MASSACHUSETTS

MIIA Town of Norwell
Plan Effective Date: 7/1/2018

# Welcome to Blue Cross Blue Shield of Massachusetts through MIIA!!

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**Visit:** http://planinfo.bluecrossma.com/customblue/2018/miiatownofnorwell

| **Plan details**: (click to view documents) | Plan documents | | Online Resources |
|---|---|---|---|
| Network Blue NE HMO | Summary | SBC | Learn more about plan features |
| Blue Care Elect PPO | Summary | SBC | Learn more about plan features |
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## Learn more about:

- Plan Options
- Wellness
- Resources

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

| | |
|---|---|
| Mail Service Pharmacy Brochure & Form | Download |
| Value-Based Drug List | Download |
| 2018 Pharmacy Formulary | Download |
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PRIVATE NCQA HEALTH INSURANCE PLAN RATINGS 2016 - 2017

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BlueCross® BlueShield®

**SUMMARY OF BENEFITS**

# Network Blue® New England

## Town of Norwell HMO

MIIA MASSACHUSETTS BASED MEMBER DRIVEN

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

# Your Care

## Your Primary Care Provider (PCP)

When you enroll in this health plan, you must choose a primary care provider. Be sure to choose a PCP who can accept you and your family members and who participates in the network of providers in New England. For children, you may choose a participating network pediatrician as the PCP.

For a list of participating PCPs or OB/GYN physicians, visit the Blue Cross Blue Shield of Massachusetts website at **www.bluecrossma.com**; consult the Provider Directory; or call the Physician Selection Service at **1-800-821-1388**.

If you have trouble choosing a doctor, the Physician Selection Service can help. They can give you the doctor's gender, the medical school she or he attended, and whether there are languages other than English spoken in the office.

## Referrals

Your PCP is the first person you call when you need routine or sick care. If your PCP decides that you need to see a specialist for covered services, your PCP will refer you to an appropriate network specialist, who is likely affiliated with your PCP's hospital or medical group.

You will not need prior authorization or referral to see a HMO Blue New England network provider who specializes in OB/GYN services. Your providers may also work with Blue Cross Blue Shield of Massachusetts regarding referrals and Utilization Review Requirements, including Pre-Admission Review, Concurrent Review and Discharge Planning, Prior Approval for Certain Outpatient Services, and Individual Case Management. For detailed information about Utilization Review, see your benefit description.

## Your Out-of-Pocket Maximum

Your out-of-pocket maximum is the most that you could pay during a plan year for copayments and coinsurance for covered services. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your out-of-pocket maximum for medical benefits is **$2,000** per member (or **$4,000** per family). Your out-of-pocket maximum for prescription drug benefits is **$3,000** per member (or **$6,000** per family).

## Emergency Room Services

In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call **911** (or the local emergency phone number). You pay a copayment per visit for emergency room services. This copayment is waived if you're admitted to the hospital or for an observation stay. See the chart for your cost share.

## Service Area

The plan's service area includes all cities and towns in the Commonwealth of Massachusetts, State of Rhode Island, State of Vermont, State of Connecticut, State of New Hampshire, and State of Maine.

## When Outside the Service Area

If you're traveling outside the service area and you need urgent or emergency care, you should go to the nearest appropriate health care facility. You are covered for the urgent or emergency care visit and one follow-up visit while outside the service area. Any additional follow-up care must be arranged by your PCP. See your benefit description for more information.

## Dependent Benefits

This plan covers dependents until the end of the calendar month in which they turn age 26, regardless of their financial dependency, student status, or employment status. See your benefit description (and riders, if any) for exact coverage details.

# Your Medical Benefits

| Covered Services | Your Cost |
|---|---|
| **Preventive Care**<br>Well-child care visits | Nothing |
| Routine adult physical exams, including related tests | Nothing |
| Routine GYN exams, including related lab tests (one per plan year) | Nothing |
| Routine hearing exams, including routine tests | Nothing |
| Hearing aids (up to $2,000 per ear every 36 months for a member age 21 or younger) | All charges beyond the maximum |
| Routine vision exams (one every 12 months) | Nothing |
| Family planning services–office visits | Nothing |
| **Outpatient Care**<br>Emergency room visits | $100 per visit<br>(waived if admitted or for observation stay) |
| Office visits, when performed by:<br>• Your PCP, OB/GYN physician, network nurse practitioner or nurse midwife<br>• Other network providers | <br>$20 per visit<br>$35 per visit |
| Chiropractors' office visits | $35 per visit |
| Acupuncture visits (up to 12 visits per plan year) | $35 per visit |
| Mental health or substance abuse treatment | $20 per visit |
| Short-term rehabilitation therapy–physical and occupational (up to 60 visits per plan year*) | $35 per visit |
| Speech, hearing, and language disorder treatment–speech therapy | $35 per visit |
| Diagnostic X-rays and lab tests, excluding CT scans, MRIs, PET scans, and nuclear cardiac imaging tests | Nothing |
| CT scans, MRIs, PET scans, and cardiac imaging tests<br>• Hospitals<br>• Other network providers | <br>$100 per category per service date**<br>Nothing |
| Home health care and hospice services | Nothing |
| Oxygen and equipment for its administration | Nothing |
| Durable medical equipment–such as wheelchairs, crutches, hospital beds | 20% coinsurance*** |
| Prosthetic devices | Nothing |
| Surgery and related anesthesia in an office, when performed by:<br>• Your PCP or OB/GYN physician<br>• Other network providers | <br>$20 per visit†<br>$35 per visit† |
| Surgery in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit | $150 per admission |
| **Inpatient Care (including maternity care)**<br>General or chronic disease hospital care (as many days as medically necessary) | $250 per admission |
| Mental hospital or substance abuse facility care (as many days as medically necessary) | $250 per admission |
| Rehabilitation hospital care (up to 60 days per plan year) | Nothing |
| Skilled nursing facility care (up to 100 days per plan year) | Nothing |

* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or for the treatment of autism spectrum disorders.

** When the copayments for CT scans, MRIs, PET scans, and/or nuclear cardiac imaging tests add up to the total of $375 per member in a calendar year, you pay nothing for these tests for the remainder of that calendar year.

*** Cost share waived for one breast pump per birth.

† Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.

| Prescription Drug Benefits* | Your Cost** |
|---|---|
| At designated retail pharmacies<br>(up to a 30-day formulary supply for each prescription or refill) | $10 for Tier 1<br>$25 for Tier 2<br>$45 for Tier 3 |
| Through the designated mail service pharmacy<br>(up to a 90-day formulary supply for each prescription or refill) | $20 for Tier 1***<br>$50 for Tier 2<br>$90 for Tier 3 |

* Generally, Tier 1 refers to generic drugs; Tier 2 refers to preferred brand-name drugs; Tier 3 refers to non-preferred drugs.
** Cost share may be waived for certain covered drugs and supplies.
*** Certain generic medications are available through the mail service pharmacy at $9. For more information, go to www.bluecrossma.com/mail-service-pharmacy.

## Get the Most from Your Plan

Visit us at **www.bluecrossma.com** or call **1-800-782-3675** to learn about discounts, savings, resources, and special programs available to you, like those listed below.

| | |
|---|---|
| **Wellness Participation Program**<br>**Reimbursement for a membership at a health club or for fitness classes**<br>This fitness program applies for fees paid to: privately-owned or privately-sponsored health clubs or fitness facilities, including individual health clubs and fitness centers; YMCAs; YWCAs; Jewish Community Centers; and municipal fitness centers. (See your benefit description for details.) | $150 per calendar year per policy |
| **Reimbursement for participation in a qualified weight loss program**<br>This weight loss program applies for fees paid to: a qualified hospital-based weight loss program or a Blue Cross Blue Shield of Massachusetts designated weight loss program. (See your benefit description for details.) | $150 per calendar year per policy |
| Blue Care Line®—A 24-hour nurse line to answer your health care questions—call 1-888-247-BLUE (2583) | No additional charge |

## Questions?

For questions about Blue Cross Blue Shield of Massachusetts, call **1-800-782-3675**, or visit us online at **www.bluecrossma.com**. Interested in receiving information from us via e-mail? Go to **www.bluecrossma.com/email** to sign up.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your benefit description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the benefit description and riders will govern. Some of the services not covered are: cosmetic surgery; custodial care; most dental care; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your benefit description and riders. **Note:** Blue Cross and Blue Shield of Massachusetts, Inc. administers claims payment only and does not assume financial risk for claims.



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**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, see www.emiia.org/health-and-dental-insurance.
For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.bluecrossma.com/sbcglossary or call **1-800-782-3675** to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$0** | See the Common Medical Events chart below for your costs for services this plan covers. |
| **Are there services covered before you meet your deductible?** | No. | You will have to meet the deductible before the plan pays for any services. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | For medical benefits, **$2,000** member / **$4,000** family; and for prescription drug benefits, **$3,000** member / **$6,000** family. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing 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. |
| **Will you pay less if you use a network provider?** | Yes. See www.bluecrossma.com/findadoctor or call 1-800-821-1388 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you 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 a referral before you see the specialist. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network (You will pay the least) | Out-of-Network (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $20 / visit | Not covered | None |
| | Specialist visit | $35 / visit; $35 / chiropractor visit; $35 / acupuncture visit | Not covered | Limited to 12 acupuncture visits per plan year |
| | Preventive care/screening/immunization | No charge | Not covered | GYN exam limited to one exam per calendar year. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | $100 for hospitals; no charge for other providers | Not covered | Copayment applies per category of test / day; pre-authorization required for certain services |
| **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 | $10 / retail supply or $20 / 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 | $25 / retail supply or $50 / mail service supply | Not covered | |
| | Non-preferred brand drugs | $45 / retail supply or $90 / mail service supply | Not covered | |
| | 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) | $150 / admission | Not covered | Pre-authorization required for certain services |
| | Physician/surgeon fees | No charge | Not covered | Pre-authorization required for certain services |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network (You will pay the least) | Out-of-Network (You will pay the most) | |
| **If you need immediate medical attention** | Emergency room care | $100 / visit | $100 / visit | Copayment waived if admitted or for observation stay |
| | Emergency medical transportation | No charge | No charge | None |
| | Urgent care | $35 / visit | $35 / visit | Out-of-network coverage limited to out of service area |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $250 / admission | Not covered | Pre-authorization required |
| | Physician/surgeon fees | No charge | Not covered | Pre-authorization required |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $20 / visit | Not covered | Pre-authorization required for certain services |
| | Inpatient services | $250 / admission | Not covered | Pre-authorization required for certain services |
| **If you are pregnant** | Office visits | No charge | Not covered | Cost sharing does not apply for preventive services; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) |
| | Childbirth/delivery professional services | No charge | Not covered | |
| | Childbirth/delivery facility services | $250 / admission | Not covered | |
| **If you need help recovering or have other special health needs** | Home health care | No charge | Not covered | Pre-authorization required |
| | Rehabilitation services | $35 / visit | Not covered | Limited to 60 visits per plan year (other than for autism, home health care, and speech therapy); pre-authorization required for certain services |
| | Habilitation services | $35 / 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 plan year; pre-authorization required |
| | Durable medical equipment | 20% coinsurance | Not covered | Cost share waived for one breast pump per birth |
| | Hospice services | No charge | Not covered | Pre-authorization required for certain services |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network (You will pay the least) | Out-of-Network (You will pay the most) | |
| **If your child needs dental or eye care** | Children's eye exam | No charge | Not covered | Limited to one exam every 12 months |
| | Children's glasses | Not covered | Not covered | None |
| | Children's dental check-up | No charge for members with a cleft palate / cleft lip condition | Not covered | Limited to members under age 18 |

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- 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 (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Acupuncture (12 visits per plan year)
- 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 12 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:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Your state insurance department might also be able to help. If you are a Massachusetts resident, you can contact the Massachusetts Division of Insurance at 1-877-563-4467 or www.mass.gov/doi. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. For more information about possibly buying individual coverage through a state exchange, you can contact your state's marketplace, if applicable. If you are a Massachusetts resident, contact the Massachusetts Health Connector by visiting www.mahealthconnector.org. For more information on your rights to continue your employer coverage, contact your plan sponsor. (A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.)

