision within 30 calendar days of receiving a completed request for coverage or payment.

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Weight Loss Benefit

If you have a Blue Cross Blue Shield of Massachusetts health plan, we've got a healthy incentive for you.

As a subscriber to Blue Cross Blue Shield of Massachusetts, your Weight Loss Benefit can save you or your family up to $150 per calendar year in qualified weight loss program fees. You can claim your Weight Loss Benefit **after** you've paid for your program.

What types of programs qualify?

Traditional Weight Watchers®´ meetings, the Weight Watchers At Work program, and hospital-based weight loss programs qualify for the Weight Loss Benefit.

The Weight Watchers Online and Weight Watchers At Home programs do not qualify for the benefit, nor do fees paid for any other weight loss programs. Fees paid for individual nutrition counseling sessions, food, books, videos, scales, or other items not included as part of the fee for the course or class do not qualify.

What do I need to do?

First, check to ensure that your coverage includes the Weight Loss Benefit. If you have any questions, call the Member Service number on the front of your ID card.

Second, enroll in a qualified weight loss program. You must pay for the course or program first, and may then submit a claim for the benefit.

Simply send us:

- **The Weight Loss Benefit Form**, answering all questions. (Please note that the $150 is per individual or family membership. Submit only once per calendar year, filed by March 31 of the following year.)
- **8.5" x 11" photocopies of paid receipts** from the qualified program in which you enroll. Receipts must show the Blue Cross Blue Shield of Massachusetts member's name, name/logo of program, amount paid per session(s), and date(s) paid. For qualified Weight Watchers programs, a photocopy of your program "Membership Book" showing this information is required.
- **Finally, mail both the form and copies of your receipts** to the address at the bottom of the Weight Loss Benefit Form. If you have any questions, please call the Member Service number on your ID card.

Note: Please keep your original receipts before sending copies with your claim. Services denied for payment will be noted on your claim summary. We do not return any receipts or claim forms.

Be sure to check with your physician before starting any weight loss program.

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Weight Loss Benefit Form

PLEASE PRINT ALL INFORMATION CLEARLY

DO NOT WRITE IN THIS SPACE
OFFICE USE ONLY

Subscriber Information (Person in whose name coverage is held)

Identification Number (including alpha prefix)	Subscriber's Last Name	First Name	Middle Initial
Address—Number and Street	City	State	Zip Code
Employer's Name			

Member Information

Member's Last Name	First Name	Middle Initial	Date of Birth: Mo. Day Yr.
Mailing Address (if different from subscriber's) Number and Street	City	State	Zip Code

Gender
- ❑ Male
- ❑ Female

Claimant is (check one):
- ❑ Subscriber (coverage holder)
- ❑ Spouse (of coverage holder)
- ❑ Child (age 18 or younger)
- ❑ Handicapped Dependent (age 19 or older)
- ❑ Student (age 19 or older)
- ❑ Stepchild
- ❑ Other (specify) _____

When to Submit this Form:

- After you have collected up to $150 in paid receipts from your qualified weight loss program.
- Once per calendar year, filed by March 31 of the following year.

Class/Program Information Required:

Attach 8.5" x 11" photocopies of paid receipts from your qualified weight loss program. Receipts must show Blue Cross Blue Shield of Massachusetts member's name, name/logo of program, amount paid per session(s), and date(s) paid. For qualified Weight Watchers programs, a photocopy of your program "Membership Book" showing this information is required.

Name and Address of Class/Program	Benefit Year*

* A 12-month period beginning January 1 and ending December 31.

Total Number of Receipt Copies Attached: _____ Total Amount Submitted: $ _____

Certification and Authorization (This form must be signed and dated below.)

I authorize the release of any information to Blue Cross and Blue Shield of Massachusetts, Inc., about my weight loss program.
I certify that the information provided in support of this submission is complete and correct and that I have not previously submitted for these services.

Subscriber's/Member's Signature: _____ Date: _____

Please print, fold, and mail this form (including copies of paid receipts) to:
Blue Cross Blue Shield of Massachusetts
Local Claims Department
PO Box 986030
Boston, MA 02298

Questions?

To verify this benefit is within your plan or for further information, call the Member Service number on the front of your ID card.

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