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the Member Service number listed on your ID card or contact your plan sponsor. (A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.)

**Does this plan provide Minimum Essential Coverage? [Yes]**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards? [Yes]**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**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 section.*

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network prenatal care and a hospital delivery)

- **The plan's overall deductible** **$0**
- **Delivery fee copay** **$0**
- **Facility fee copay** **$250**
- **Diagnostic tests copay** **$0**

**This EXAMPLE event includes services like:**
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| **Total Example Cost** | **$12,713** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $266 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$326** |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$0**
- **Specialist visit copay** **$35**
- **Primary care visit copay** **$20**
- **Diagnostic tests copay** **$0**

**This EXAMPLE event includes services like:**
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| **Total Example Cost** | **$7,389** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $1,479 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $55 |
| **The total Joe would pay is** | **$1,534** |

### Jacquie's Simple Fracture
(in-network emergency room visit and follow-up care)

- **The plan's overall deductible** **$0**
- **Specialist visit copay** **$35**
- **Emergency room copay** **$100**
- **Ambulance services copay** **$0**

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| **Total Example Cost** | **$1,925** |
|---|---|

**In this example, Jacquie would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $275 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Jacquie would pay is** | **$275** |

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

MASSACHUSETTS

# MCC Compliance

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


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BlueCross® BlueShield®

**SUMMARY OF BENEFITS**

# Blue Care Elect® Value Plus

## Town of Norwell PPO

MIIA MASSACHUSETTS BASED MEMBER DRIVEN

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

# Your Choice

## When You Choose Preferred Providers

You receive the highest level of benefits under your health care plan when you obtain covered services from preferred providers. These are called your "in-network" benefits. See the charts for your cost share.

Note: If a preferred provider refers you to another provider for covered services (such as a lab or specialist), make sure the provider is a preferred provider in order to receive benefits at the in-network level. If the provider you use is not a preferred provider, you're still covered, but your benefits, in most situations, will be covered at the out-of-network level, even if the preferred provider refers you.

## How to Find a Preferred Provider

There are a few ways to find a preferred provider:

- Look up a provider in the Provider Directory. If you need a copy of your directory, call Member Service at the number on your ID card.
- Visit the Blue Cross Blue Shield of Massachusetts website at **www.bluecrossma.com/findadoctor**
- Call the Physician Selection Service at **1-800-821-1388**

## When You Choose Non-Preferred Providers

You can also obtain covered services from non-preferred providers, but your out-of-pocket costs are higher. These are called your "out-of-network" benefits. See the charts for your cost share.

You must pay a plan-year deductible before you can receive coverage for most out-of-network benefits under this plan. If you are not sure when your plan year begins, contact Blue Cross Blue Shield of Massachusetts. Your deductible is **$250** per member (or **$500** per family).

Payments for out-of-network benefits are based on the Blue Cross Blue Shield allowed charge as defined in your benefit description. You may be responsible for any difference between the allowed charge and the provider's actual billed charge (this is in addition to your deductible and/or your coinsurance).

## Your Out-of-Pocket Maximum

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments, and coinsurance for covered services. Your out-of-pocket maximum for medical benefits is **$2,000** per member (or **$4,000** per family) for in-network and out-of-network services combined. Your out-of-pocket maximum for prescription drug benefits is **$3,000** per member (or **$6,000** per family).

## Emergency Room Services

In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call **911** (or the local emergency phone number). You pay a copayment per visit for in-network or out-of-network emergency room services. This copayment is waived if you are admitted to the hospital or for an observation stay. See the chart for your cost share.

## Utilization Review Requirements

Certain services require pre-approval through Blue Cross Blue Shield of Massachusetts for you to have benefit coverage, this includes non-emergency and non-maternity hospitalization and may include certain outpatient services, therapies, procedures (such as MRIs and CT Scans), and drugs. You should work with your provider to determine if pre-approval is required. If your provider, or you, do not get pre-approval when it is required, your benefits will be reduced or denied, and you may be fully responsible for payment to the service provider. Refer to your benefit description for requirements and the process you should follow for Utilization Review, including Pre-Admission Review, Pre-Service Approval (for certain outpatient services), Concurrent Review and Discharge Planning, and Individual Case Management.

## Dependent Benefits

This plan covers dependents until the end of the calendar month in which they turn age 26, regardless of their financial dependency, student status, or employment status. See your benefit description (and riders, if any) for exact coverage details.

# Your Medical Benefits

| Covered Services | Your Cost In-Network | Your Cost Out-of-Network |
|---|---|---|
| **Preventive Care**<br>Well-child care exams, including related tests, according to age-based schedule as follows:<br>• 10 visits during the first year of life<br>• Three visits during the second year of life (age 1 to age 2)<br>• Two visits for age 2<br>• One visit per plan year age 3 and older | Nothing | 20% coinsurance after deductible |
| Routine adult physical exams, including related tests (one per plan year) | Nothing | 20% coinsurance after deductible |
| Routine GYN exams, including related lab tests (one per plan year) | Nothing | 20% coinsurance after deductible |
| Routine hearing exams, including routine tests | Nothing | 20% coinsurance after deductible |
| Hearing aids (up to $2,000 per ear every 36 months for a member age 21 or younger) | All charges beyond the maximum | 20% coinsurance after deductible and all charges beyond the maximum |
| Routine vision exams (one every 24 months) | Nothing | 20% coinsurance after deductible |
| Family planning services–office visits | Nothing | 20% coinsurance after deductible |
| **Outpatient Care**<br>Emergency room visits | $100 per visit<br>(waived if admitted or for observation stay) | $100 per visit, no deductible<br>(waived if admitted or for observation stay) |
| Clinic visits; physicians' and podiatrists' office visits | $20 per visit | 20% coinsurance after deductible |
| Chiropractors' office visits | $20 per visit | 20% coinsurance after deductible |
| Acupuncture visits (up to 12 visits per plan year) | $20 per visit | $20 per visit, no deductible |
| Mental health or substance abuse treatment | $20 per visit | 20% coinsurance after deductible |
| Short-term rehabilitation therapy–physical and occupational (up to 100 visits per plan year*) | $20 per visit | 20% coinsurance after deductible |
| Speech, hearing, and language disorder treatment–speech therapy | $20 per visit | 20% coinsurance after deductible |
| Diagnostic X-rays and lab tests, excluding MRIs, CT scans, PET scans, and nuclear cardiac imaging tests | Nothing | 20% coinsurance after deductible |
| MRIs, CT scans, PET scans, and nuclear cardiac imaging tests<br>• Hospitals<br>• Other covered providers | <br>$25 per category per service date<br>Nothing | <br>20% coinsurance after deductible<br>20% coinsurance after deductible |
| Home health care and hospice services | Nothing | 20% coinsurance after deductible |
| Oxygen and equipment for its administration | Nothing | 20% coinsurance after deductible |
| Durable medical equipment–such as wheelchairs, crutches, hospital beds | 20% coinsurance** | 40% coinsurance after deductible** |
| Prosthetic devices | 20% coinsurance | 40% coinsurance after deductible |
| Surgery and related anesthesia<br>• Office and health center services<br>• Hospital and other day surgical facility services | <br>$20 per visit***<br>$150 per admission | <br>20% coinsurance after deductible<br>20% coinsurance after deductible |
| **Inpatient Care (including maternity care)**<br>General or chronic disease hospital care (as many days as medically necessary) | $250 per admission | 20% coinsurance after deductible |
| Mental hospital or substance abuse facility care (as many days as medically necessary) | $250 per admission | 20% coinsurance after deductible |
| Rehabilitation hospital care (up to 60 days per plan year) | Nothing | 20% coinsurance after deductible |
| Skilled nursing facility care (up to 100 days per plan year) | Nothing | 20% coinsurance after deductible |

* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or for the treatment of autism spectrum disorders.
** In-network cost share waived for one breast pump per birth (20% coinsurance after deductible out-of-network).
*** Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.

| Prescription Drug Benefits* | Your Cost In-Network** | Your Cost Out-of-Network |
|---|---|---|
| At designated retail pharmacies<br>(up to a 30-day formulary supply for each prescription or refill) | $10 for Tier 1<br>$25 for Tier 2<br>$45 for Tier 3 | Not covered |
| Through the designated mail service pharmacy<br>(up to a 90-day formulary supply for each prescription or refill) | $20 for Tier 1***<br>$50 for Tier 2<br>$90 for Tier 3 | Not covered |

* Generally, Tier 1 refers to generic drugs; Tier 2 refers to preferred brand-name drugs; Tier 3 refers to non-preferred drugs.
** Cost share may be waived for certain covered drugs and supplies.
*** Certain generic medications are available through the mail service pharmacy at $9. For more information, go to www.bluecrossma.com/mail-service-pharmacy.

## Get the Most from Your Plan

Visit us at **www.bluecrossma.com** or call **1-800-782-3675** to learn about discounts, savings, resources, and special programs available to you, like those listed below.

| | |
|---|---|
| **Wellness Participation Program**<br>**Reimbursement for a membership at a health club or for fitness classes**<br>This fitness program applies for fees paid to: privately-owned or privately-sponsored health clubs or fitness facilities, including individual health clubs and fitness centers; YMCAs; YWCAs; Jewish Community Centers; and municipal fitness centers. (See your benefit description for details.) | $150 per calendar year per policy |
| **Reimbursement for participation in a qualified weight loss program**<br>This weight loss program applies for fees paid to: a qualified hospital-based weight loss program or a Blue Cross Blue Shield of Massachusetts designated weight loss program. (See your benefit description for details.) | $150 per calendar year per policy |
| Blue Care Line®—A 24-hour nurse line to answer your health care questions—call **1-888-247-BLUE (2583)** | No additional charge |

## Questions?

For questions about Blue Cross Blue Shield of Massachusetts, call **1-800-782-3675**, or visit us online at **www.bluecrossma.com**. Interested in receiving information from us via e-mail? Go to **www.bluecrossma.com/email** to sign up.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your benefit description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the benefit description and riders will govern. Some of the services not covered are: cosmetic surgery; custodial care; most dental care; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your benefit description and riders. **Note:** Blue Cross and Blue Shield of Massachusetts, Inc. administers claims payment only and does not assume financial risk for claims.



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BlueCross® BlueShield®

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**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, see **www.emiia.org/health-and-dental-insurance**.
For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at **www.bluecrossma.com/sbcglossary** or call **1-800-782-3675** to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$0** in-network; **$250** member / **$500** family out-of-network. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Emergency room and emergency transportation. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | For medical benefits, **$2,000** member / **$4,000** family; and for prescription drug benefits, **$3,000** member / **$6,000** family. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing 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. |
| **Will you pay less if you use a network provider?** | Yes. See www.bluecrossma.com/findadoctor or call 1-800-821-1388 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network (You will pay the least) | Out-of-Network (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $20 / visit | 20% coinsurance | Deductible applies first for out-of-network |
| | Specialist visit | $20 / visit; $20 / chiropractor visit; $20 / acupuncture visit | 20% coinsurance; 20% coinsurance / chiropractor visit; $20 / acupuncture visit | Deductible applies first for out-of-network except for acupuncture visits; limited to 12 acupuncture visits per plan year |
| | Preventive care/screening/immunization | No charge | 20% coinsurance | Deductible applies first for out-of-network; limited to age-based schedule and / or frequency. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge | 20% coinsurance | Deductible applies first for out-of-network |
| | Imaging (CT/PET scans, MRIs) | $25 for hospitals; no charge for other providers | 20% coinsurance | Deductible applies first for out-of-network; copayment applies per category of test / day; pre-authorization may be required |
| **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 | $10 / retail supply or $20 / 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 | $25 / retail supply or $50 / mail service supply | Not covered | |
| | Non-preferred brand drugs | $45 / retail supply or $90 / mail service supply | Not covered | |
| | Specialty drugs | Applicable cost share (generic, preferred, non-preferred) | Not covered | When obtained from a designated specialty pharmacy; pre-authorization required for certain drugs |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network (You will pay the least) | Out-of-Network (You will pay the most) | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $150 / admission | 20% coinsurance | Deductible applies first for out-of-network |
| | Physician/surgeon fees | No charge | 20% coinsurance | Deductible applies first for out-of-network |
| **If you need immediate medical attention** | Emergency room care | $100 / visit | $100 / visit | Copayment waived if admitted or for observation stay |
| | Emergency medical transportation | No charge | No charge | None |
| | Urgent care | $20 / visit | 20% coinsurance | Deductible applies first for out-of-network |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $250 / admission | 20% coinsurance | Deductible applies first for out-of-network; pre-authorization required |
| | Physician/surgeon fees | No charge | 20% coinsurance | Deductible applies first for out-of-network; pre-authorization required |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $20 / visit | 20% coinsurance | Deductible applies first for out-of-network; pre-authorization required for certain services |
| | Inpatient services | $250 / admission | 20% coinsurance | Deductible applies first for out-of-network; pre-authorization required for certain services |
| **If you are pregnant** | Office visits | No charge | 20% coinsurance | Deductible applies first for out-of-network; cost sharing does not apply for in-network preventive services; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) |
| | Childbirth/delivery professional services | No charge | 20% coinsurance | |
| | Childbirth/delivery facility services | $250 / admission | 20% coinsurance | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | In-Network (You will pay the least) | Out-of-Network (You will pay the most) | |
| **If you need help recovering or have other special health needs** | Home health care | No charge | 20% coinsurance | Deductible applies first for out-of-network; pre-authorization required |
| | Rehabilitation services | $20 / visit | 20% coinsurance | Deductible applies first for out-of-network; limited to 100 visits per plan year (other than for autism, home health care, and speech therapy) |
| | Habilitation services | $20 / visit | 20% coinsurance | Deductible applies first for out-of-network; rehabilitation therapy coverage limits apply; cost share and coverage limits waived for early intervention services for eligible children |
| | Skilled nursing care | No charge | 20% coinsurance | Deductible applies first for out-of-network; limited to 100 days per plan year; pre-authorization required |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | Deductible applies first for out-of-network; in-network cost share waived for one breast pump per birth (20% coinsurance for out-of-network) |
| | Hospice services | No charge | 20% coinsurance | Deductible applies first for out-of-network; pre-authorization required for certain services |
| **If your child needs dental or eye care** | Children's eye exam | No charge | 20% coinsurance | Deductible applies first for out-of-network; limited to one exam every 24 months |
| | Children's glasses | Not covered | Not covered | None |
| | Children's dental check-up | No charge for members with a cleft palate / cleft lip condition | 20% coinsurance for members with a cleft palate / cleft lip condition | Limited to members under age 18; deductible applies first for out-of-network |

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Children's glasses
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Private-duty nursing

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Acupuncture (12 visits per plan year)
- Bariatric surgery
- Chiropractic care
- Hearing aids ($2,000 per ear every 36 months for members age 21 or younger)
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- 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:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Your state insurance department might also be able to help. If you are a Massachusetts resident, you can contact the Massachusetts Division of Insurance at 1-877-563-4467 or www.mass.gov/doi. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. For more information about possibly buying individual coverage through a state exchange, you can contact your state's marketplace, if applicable. If you are a Massachusetts resident, contact the Massachusetts Health Connector by visiting www.mahealthconnector.org. For more information on your rights to continue your employer coverage, contact your plan sponsor. (A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.)

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the Member Service number listed on your ID card or contact your plan sponsor. (A plan sponsor is usually the member's employer or organization that provides group health coverage to the member.)

**Does this plan provide Minimum Essential Coverage? [Yes]**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards? [Yes]**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**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 section.*

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network prenatal care and a hospital delivery)

| | |
|---|---|
| ■ **The plan's overall deductible** | **$0** |
| ■ **Delivery fee copay** | **$0** |
| ■ **Facility fee copay** | **$250** |
| ■ **Diagnostic tests copay** | **$0** |

**This EXAMPLE event includes services like:**
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| **Total Example Cost** | **$12,713** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $266 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$326** |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| ■ **The plan's overall deductible** | **$0** |
| ■ **Specialist visit copay** | **$20** |
| ■ **Primary care visit copay** | **$20** |
| ■ **Diagnostic tests copay** | **$0** |

**This EXAMPLE event includes services like:**
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| **Total Example Cost** | **$7,389** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $1,449 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $55 |
| **The total Joe would pay is** | **$1,504** |

### Jacquie's Simple Fracture
(in-network emergency room visit and follow-up care)

| | |
|---|---|
| ■ **The plan's overall deductible** | **$0** |
| ■ **Specialist visit copay** | **$20** |
| ■ **Emergency room copay** | **$100** |
| ■ **Ambulance services copay** | **$0** |

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| **Total Example Cost** | **$1,925** |
|---|---|

**In this example, Jacquie would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $200 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Jacquie would pay is** | **$200** |

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

MASSACHUSETTS

# MCC Compliance

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


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MASSACHUSETTS

# 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.

## 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.

MASSACHUSETTS

EXPRESS SCRIPTS


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# 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

Detach Here

For all orders after 08/01/2011, use this form.
Fold and tear off this piece before putting in the return envelope.

## 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

REMINDER: This section must be removed before mailing.

1042

| Patient 1 (Cardholder) | | Patient 2 |
|---|---|---|
| Name: _____<br>I want non-child resistant caps, when available.<br>Date of Birth (MM/DD/YYYY) / / | **Date of Birth is required for patient identification.**<br>Failure to provide complete and accurate information may prevent the pharmacy from detecting drug related problems. | Name: _____<br>I want non-child resistant caps, when available.<br>Date of Birth (MM/DD/YYYY) / / |
| **DRUG ALLERGIES**<br>List other Allergies here: | **No Known Allergies**<br>Acetaminophen/Tylenol®<br>Amoxicillin<br>Aspirin<br>Cephalosporin (i.e., Keflex®, Cephalexin)<br>Codeine<br>Erythromycin, Biaxin®, Zithromax®<br>NSAIDs (i.e., Ibuprofen, Naproxen)<br>Oxycodone (i.e., OxyContin®, Percocet®)<br>Penicillin<br>Sulfa<br>Tetracycline (i.e., Doxycycline, Minocycline) | List other Allergies here: |
| **HEALTH CONDITIONS**<br>List other Health Conditions here: | **No Known Health Conditions**<br>Arthritis (715.9)<br>Asthma (493.9)<br>Chronic Bronchitis or Emphysema (496)<br>Depression (311)<br>Diabetes Type I (250.01)<br>Diabetes Type II (250.00)<br>Epilepsy/Seizures (345.9)<br>GERD (530.81)<br>Glaucoma (365.9)<br>High Cholesterol (272.9)<br>Hormone Replacement Therapy (627.9)<br>Hypertension (401.9)<br>Thyroid: Low (244.9) | List other Health Conditions here: |
| **OTC**<br>List other OTC that you take on a regular basis: | **No Over-the-Counter Medications**<br>Acetaminophen/Tylenol®<br>Advil®/Aleve®/Motrin®<br>Aspirin/Excedrin® | List other OTC that you take on a regular basis: |
| **DEVICES**<br>List Medical Devices here: | **No Medical Devices**<br>Medical Devices (i.e., Glucose Testing Device, Insulin Pump, Nebulizer) and specify brand name and model. | List Medical Devices here: |
| **OTHER**<br>List other Prescription Medications here: | **No Other Prescriptions**<br>Prescription Medications not filled through Express Scripts Pharmacy. | List other Prescription Medications here: |

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.

MLR- DRAFTONLY (MAILER) REV 07/27/2011

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# 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 Fold 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**

EXPRESS SCRIPTS®
**Home Delivery Service**
**PO Box 66566**
**St Louis, MO 63166-9967**

## 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 presciption order form

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Pref Pref Pref

Detach envelope to mail presciption order form

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Glue

Inside envelope

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Inside envelope

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MASSACHUSETTS

# Value-Based Benefit Medications List

For health plans that include the value-based pharmacy benefit, the following medications are eligible at a reduced cost when purchased through our Mail Service Pharmacy. In addition, if you have a Saver plan, the deductible for these medications is waived when purchased through the Mail Service Pharmacy. Please refer to your benefit materials for more information on your plan's limitations and exclusions. This list is effective as of January 1, 2017, and may be updated as necessary. Find the latest information on specific medications by visiting **bluecrossma.com/pharmacy.**

## Medications Commonly Used in the Treatment of Asthma

| | | | |
|---|---|---|---|
| Albuterol Inhalation Solution | Flovent/Diskus | Montelukast | Qvar |
| Aminophylline | Flovent HFA | ProAir/HFA | Theochron |
| Budesonide nebulizer solution | Ipratropium nebulizer solution | ProAir RespiClick | Theophylline |
| Cromolyn nebulizer solution | Ipratropium-albuterol | Pulmicort | Zafirlukast |

## Medications Commonly Used in the Treatment of Diabetes

| | | | |
|---|---|---|---|
| Acarbose | Glipizide/Metformin HCL | Lantus | Tolazamide |
| Chlorpropamide | Glyburide | Metformin | Tolbutamide |
| Glimepiride | Glyburide/Metformin HCL | Metformin ER | |
| Glipizide | Glyburide-Micro | Nateglinide | |
| Glipizide ER | Humalog | One Touch Test Strips | |
| Glipizide XL | Humulin | Symlin | |

## Medications Commonly Used in the Treatment of Coronary Artery Disease or Cardiovascular Disease Risk Factors

**(High Blood Pressure and High Cholesterol)**

You pay less for the following medications when purchased through the Mail Service Pharmacy. However, you qualify **ONLY** if you're taking a medication to treat high blood pressure **AND** a medication to treat high cholesterol.

| High Blood Pressure | | | |
|---|---|---|---|
| Amiloride/HCTZ | Bisoprolol/HCTZ | Diltiazem HCL | Enalapril |
| Amlodipine | Captopril | Diltiazem HCL ER Cap | Enalapril/HCTZ |
| Amlodipine/Benazepril | Carvedilol | Diltiazem HCL SR Cap | Eplerenone |
| Atenolol | Chlorthalidone | Diltiazem HCL XR Cap | Felodipine ER |
| Atenolol/Chlorthalidone | Clonidine | Diltiazem HCL XT Cap | Furosemide |
| Benazepril | Diltiazem CD | Diltiazem XR Cap | Hydralazine |
| Benazepril/HCTZ | Diltiazem HCl Tab | Doxazosin | Hydrochlorothiazide |

Medications Commonly Used in the Treatment of Coronary Artery Disease or Cardiovascular Disease Risk Factors (continued)

| High Blood Pressure (continued) | | | |
|---|---|---|---|
| Irbesartan | Methazolamide | Nifedipine ER | Triamterene/HCTZ |
| Irbesartan/HCTZ | Metoprolol | Nifedipine XL | Verapamil |
| Lisinopril | Metoprolol succinate ER | Propranolol | Verapamil ER |
| Lisinopril/HCTZ | Nadolol | Ramipril | Valsartan |
| Losartan Potassium | Nicardipine | Spironolactone | Valsartan/HCTZ |
| Losartan Potassium/HCTZ | Nifedipine CR | Terazosin | |

| High Cholesterol | | | |
|---|---|---|---|
| Atorvastatin | Colestipol | Gemfibrozil | Prevalite |
| Cholestyramine/Light | Fenofibrate | Pravastatin | Simvastatin |

## Medications Commonly Used in the Treatment of Depression

If you're taking one of the above medications to treat asthma, diabetes, or both a medication to treat high blood pressure and cholesterol, then you'll will also pay less for the following medications to treat depression when obtained from the Mail Service Pharmacy.

| | | | |
|---|---|---|---|
| Citalopram | Fluoxetine | Paroxetine-CR | Sertraline |
| Escitalopram | Fluvoxamine | Paroxetine HCL | |

## Medications Commonly Used When Quitting Tobacco

You pay nothing for the following medications. They're available at retail pharmacies in addition to the Mail Service Pharmacy.

| | | | |
|---|---|---|---|
| Buproban | Commit | Nicotine[2] | Nicotrol |
| Bupropion HCL ER[1] | Nicoderm CQ | Nicotine Gum[2] | Nicotrol NS |
| Bupropion HCL SR[1] | Nicorelief | Nicotine Lozenge[2] | NTS |
| Chantix | Nicorette | Nicotine Patch[2] | |

1. Generics of Zyban only.

2. Also includes various store brands.

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Covered Medications (Formulary)

# Learn About Your Pharmacy Program

## Effective January 1, 2018

### This guide provides an overview of the program, and lists some of the medications covered under your plan, including:

- Over-the-Counter Medications
- Quality Care Dosing Medications
- Prior Authorization Medications
- Specialty Pharmacy Medications
- Step Therapy Medications

# Table of Contents

# 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've carefully developed a substantial covered medication list that includes many medications that are available at affordable out-of-pocket costs.**

## About This Guide

This guide is up-to-date as of January 1, 2018, and is subject to change. Use it as a reference whenever you need coverage information about our pharmacy program. For the most current and complete information about covered medications, visit our website at **bluecrossma.com/medications**.

## Mail Service Pharmacy

You can have certain prescriptions delivered right to your door when you order online through Express Scripts®´, our pharmacy manager, at e**xpress-scripts.com**. You'll also be able to purchase a 90-day supply of some maintenance medications, such as those used to treat high blood pressure, for less money than you'd pay at a retail pharmacy.

To use the Mail Service Pharmacy, download the order form at **bluecrossma.com/pharmacy**, or call **1-800-262-BLUE (2583)**.

## Online Resources

### Medication Lookup

Search for covered medications, quickly and easily, at **bluecrossma.com/medications**. Your individual coverage may vary. Changes to our current medications usually take place on January 1st and July 1st.

### MyBlue

Discover a more personalized experience when looking up your health care information, such as detailed plan information and claims. Log in or create an account at **bluecrossma.com/myblue**.

### Express Scripts

Get information about your specific pharmacy coverage by visiting **express-scripts.com**. There, you can look up the cost of medications, find a pharmacy, and set up home delivery.

# Pharmacy Program Overview

## What You Pay For Medications

Our covered medications list is based on a tiered cost structure. When you fill a prescription, the amount you pay the pharmacy is determined by the tier your medication is on and your benefits. 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 tell you how much you owe.

### In a 3-tier structure

Usually, you'll pay the least for Tier 1 medications and the most for Tier 3 medications.

### In a 4-tier structure

Usually, you'll pay the least for Tier 1 medications and the most for Tier 4 medications.

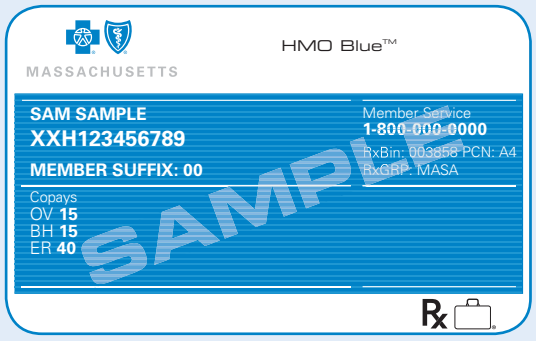
The amount you pay may include your copayment, co-insurance, and deductibles. For more about your specific prescription benefit costs, review the information in your benefit literature, which you should have received when you enrolled in your plan, or call the Member Service number listed on the front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

## Compounded Medications

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 made to order by a pharmacist when existing, commercially-available medications don't meet your specific needs as determined by your provider. Some compounded medications may need prior authorization, have Quality Care Dosing guidelines, or require an exception.

## Covered Medications List Changes

Our covered medications list may change from time to time. These changes may include changing medications to a non-covered status, changing medication tier status, applying Quality Care Dosing limitations, and/or moving medications to a retail specialty pharmacy. We notify any impacted members of these changes via direct mailing at least 30 days in advance of the change.




## 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 on the left.

# Over-the-Counter Medications

For non-grandfathered health plans under the Affordable Care Act (ACA), the following list includes over-the-counter medications that are covered at no cost to you when they are prescribed by your doctor. This list is up-to-date as of January 1, 2018, and may change from time to time.

- **Generic Aspirin (81mg)**
- **Generic Folic Acid** is covered for people up to age 50
- **Generic Iron** is covered for infants up to 12 months old
- **Generic Smoking Cessation** (e.g., nicotine gum, lozenges, and patches) is covered for up to two 90-day supplies per calendar year
- **Generic Vitamin D** is covered for people ages 65 and older
- **Generic contraceptives** (e.g., female condoms, sponges, and spermicide) are covered

# Quality Care Dosing

Our Quality Care Dosing program helps to ensure the quantity and dosage meet the Food and Drug Administration's (FDA) regulations, clinical standards, and manufacturer's guidelines of the medications you receive. When you fill a prescription for one of the following medications, it's 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

You may fill a quantity up to the allowed limit, but quantities greater than the allowed limit will be denied.

**Note:** Your doctor may request an exception for medications that are subject to Quality Care Dosing when medically necessary.

This list of medications in our Quality Care Dosing program is up-to-date as of January 1, 2018, and may change from time to time.

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

# 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
Adlyxin * (ST)
Advair Diskus (PA)
Advair HFA (PA)
Advicor
Adyphren *
Adzenys XR *
Aerobid *
Aerobid-M *
Aerospan *
Air Duo * (PA)
Akynzeo *
Alendronate Sodium
Alora *
Alosetron
Alrex *
Alsuma *
Altoprev *
Alupent inhaler
Alvesco *
Ambien *
Ambien CR *
Amethia
Amethis Lo
Amerge
Amitiza
Amlodipine
Amlodipine-Atorvastatin
Ampyra (PA) (SP)
Anoro Ellipta
Anzemet *
Aplenzin ER *
Aptenzio XR *
Aranesp * (PA) (SP) (SPO)
Arava *
Arcapta Neohaler *
Arnuity Ellipta
Arixtra *
Arymo ER * (PA)
Armonair RespiClick *
Ashlyna
Asmanex Twisthaler *
Astelin
Astepro *
Atelvia DR * (ST)
Atomoxetine (PA)
Atorvastatin
Atrovent (nasal spray)
Atrovent HFA
Auvi-Q *
Avandamet (ST)
Avandia (ST)
Avinza *
Avonex (SP) (SPO)
Axert *
Azelastine (nasal spray)
Azmacort *
Basaglar *
Belbuca (PA)
Belsomra *
Belviq (PA)
Belviq XR (PA)
Betaseron (SP) (SPO)
Bevespi AeroSphere *
Binosto * (PA)
Boniva tablets * (ST)
Breo Ellipta *
Brisdelle *
Budeprion SR
Budeprion XL
Budesonide (nebules)
Bunavail
Buprenorphine
Buprenorphine-Naloxone
Buprenex
Buprenorphine patch (PA)
Bupropion SR
Bupropion XL
Butorphanol NS
Butrans (PA)
Bydureon (ST)
Byetta (ST)
Cabergoline
Caduet *
Camrese
Camrese Lo
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
Cotempla XR ODT *
Contrave (PA)
Copaxone (SP) (SPO)
Cosentyx (PA)
Crestor *
Crolom ophthalmic
Cromolyn ophthalmic
Cymbalta
Daklinza * (PA) (SP)
Daysee
Desvenlafaxine ER *
Dexilant * (PA)
Dexmethylphenidate ER
Dexmethylphenidate XR
Dextroamphetamine/ Amphetamine ER
Diclofenac gel
Diclofenac solution
Diflucan (150 mg only)
Dihydroergotamine (nasal spray)
DM 2 Kit *
Doxazosin
Dulera (PA)
Duloxetine
Duloxetine DR
Duragesic * (PA)
Edluar *
Effexor XR *
Eletriptan
Embeda *
Emend
Emverm **
Enbrel (PA) (SP) (SPO)
Enoxaparin

* 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

# Quality Care Dosing

Epclusa (PA) (SP)
Epinephrine injection
Epi-Pen Auto-Injector
Epogen * (PA) (SP) (SPO)
Escitalopram
Esomeprazole (PA)
Esomeprazole Strontium * (PA)
Estraderm
Estradiol patch
Estrasorb *
Estrogel *
Eszopiclone
Evamist *
Evzio
Exalgo *
Extavia (SP) (SPO)
Ezetimibe
Exetimibe/Simvastatin
Famciclovir
Famvir *
Farydak (PA)
Farxiga * (ST)
Fayosim
Fentanyl oral/mucosal (PA)
Fentanyl patch (PA)
Fentora * (PA)
Fetzima *
Flovent/HFA
Fluconazole (150 mg only)
Fluoxetine
Fluoxetine DR
Fluticasone/Salmeterol (PA)
Fluvastatin XR
Fluvastatin
Fluvoxamine
Fluvoxamine CR
Focalin XR *
Fondaparinux
Foradil
Forfivo XL *
Forteo (PA) (SP) (SPO)
Fosamax * (ST)
Fosamax Plus D (ST)
Fragmin *
Frova *
Frovatriptan
Gatifloxacin
Glatiramer (SP) (SPO)
Glatopa (SP) (SPO)
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
Impavido
Incruse Ellipta (PA)
Infergen (PA) (SP) (SPO)
Insulins (all)
Intermezzo *
Introvale
Invokamet (ST)
Invokamet XR (ST)
Invokana (ST)
Ipratropium NS
Irenka DR *
Itraconazole
Jardiance (ST)
Jolessa
Kadian * (PA)
Kalydeco (PA) (SP)
Kerydin *
Ketorolac ophthalmic
Keveyis
Kevzara (PA) (SP)
Khedezla *
Kytril *
Lamisil *
Lansoprazole
Lansoprazole/Amoxicillin/ Clarithromycin
Lazanda * (PA)
Leflunomide
Lescol *
Lescol XL *
Levalbuterol HFA *
Levonorgestrel/ Ethinyl Estradiol
Levonorgestrel/Ethinyl Estradiol/Ethinyl Estradiol
Lexapro
Lidociane 5% cream
Lidocaine Patch
Lidoderm
Linzess
Lipitor *
Liptruzet *
Livalo *
LoSeasonique *
Lotronex
Lovastatin
Lovenox *
Lunesta
Luvox CR *
Lysteda *
Mavyret ** (PA) (SP)
Maxair Autohaler *
Maxalt *
Maxalt-MLT *
Meloxicam
Menostar *
Metadate CD
Methylphenidate CD
Methylphenidate ER
Methylphenidate LA
Mevacor *
Migranal
Migranow Kit *
Minivelle
Mirtazapine
Mirtazapine Rapid Dissolve
Mobic *
Morphabond ER * (PA)
Morphine Sulfate ER (PA)
Movantik
Moxeza *
MS Contin (PA)
Mydayis *
Naptara
Naratriptan
Narcan
NebuPent
Neulasta (SP)
Neupogen (SP)
Nexium * (PA)
Norvasc *
Nucynta ER * (PA)
Nuplazid
Ocaliva **

* 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
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(PA17) prior authorization required for members who are 17 years of age or older
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# Quality Care Dosing

Odomzo
Olanzepine-Fluoxetine
Olopatadine Nasal
Olysio * (PA) (SP)
Omeprazole
Omeprazole-Sod. Bicarbonate * (PA)
OmePPI (PA)
Omontys (PA) (SP)
Ondansetron
Ondansetron ODT
Onmel *
Onsolis * (PA)
Onezetra Xsail *
Opana ER * (PA)
Oralair (PA)
Oramorph SR * (PA)
Orkambi (PA) (SP)
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 *
Pennsaid *
Pexeva *
Pioglitazone (ST)
Pioglitazone-Glimepiride (ST)
Pioglitazone-Metformin (ST)
Plegridy * (SP)
Praluent (PA) (SP)
Pravachol *
Pravastatin
Prevacid * (PA)
PrevPac *
Prilosec * (PA)
Pristiq *
Pristiq ER *
ProAir HFA
ProAir Respiclick
Procrit (PA) (SP) (SPO)
Protonix * (PA)
Proventil HFA *
Prozac *
Prozac Weekly *
Pulmicort Flexhaler
Pulmicort Respules
Qualaquin
Quartette *
Quasense
Quillichew *
Quinine Sulfate
Qutenza (SP)
QVAR
Rabeprazole
Ragwitek (PA)
Rapaflux
Rebif (SP) (SPO)
Relpax *
Remeron *
Remeron Soltab *
Repatha * (PA) (SP)
Restasis (PA)
Rexulti *
Risedronate
Ritalin LA *
Rivelsa
Rizatriptan
Rozerem
Rosuvastatin
Sancuso *
Sarafem *
Saxenda (PA)
Seasonique *
Seebri Neohaler *
Selferma
Serevent Diskus
Sertraline
Setlakin
Silenor *
Siliq ** (SP)
Simcor *
Simponi (PA) (SP) (SPO)
Simvastatin
Soliqua * (ST)
Sonata
Sovaldi * (PA) (SP)
Spiriva
Sporanox *
Stiolto Respimat
Strattera (PA17)
Striverdi Respimat
Suboxone
Subsys * (PA)
Subutex
Sumatriptan
Sumavel Dosepro *
Symbicort (PA)
Symbyax
Synjardy (ST)
Taltz * (PA) (SP)
Tanzeum * (ST)
Technivie * (PA) (SP)
Terazosin
Terbinafine
Terbinex *
Tivorbex *
Toujeo Solostar
Tranexamic Acid
Tremfya ** (SP)
Tresiba *
Treximet *
Trintellix *
Triptodur (SP)
Trulance *
Trulicity (ST)
Tudorza
Tymlos (PA) (SP) (SPO)
Utibron Neohaler *
Valacylovir
Valtrex
Varubi
Venlafaxine ER capsule
Venlafaxine ER tablet
Ventolin HFA *
Viberzi *
Victoza (ST)
Viekira PAK * (PA) (SP)
Viekira XR * (PA) (SP)
Vigamox *
Viibryd *
Vivelle
Vivelle-Dot
Vivitrol (SPO)
Vivlodex *
Voltaren gel
Vosevi (PA) (SP)
Vytorin *
Vyvanse *
Wellbutrin SR *

* 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
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(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
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(ST) step therapy required

# Quality Care Dosing

Wellbutrin XL *
Xartemis XR * (PA)
Xeljanz (PA) (SP)
Xeljanz XR (PA) (SP)
Xermelo
Xiidra (PA)
Xifaxan
Xigduo * (ST)
Xopenex HFA *
Xtampza ER * (PA)
Xultophy * (ST)
Xuriden
Yosprala * (PA)
Zaleplon
Zarxio
Zegerid * (PA)
Zembrace Symtouch *
Zepatier * (PA) (SP)
Zetia *
Zinbryta * (SP)
Zocor *
Zofran *
Zofran ODT *
Zohydro ER * (PA)
Zolmitriptan
Zolmitriptan ODT
Zoloft *
Zolpidem
Zolpidem CR
Zolpidem SL
Zolpimist *
Zomig *
Zomig ZMT *
Zubsolv
Zuplenz *
Zydelig (PA) (SP)
Zynbryta **
Zymar *
Zymaxid *

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(SP) medication is part of the specialty pharmacy benefit
(SPO) pharmacy benefit only
(ST) step therapy required

# 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.

Another part of our prior authorization program is step therapy. Please refer to the Step Therapy section in this brochure for more information.

This list of medications that require prior authorization is up-to-date as of January 1, 2018, and may change from time to time.

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

# Prior Authorization

Abstral * (QCD)
AcipHex * (QCD)
Actemra (SP)
Acthar (SP)
Actiq * (QCD)
Adcirca (SP)
Addyi *
Advair HFA (QCD)
Air Duo * (QCD)
Alecensa (SP)
Amevive (MBO)
Amodafanil
Amphetamines (e.g Amphetamine, Methamphetamine, Liquadd, Procentra)
Ampyra (QCD) (SP)
Aralast (MBO)
Aralast NP (MBO)
Aranesp * (QCD) (SP) (SPO)
Arymo ER * (QCD)
Atomoxetine (QCD)
Avinza * (QCD)
Belbuca * (QCD)
Belviq (QCD)
Belviq XR (QCD)
Binosto *
Boniva syringe * (SP)
Botox/Botulinum Toxin (SP)
Buprenex
Buprenorphine patch (QCD)
Butrans (QCD)
Ceredase (MBO)
Cerezyme (SP)
Cimzia (SP) (SPO)
Cinqair (SP)
Cinryze (MBO)
Contrave (QCD)
Cotellic (SP)
Cosentyx (SP) (SPO)
Daklinza * (QCD) (SP)
Desoxyn (PA17)
Dexilant * (QCD)
Dexedrine (PA17)
Dextroamphetamines (PA17)
Dificid *
Diskets
Dulera (QCD)
Dolophine
Dupixent (SP)
Duragesic * (QCD)
Dysport (SP)
Egrifta (SP)
Elidel
Embeda * (QCD)
Enbrel (QCD) (SP) (SPO)
Enteral formula
Entyvio * (SP)
Epclusa (QCD) (SP)
Epogen * (QCD) (SP) (SPO)
Erbitux (MBO)
Esomeprazole (QCD)
Esomeprazole Strontium * (QCD)
Euflexxa * (SPO)
Evekeo *
Exalgo * (QCD)
Eylea (MBO)
Factor VIII, VIIIa, IX, XIII (MBO)
Farydak (SP)
Fentanyl patch (QCD)
Fentanyl oral/mucosal (QCD)
Fentora * (QCD)
Fluticasone/Salmeterol (QCD)
Forteo (QCD) (SP) (SPO)
Gel-One * (SPO)
Gelsyn-3 * (SPO)
Genotropin * (SP) (SPO)
Geref
Grastek (QCD)
Harvoni (QCD) (SP)
Hetlioz (QCD)
Humatrope (SP) (SPO)
Humira (QCD) (SP) (SPO)
Hyalgan * (SPO)
Hydromorphone ER
Hydroxyprogesterone (SP)
Hymovis * (SPO)
Hysingla ER * (QCD)
Ibandronate injection/ syringe (SP)
Ibrance (QCD) (SP)
Idhifa (SP)
Ilaris (SP) (SPO)
Increlex (SP) (SPO)
Incruse Ellipta (QCD)
Inflectra (SP)
Interferons (alpha, gamma)
Iplex
IV Immunoglobulin (MBO)
Juxtapid (SP)
Kadian * (QCD)
Kalydeco (QCD) (SP)
Kevzara (SP)
Kineret (SP) (SPO)
Kisqali (SP)
Kisqali Femara (SP)
Kynamro (SP)
Lazanda * (QCD)
Lenvima (SP)
Leukine (SP)
Liquadd (PA17)
Lucentis (MBO)
Lynparza
Lyrica
Macugen (MBO)
Mavyret ** (QCD) (SP)
Makena (SP)
Mekinist
Methadone
Methadose
Methamphetamine (PA17)
Modafinil
Monovisc * (SPO)
Morphabond ER * (QCD)
Morphine Sulfate CR (QCD)
Morphine Sulfate ER (QCD)
MS Contin (QCD)
Myalept (SP)
Myobloc (SP)
Nexium * (QCD)
Norditropin * (SP) (SPO)
Nucala (SP)
Nucynta ER * (QCD)
Nutritional Supplements
Nutropin (SP) (SPO)
Nuvigil * (PA17)
Olysio * (QCD) (SP)
Omeprazole-Sod. Bicarbonate * (QCD)
OmePPI (QCD)
Omnitrope (SP) (SPO)
Omontys (SP) (SPO)
Onsolis * (QCD)
Opana ER * (QCD)
Opdivo (SP)
Oralair (QCD)
Oramorph SR * (QCD)
Orencia * (SP)

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# Prior Authorization

Orkambi (SP)
Orthovisc * (SPO)
Otezla (QCD) (SP)
Oxycodone ER (QCD)
Oxycontin (QCD)
Oxymorphone ER (QCD)
Praluent (QCD) (SP)
Preservative-Free Morphine (MBO)
Prevacid * (QCD)
Prilosec * (QCD)
Procentra (PA17)
Procrit (QCD) (SP) (SPO)
Prolastin (MBO)
Prolastin C (MBO)
Proleukin (SP)
Prolia (SP) (SPO)
Protonix * (QCD)
Protopic
Protropin (SPO)
Provigil (PA17)
Ragwitek (QCD)
Raptiva
Reclast (MBO)
Regranex
Remicade (SP)
Renflexis (SP)
Repatha * (QCD) (SP)
Respiratory SyncytialVirus IG/ Synagis (SP)
Restasis (QCD)
Revatio * (SP)
Rituxan (SP)
Rydapt (SP)
Saizen * (SP) (SPO)
SaizenPrep * (SP) (SPO)
Saxenda (QCD)
Serostim (SP) (SPO)
Sildenafil (SP)
Simponi (QCD) (SP) (SPO)
Simponi Aria (SP)
Sovaldi * (QCD) (SP)
Spinraza (SP)
Stelara (SP) (SPO)
Strattera (PA17) (QCD)
Subsys * (QCD)
Supartz * (SPO)
Symbicort (QCD)
Synvisc * (SPO)
Synvisc One * (SPO)
Tacrolimus (topical)
Tafinlar (SP)
Taltz * (QCD) (SP)
Technivie * (QCD) (SP)
Tev-Tropin * (SP) (SPO)
Topical Retinoic Acid Derivatives (e.g. Retin-A) (PA30)
TPN (total parenteral nutrition) (MBO)
Tymlos (QCD) (SP) (SPO)
Tysabri (MBO)
Venclexta (SP)
Vectibix (MBO)
Victrelis (SP)
Viekira XR * (QCD) (SP)
Viekira PAK * (QCD) (SP)
Vosevi (QCD) (SP)
Xalkori (SP)
Xartemis XR * (QCD)
Xeljanz (QCD) (SP)
Xeljanz XR (QCD) (SP)
Xeomin (SP)
Xgeva (SP) (SPO)
Xiaflex (MBO)
Xiidra (QCD)
Xolair (SP)
Xtampza ER (QCD)
Yosprala * (QCD)
Zegerid * (QCD)
Zelboraf (SP)
Zenzedi (PA17)
Zepatier * (QCD) (SP)
Zohydro ER * (QCD)
Zomactin * (SP) (SPO)
Zometa (MBO)
Zorbtive (SPO)
Zydelig (QCD) (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 provide 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.

## Network Pharmacy Information

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

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

### AllCare Plus
1-855-880-1091
allcarepluspharmacy.com

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

### Onco360, Oncology Pharmacy Solutions
1-877-662-6633
onco360.com

### AllianceRx Walgreens Prime
1-800-649-2872 / Fax: 866-935-0719
alliancerxwp.com

## Network Pharmacy Information for Medications Most Commonly Used for Fertility

### AcariaHealth Fertility
1-877-928-5125 / Fax: 866-927-9870
acariahealth.com/index.php/explore/infertility

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

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

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

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

### AllianceRx Walgreens Prime
1-800-424-9002
alliancerxwp.com

This list is up-to-date as of January 1, 2018, and may change from time to time.

You can find the latest information about your medications and look up pharmacy contact information by visiting **bluecrossma.com/pharmacy**.

# Specialty Pharmacy Medications

## 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 Folinate
Camptosar
Carboplatin
Carimune (PA)
Cerubidine
Cerezyme (PA)
Cimzia * (PA) (SPO)
Cinqair (PA)
Cisplatin
Cladribine
Copaxone (QCD) (SPO)
Cosentyx (PA) (SPO)
Cosmegen
Cuvitru (PA)
Cyclophosphamide
Cyramza
Cytarabine
Cytogam (PA)
Cytoxan
Dacarbazine
Dactinomycin
Darzalex
Daunorubicin HCL
DaunoXome
DDAVP *
Depocyt
Desmopressin Acetate
Dexrazoxane
Docefrez
Docetaxel
Doxil
Doxorubicin HCl
DTIC-Dome
Dupixent (PA)
Dysport (PA)
Egrifta (PA)
Eligard
Ellence
Eloxatin
Elspar
Empliciti
Enbrel (PA) (QCD) (SPO)
Entyvio * (PA)
Epirubicin
Epogen * (PA) (QCD) (SPO)
Ethyol
Etopophos
Etoposide
Extavia * (QCD) (SPO)
Faslodex
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)
Glatiramer (QCD) (SPO)
Glatopa (QCD) (SPO)
Granix
Herceptin
Hizentra (PA)
Humatrope (PA) (SPO)
Humira (PA) (QCD) (SPO)
Hycamtin
Hydroxyprogesterone (PA)
HyQvia (PA)
Ibandronate injection/ syringe (PA)
Idamycin PFS
Idarubicin
Ifex
Ifosfamide
Ifosfamide/Mesna
Ilaris (PA) (SPO)
Imfinzi
Increlex (PA) (SPO)
Inflectra (PA)
Intron A (PA) (SPO)
Irinotecan
Istodax
Kenalog
Kevzara (PA)
Keytruda
Kineret (PA) (SPO)
Kynamro
Lemtrada * (SPO)
Levoleucovorin
Leucovorin Calcium
Leukine (PA)
Leuprolide Acetate (SPO)
Leustatin
Lipodox
Lipodox-50
Lupaneta Pack
Lupron Depot
Lupron Depot-Ped
Makena (PA)
Marqibo
Mesna
Mesnex
Methotrexate
Mircera
Mitomycin
Mitoxantrone
Mozobil
Mustargen

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# Specialty Pharmacy Medications

Myalept (PA)
Mylotarg
Myobloc (PA)
Naptara
Navelbine
Neosar
Neulasta (QCD)
Neumega
Neupogen (QCD)
Nipent
Norditropin * (PA) (SPO)
Norditropin Flexpro * (PA) (SPO)
Norditropin Nordiflex * (PA) (SPO)
Novantrone
Nplate
Nucala (PA)
Nutropin (PA) (SPO)
Nutropin AQ (PA) (SPO)
Nutropin AQ Nuspin (PA) (SPO)
Octagam (PA)
Octreotide injection (SPO)
Omnitrope * (PA) (SPO)
Oncaspar
Opdivo (PA)
Orencia * (PA)
Otrexup *
Oxaliplatin
Paclitaxel
Pamidronate
Pamidronate disodium
Pegasys (QCD) (SPO)
Peg-Intron (QCD) (SPO)
Photofrin
Plegridy * (QCD)
Praluent (PA) (QCD)
Privigen (PA)
Procrit (PA) (QCD) (SPO)
Proleukin (PA)
Prolia (PA) (SPO)
Radicava
Rebif (QCD) (SPO)
Remicade (PA)
Renflexis (PA)
Repatha * (PA) (QCD)
Revatio * (PA)
Rituxan (PA)
Ruconest
Saizen * (PA) (SPO)
SaizenPrep * (PA) (SPO)
Sandostatin (SPO)
Sandostatin-LAR
Serostim (PA) (SPO)
Signafor
Signafor LAR
Siliq ** (QCD)
Simponi (PA) (QCD) (SPO)
Simponi Aria * (PA)
Simulect
Somatuline
Somavert (SPO)
Spinraza (PA)
Stelara (PA) (SPO)
Sylatron (PA)
Sylvant
Synagis (PA)
Synribo
Taltz * (PA) (QCD)
Tarabine
Taxol
Taxotere
Tecentriq
Teniposide
Tepadina
Tev-Tropin * (PA) (SPO)
TheraCys
Thiotepa
Thyrogen
Toposar
Totect
Trelstar
Trelstar LA
Trelstar Depot
Tremfya ** (QCD)
Triptodur (QCD)
Tymlos (PA) (QCD) (SPO)
Unituxin
Valstar
Velcade
Vimizim
VinBLAStine
Vincasar PFS
VinCRIStine
Vinorelbine
Vivitrol
Vumon
Xeomin (PA)
Xgeva (PA) (SPO)
Xolair (PA)
Zaltrap
Zanosar
Zarxio
Zinbryta * (QCD)
Zinecard
Zoladex
Zomacton * (PA) (SPO)
Zorbtive (PA) (SPO)

## Oral Medications

Adcirca (PA)
Adempas
Afinitor
Alcensa
Alkeran
Alunbrig
Ampyra (PA) (QCD)
Aubagio
Bethkis
Bosulif
Cabometyx
Capecitabine
Carbaglu
Cayston
Cerdelga
Cometriq
Copegus (SPO)
Cotellic
Cystagon
Cytoxan
Daklinza * (PA) (QCD)
Daraprim
Duopa
Epclusa (PA) (QCD)
Erivedge
Esbriet
Erivedge
Etoposide
Exjade
Farydak (PA)
Gilenya (QCD)
Gilotrif
Gleevec
Harvoni (PA) (QCD)
Hetlioz (PA)
Hycamtin
Ibrance (PA)
Iclusig
Idhifa (PA)

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# Specialty Pharmacy Medications

Imatinib
Imbruvica
Inlyta
Iressa
Jadenu
Jakafi
Juxtapid (PA)
Kalydeco (PA) (QCD)
Kisqali (PA)
Kisqali Femara (PA)
Kitabis PAK *
Korlym
Kuvan
Lenvima (PA)
Letairis
Lonsurf
Mavyret ** (PA) (QCD)
Mekinist
Mesnex
Moderiba
Nerlynx
Nexavar
Ninlaro
Northera *
Nuplazid
Odomzo
Ofev
Oforta
Olysio * (PA) (QCD)
Opsumit
Orenitram
Orfadin (SPO)
Orkambi (PA) (QCD)
Otezla (PA) (QCD)
Otezla Starter Pack (PA) (QCD)
Pomalyst
Procysbi
Promacta
Pulmozyme (SPO)
Ravicti
Rebetol (SPO)
Revatio * (PA)
Revlimid
Ribapak (SPO)
Ribasphere (SPO)
Ribatab
Ribavirin (SPO)
Rilutek
Riluzole
Rubraca
Rydapt (PA)
Sabril
Samsca
Sildenafil (PA)
Sovaldi * (PA) (QCD)
Sprycel
Stivarga
Sucraid
Sutent
Tafinlar (PA)
Tagrisso
Tarceva
Tasigna
Tecfidera
Technivie * (PA) (QCD)
Temodar
Temozoloamide
Tetrabenazine
Thalomid
TOBI ampules (SPO)
TOBI-Podhaler (SPO)
Tobramycin ampules
Tracleer
Tykerb
Tyvaso
Uptravi
Veltassa *
Venclexta (PA)
Viekira PAK * (PA) (QCD)
Viekira XR * (PA) (QCD)
Vigabatrin
Vosevi (PA) (QCD)
Votrient
Xalkori (PA)
Xeljanz (PA) (QCD)
Xeljanz XR (PA) (QCD)
Xeloda
Xenazine
Xtandi
Xyrem
Zavesca
Zelboraf (PA)
Zepatier * (PA) (QCD)
Zolinza
Zydelig (PA) (QCD)
Zykadia (PA)
Zytiga

## Topical

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

## Fertility Medications

Bravelle * (SPO)
Cetrotide (SPO)
Clomid
Clomiphene
Endometrin
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)
Makena (PA)
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, 2018, and may change from time to time.

For the most up-to-date list of medications that require step therapy, please visit our website **bluecrossma.com/pharmacy,** click on **Pharmacy Management Program**, and proceed to **Step Therapy**.

# Step Therapy

## Diabetes Management

Adlyxin * (QCD)
Alogliptin *
Alogliptin/Metformin *
Alogliptin/Pioglitazone *
ACTOplus Met (QCD)
ACTOplus Met XR (QCD)
Actos (QCD)
Avandamet (QCD)
Avandaryl
Avandia (QCD)
Byetta (QCD)
Bydureon (QCD)
Duetact
Farxiga * (QCD)
Fortamet *
Glucophage *
Glucophage XR *
Glumetza *
Glyxambi * (QCD)
Invokana (QCD)
Invokamet (QCD)
Invokamet XR (QCD)
Janumet
Janumet XR
Januvia
Jardiance
Jentadueto *
Jentadueto XR *
Kazano *
Kombiglyze XR
Metformin Film Coated ER *
Metformin ER *
Nesina *
Onglyza
Oseni *
Pioglitazone (QCD)
Pioglitazone-Glimepiride (QCD)
Pioglitazone-Metformin (QCD)
Prandin *
Prandimet *
Soliqua * (QCD)
Synjardy
Tanzeum * (QCD)
Tradjenta *
Trulicity (QCD)
Victoza (QCD)
Xigduo * (QCD)
Xultophy * (QCD)

## Glaucoma

Lumigan
Rescula *
Travatan
Travatan Z
Xalatan

## Osteoporosis Treatment (Oral)

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

## Pain Relievers (Cox II Inhibitors)

Capxib *
Celebrex (QCD)
Celecoxib (QCD)
Lidoxib *

## Prostate Treatment

Avodart
Jalyn
Proscar *

## 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

Axiron
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 medication is approved, it will be covered at the highest tier. 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, 2018, 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, **bluecrossma.com/medications** and proceed to the **Medications That Are Not Covered** section.

# Non-Covered Medication

Abilify
Abilify DiscMelt
Abilify Maintenna
Absorica
Abstral (PA) (QCD)
Acanya
Accolate
Accu-Chek diabetic testing supplies (QCD)
Accucaine
AccuNeb
Accupril
Accuretic
Accutane
Aceon
AcipHex (PA) (QCD)
Acticlate
Actigall
Actiq (PA) (QCD)
Active Injection D
Active-PAC
Activella
Acular (QCD)
Acular LS (QCD)
Acuvail
Aczone
Adalat CC
Adazin
Adderall
Addyi (PA)
Adlyxin (QCD) (ST)
Adoxa CK
Adoxa TT
Advanced Allergy Collection Kit
Advocate Redi-Code diabetic testing supplies (QCD)
Adyphren
Adzenys XR (QCD)
Aerobid (QCD)
Aerobid-M (QCD)
Aerospan (QCD)
Agoneaze
Air Duo (PA) (QCD)
Airet
Akynzeo (QCD)
Alcortin-A
Aleveer
Alivycin Plus Kit
Alivycin Antipruritic SG gel
Alodox
Alogliptin (ST)
Alogliptin/Metformin (ST)
Alogliptin/Pioglitazone (ST)
Aloquin
Alora (QCD)
Alrex (QCD)
Alsuma (QCD)
Altabax
Altace
Altoprev (QCD)
Aluvea
Alvesco (QCD)
Ambien (QCD)
Ambien CR (QCD)
Amrix
Amturnide
Ana-Lex
Anafranil
Analpram Advanced
Analpram-E kit
Angeliq
Anodyne LPT
Antara
Anusol HC Suppository
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)
Arymo ER (PA) (QCD)
Armonair RespiClick (QCD)
Arze-Ject-A kit
Asacol HD
Ascensia diabetic testing supplies (QCD)
Asmanex Twisthaler (QCD)
Assure diabetic testing supplies (QCD)
Astepro (QCD)
Astero
Atacand
Atacand HCT
Atelvia DR (QCD) (ST)
Ativan
Atopiclair
Atralin
Atrapro Dermal Spray
Atrapro CP
Atrapro Hydrogel
Atropen
Augmentin XR
Aurstat
Auryxia
Auvi-Q (QCD)
Avalide
Avapro
Avelox
Avidoxy
Avidoxy DK
Avinza (PA) (QCD)
Avita
Axert (QCD)
Axid
Azasite
Azmacort (QCD)
Azor
B-D diabetic testing supplies (QCD)
Basaglar (QCD)
Belsomra (QCD)
Benicar
Benicar HCT
BenzaClin gel
BenzaClin kit
BenzaClin pump
Besivance
Betaloan SUIK kit
Bevespi AeroSphere (QCD)
BG-Star diabetic testing supplies (QCD)
Binosto (QCD) (ST)
Bionect
Boniva syringe (PA) (SP)
Boniva tablets (QCD) (ST)
Bravelle (SP)
Breo Ellipta (QCD)
Brevicon
Brilinta
Brisdelle (QCD)
Bromday
Bromsite
Brovana
Bystolic
Byvalson

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# Non-Covered Medication

Caduet (QCD)
Calcitriol Topical
Cambia
Caphosol
Capoten
Capxib (ST)
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
Ceracade Skin Barrier
Ceramax
Cesamet (QCD)
Cetraxel
Chenodal
Chibroxin Ocumeter
Cimzia (PA) (SP) (SPO)
Cipro-XR
Cleanse and Treat
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
Cool diabetic testing supplies (QCD)
Coreg
Coreg CR
Corlanor
Cosopt PF
Cotempla XR ODT (QCD)
Cozaar
Crestor (QCD)
CVS Advanced diabetic testing supplies (QCD)
Cymbalta (QCD)
D-Care 100X
Daklinza (PA) (QCD) (SP)
Daliresp
Darvocet N-100
Daxbia
Daypro
Daytrana
DDAVP
Delzicol
Delzicol DR
Demulen
Depo-Sub Q Provera 104
Derma-Smoothe/FS
Dermacin RX Cinolone-1 CPI
Dermacin Rx Chlorhexacin
Dermacin Rx Empraciane
Dermacin RX Prizopak
Dermacin RX PHN
Dermacin RX Silpak
Dermacin Silazone Pharmpak
Dermacin RX Surgical Pharmpak
Dermacin Rx Therazole Pak
Dermacin RX ZRM
Dermapak Plus Kit
Dermasilk RX SDS
Dermasorb-AF
Dermasorb-HC
Dermasorb-TA
Dermasorb-XM
Dermawerx SDS
Dermawerx Surgical Plus Pack
Dermazone
Dermazyl
DermOtic
Desogen
Desonil + Plus
DesOwen kit
Desvenlafaxine ER (QCD)
Detrol (ST)
Detrol LA (ST)
Dexedrine (PA)
Dexilant (PA) (QCD)
Diclo-Xrylix Sheet Kit
Diclotral
Diclozor
Dificid (PA)
Dilacor XR
Dilaudid
Diovan
Diovan HCT
Dipentum
Dispermox
Ditropan (ST)
Ditropan XL (ST)
Divigel
DM2 Kit
DMT Suik
Dolotranz
Doubledex
Duac
Duac CS
Duavee
Duexis
Duragesic (PA) (QCD)
Durezol
Duzallo
Dyloject
Dynabac
Dynacin
Dynacirc
Dynacirc CR
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
Edarbyclor

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# Non-Covered Medication

Edluar (QCD)
Effexor
Effexor XR (QCD)
Elenza
Elestrin
Eletone
Elizia
Embeda (QCD)
Embrace diabetic testing supplies (QCD)
Emsam
Enablex (ST)
Enjuvia
Entresto
Entyvio (PA) (SP)
Epaned
EpiCeram
Epiduo
Epiduo Forte
Epinephrine Snap-V
Episil
Episnap Convenience Kit
Epogen (PA) (SP) (SPO)
Epy Kit
Equetro
Ertaczo
Esomeprazole Strontium (QCD) (ST)
Estrace
Estrasorb (QCD)
Estrogel (QCD)
Eucrisa
Euflexxa (PA) (SPO)
Evamist (QCD)
Evekeo (PA)
Evoclin
ExacTech diabetic testing supplies (QCD)
Exalgo (PA) (QCD)
Exforge
Exforge HCT
Extavia (SP)
Extina
Factive
Falessa kit
Famvir (QCD)
Fanapt
Farxiga (ST)
FazaClo
Femring
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
Flolipid
Flumist
Fluoroplex
FML Forte
Focalin
Focalin XR (QCD)
Follistim AQ (SP)
Fora V12 diabetic testing supplies (QCD)
Forfivo XL (QCD)
Fortamet (ST)
Fortesta (ST)
Fosamax (QCD) (ST)
Fragmin (QCD)
Freestyle diabetic testing supplies (QCD)
Frova (QCD)
Ganirelix (SP) (SPO)
Garamide
Gel-One (PA) (SPO)
Gelclair
Gelnique (ST)
Gelsyn-3 (PA) (SPO)
GelX
Genotropin (PA) (SP) (SPO)
Geodon
Genestrip diabetic testing supplies (QCD)
GE 100 diabetic testing supplies (QCD)
Gialax
Giazo
Glucocard diabetic testing supplies (QCD)
Glucometer diabetic testing supplies (QCD)
Glucophage
Glucophage XR
Glumetza
Glyxambi (QCD) (ST)
Gmate diabetic testing supplies (QCD)
GNP diabetic testing supplies (QCD)
Gocovri
GoLytely
Halonate
Halotin
Healthpro diabetic testing supplies (QCD)
Helidac
Horizant
HPR
HPR Plus
HPR Plus Hydrogel Kit
Humana True Metrix diabetic testing supplies (QCD)
Hyalgan (PA) (SPO)
Hydrocortisone-Lidocaine kit
Hylase
Hylatopic
Hylatopic Plus
Hylatopic Plus-Aurstat
Hylira
Hymovis (PA) (SPO)
Hysingla ER (PA) (QCD)
Hytrin (QCD)
Hyzaar
IB-Stat
IC400 kit
IC800 kit
Ilevro
Imuran
Inderal LA
Inderal XL
Inflamma K
Innohep
InnoPran XL
Intermezzo (QCD)
Intuniv
Invega
Iquix
Irenka DR (QCD)
Istalol
Jentadueto (ST)
Jentadueto XR (ST)

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# Non-Covered Medication

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)
Lamictal ODT
Lamisil (QCD)
Lamisil Granules (QCD)
Latuda
Lazanda (PA) (QCD)
Lemtrada (SP) (SPO)
Lescol (QCD)
Lescol XL (QCD)
Leva Set
Levalbuterol HFA (QCD)
Levaquin
Levemir (QCD)
Levlen
Lexapro (QCD)
Lexxel
Liberty diabetic testing supplies (QCD)
Lido-Prilo Caine Pak
Lidociane HC Kit
Lidocodex I
Lidodextrapine
Lidopac
Lidopril
Lidotrans 5 Pac
Lidotrex
Lidovex
Lidovir
Lidoxib (ST)
Lipitor (QCD)
Lipofen
Liprozone Pak
Liptruzet (QCD)
Livalo (QCD)
Livixil PAK
Lodine
Lodine XL
Lofibra
Lopressor
Loprox Kit
Lorabid
Lorenza
LoSeasonique (QCD)
Lotensin
Lotensin HCT
Loutrex
Lovaza
Lovenox (QCD)
Lunesta (QCD)
Luvox CR (QCD)
Luzu
Lysteda (QCD)
Lytensopril
MAC Patch
Marvona SUIK
Mavik
Maxair Autohaler (QCD)
Maxalt (QCD)
Maxalt-MLT (QCD)
Maxipime
MB Hydrogel
Medolor Kit
Medroloan SUIK
Medroloan II SUIK
Medrox Patch
Megace ES
Menostar (QCD)
Mentho-Caine Kit
Mesalamine HD
Metaglip
Metformin ER (ST)
Metformin Film Coated ER (ST)
Metozolv ODT
Metrogel kit
Mevacor (QCD)
Micardis
Micardis HCT
Microdot diabetic testing supplies
Migranow
Minastrin Fe Chewable
Minocin
Minocin Combo Pack
Mirapex ER (ST)
Mobic (QCD)
Momexin
Monodox
Monopril
Monopril HCT
Monovisc (PA) (SPO)
Morgidox Kit
Morphabond ER (PA) (QCD)
MoviPrep
Moxatag
Moxeza (QCD)
Mydayis (QCD)
Myoxin
Namzaric
Naprelan
Naprelan CR
Napropak Cool Kit
Naprosyn
Naprosyn EC
Nascobal
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
Noxipak
NuCort
Nucynta
Nucynta ER (PA) (QCD)
Nudiclo SoluPak
Nudiclo TabPak
NuLytely

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# Non-Covered Medication

Nusurgepak Surgical Prep
Nutraseb
NutriaRx Pak
NutriDox
Nuvessa
Nuvigil (PA)
Nyata Kit
Ocudox kit
Oleptro ER
Olux
Olysio (PA) (QCD) (SP)
Omnicef
Omnitrope (PA) (SP) (SPO)
Onexton
Onmel (QCD)
Onsolis (PA) (QCD)
Onzetra Xsail (QCD)
Opana
Opana ER (PA) (QCD)
Optase
Optium diabetic testing supplies (QCD)
Oracea
Oramorph SR (PA) (QCD)
Orapred ODT
Oravig
Orencia (PA) (SP)
Oroxin
Ortho-Prefest
Orthovisc (PA) (SPO)
Oseni (ST)
Osmoprep
Osphena
Otrexup (SP)
Ovcon
Oxaydo
Oxecta
Oxytrol (ST)
P-Care
P-Care K
P-Care M
P-Care MG
P-Care X
Pain Relief Patch
Paingo KFT
Pamelor
Pamine FQ
Pancreaze
Paptase
Patanase (QCD)
Paxil (QCD)
Paxil CR (QCD)
PCE
PCE Dispertab
Pediaderm AF
Pediaderm HC
Pediaderm TA
PediPak
Penlac (QCD)
Pennsaid (QCD)
Pepcid
Percocet
Pertzye
Pexeva (QCD)
Pharmacist Choice diabetic testing supplies (QCD)
Picato
Plaquenil
Plegridy (QCD) (SP)
POD Care 100K
POD Care 100KG
PR-Cream
Pram-HCA
Pramcort
Pramosone E
PrandiMet (ST)
Pravachol (QCD)
Precision QID diabetic supplies (QCD)
Precision X-Tra diabetic supllies (QCD)
Premium diabetic testing supplies (QCD)
Prepopik
Presera
Prestalia
Prestige diabetic testing supplies (QCD)
Prevacid (PA) (QCD)
Prevacid NapraPAC
PrevPac
Prilolid
Prilosec (PA) (QCD)
Prinivil
Prinzide
Pristiq (QCD)
Pristiq ER (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
Qbrelis
Quartette (QCD)
Quillichew ER
Quillivant XR
Quinja
Quixin
RadiaPlex Rx
Radigel
Raniclor
Rapaflo
Rasuvio
Rayaldee
Rayos
Readysharp Betamethasone
Readysharp Bupivicaine
Readysharp Dexamethasone
Readysharp Ketorolac
Readysharp Lidocaine
Readysharp Methylprednisolone
Readysharp Triamcinolone
Reciphexamine
Recothrom
Regenecare
Relador Pak
Relador Pak Plus
Relafen
Relion diabetic testing supplies (QCD)
Relpax (QCD)
Relyyks
Relyyt
Remeron (QCD)
Remeron Soltab (QCD)
Renovo

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# Non-Covered Medication

Repatha (PA) (QCD) (SP)
Requip (ST)
Requip XL (ST)
Rescula (ST)
Restoril
Retin-A Micro (PA30)
Revatio (PA) (SP)
Rexulti (QCD)
Rinnovi
Risperdal M-Tab
Ritalin
Ritalin LA (QCD)
Ritalin SR
Rosadan
Rosanil
Rybix ODT
Rynatan
Rytary ER
Rythmol
Ryzolt
Saizen (PA) (SP) (SPO)
SaizenPrep (PA) (SP) (SPO)
Salicylic Acid 6% Kit
Salicylic Acid-Ceramide kit
Salkera
Salvax
Salvax Duo
Salvax Duo Plus
SanadermRx Skin Repair
Sanctura (ST)
Sanctura XR (ST)
Sancuso (QCD)
Saphris
Sarafem (QCD)
Savaysa
Scalacort
Scar
Seasonique (QCD)
Sebuderm
Seebri Neohaler (QCD)
Senophylline
Sernivo
Seroquel
Seroquel XR
Silazone-II
Silenor (QCD)
Silvera
Silvrstat
Simbrinza
Simcor (QCD)
Sinelee
Sinemet
Singulair
Sitavig
Skelid
Sklice
Smart Sense diabetic testing supplies (QCD)
SmartRx Gaba-V
SmartRx GabaKit
Sof-Tact diabetic supplies (QCD)
Solaice
Solaraze
Soliqua (QCD) (ST)
Solodyn
Soltamox
Solupak
Solus V2 diabetic testing supplies (QCD)
Soma
Sonata (QCD)
Soolantra
Sovaldi (PA) (QCD) (SP)
Spectracef
Sporanox (QCD)
Spritam
Sprix
Stavzor
Striant
Subsys (PA) (QCD)
Suclear
Sular
Sumadan
Sumavel Dosepro (QCD)
Sumaxin
Sumaxin CP
Sumaxin TS
Supartz (PA) (SPO)
Suprep
Sure Result Tak Pack
Sustol
Synalar Combo-Pack
Synalar TS
Synvexia TC
Synvisc (PA) (SPO)
Synvisc-One (PA) (SPO)
Tagamet
Taltz (PA) (QCD) (SP)
Tanzeum (QCD) (ST)
Targadox
Taytulla
Technivie (PA) (QCD) (SP)
Tekamlo
Tekturna
Tekturna HCT
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
Tolak
Tornalate
Toronova SUIK
Toronova II SUIK
Toviaz (ST)
Tradjenta (ST)
Tranxene T-Tab
Tranzarel
Tresiba (QCD)
Tretin-X (PA)
Treximet (QCD)
Trezix
Tribenzor
Tricor
Triglide

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# Non-Covered Medication

Tri-Levlen
Trilipix
Trilipix DR
Triloan SUIK
Triloan II SUIK
Trinalin
Trintellix (QCD)
Tri-Norinyl
TriOxin
Tri-Sila Topical
Tritec
Tropazone
True Metrix diabetic supplies (QCD)
TrueTest diabetic supplies (QCD)
TrueTrack diabetic supplies (QCD)
Trulance (QCD)
Twynsta
Ultracet
Ultram
Ultram ER
Ultrasal ER
Ultravate PAC
Ultravate X
Ultressa
Unistrip 1 diabetic testing supples (QCD)
Up & Up diabetic testing supplies (QCD)
Uramaxin
Urea kit
Utibron NeoHaler (QCD)
Vacustim Silver Kit
Valium
Valturna
Vanos
Vantin
Vascepa
Vaseretic
Vasolex
Vasotec
Vectical
Vectrin
Velma
Velphoro
Veltassa (SP)
Veltin (PA30)
Ventolin HFA (QCD)
Veregen
Vexa
Vexol
Viberzi (QCD)
Viekira XR (PA) (QCD) (SP)
Viekira PAK (PA) (QCD) (SP)
Vigamox (QCD)
Viibryd (QCD)
Vimovo
Virasal
Vivlodex
Vogelxo (ST)
Voltaren
Voltaren XR
Vopac MDS
Vraylar
Vusion
Vytorin (QCD)
Vyvanse (QCD)
Wavesense diabetic testing supplies (QCD)
Welchol
Wellbutrin
Wellbutrin SR (QCD)
Wellbutrin XL (QCD)
Whytederm Surgipak
Whytederm Trilasil Pack
Wound Debride 4% Lidocaine
Xanax
Xanax XR
X-Clair
Xartemis XR (PA) (QCD)
Xenaderm
Xerese
Xibrom
Xifaxan
Xigduo (QCD) (ST)
Xilapak
Xolegel
Xolox
Xopenex HFA (QCD)
Xopenex nebules
Xryliderm
Xrylix
Xtampza ER (PA) (QCD)
Xultophy (QCD) (ST)
Xyralid
Yosprala (PA) (QCD)
Z-Pram
Zanabin Antipruritic Gel
Zanaflex
Zantac
Zebeta
Zecuity (SP)
Zegerid (PA) (QCD)
Zelapar
Zembrace Symtouch (QCD)
Zenieva
Zepatier (PA) (QCD) (SP)
Zeruvia
Zestril
Zetia (QCD)
Zetyocaine
Ziana
Zinbryta (QCD) (SP)
Zinotic
Zinotic ES
Zipsor
Zithromax
Zmax
Zocor (QCD)
Zofran (QCD)
Zofran ODT (QCD)
Zohydro ER (PA) (QCD)
Zoloft (QCD)
Zolpimist (QCD)
Zomacton (PA) (SPO)
Zomig (QCD)
Zomig ZMT (QCD)
Zontivity
Zorvolex
Zovirax
Zuplenz (QCD)
Zurampic
Zyflo
Zyflo CR
Zymar (QCD)
Zymaxid
Zypram
Zyprexa
Zyprexa IM
Zyprexa Relprevv
Zyprexa Zydis
Zytopic

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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

# Medication Resource List Index

# Medication Resource List Index

# Medication Resource List Index



## E



## F

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## Q



## R



## S

# Medication Resource List Index



## T

# Medication Resource List Index

# Medication Resource List Index

# New Medication Approval Process

Our Pharmacy and Therapeutics Committee (the 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 list as they are approved by the Committee throughout the year.

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

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# You have options

# Quicker, Less Expensive Alternatives to the ER

You should always go to the nearest emergency room in a life-threatening situation. But in other cases, even for urgent injuries, you have other options that can save you time and money.

## First, Talk to Your Primary Care Provider

Unless it's a true emergency, it's always best to call your doctor's office first, even after hours. He or she may want to see you or suggest alternatives to the emergency room. If the doctor's office is closed, there may be recorded after-hours care instructions or the option to speak with an on-call nurse or doctor who can provide advice based upon your medical history. After you call your doctor, in the absence of severe symptoms, consider the options below:

| Option | What It Is | What They Can Help You With | Hours | Relative Cost | How to Find One |
|---|---|---|---|---|---|
| **Blue Care Line**[SM] | Speak with a nurse by phone. Explain your symptoms, and the nurse will help you decide what to do next. | Assessment for the treatment of:<br>• Fever<br>• Dizziness<br>• Cuts<br>• General discomfort | 24/7 | No cost | Call the Blue Care Line at **1-888-247-BLUE (2583)** |
| **Telehealth** | Real-time video visits with a doctor, when you have common conditions and it's difficult to get to the doctor's office. | • Back pain<br>• Bronchitis<br>• Cough<br>• Diarrhea<br>• Fever<br>• Rashes<br>• Respiratory infections<br>• Sinus infections<br>• Sore throat<br>• Skin conditions<br>• Urinary tract infections<br>Plus, some symptoms treated at limited service clinics and some symptoms treated at urgent care centers | 24/7 for medical care | $$ | Visit **bluecrossma.com/telehealth** to learn more. |
| **Limited Services Clinics**[1] | Clinics located within your local pharmacy that treat simple medical concerns that don't need the emergency room. | • Colds & flu<br>• Contraceptive care<br>• Earache<br>• Diarrhea<br>• Gout<br>• Headache<br>• Heartburn<br>• Indigestion<br>• Joint pain<br>• Nausea<br>• Pinkeye<br>• Sore throat<br>• Strains & sprains<br>• Yeast infection<br>• Vomiting | Days, evenings, weekends | $$ | In Massachusetts:<br>Go to **bluecrossma.com/findadoctor**<br>• Select Medical Facility<br>• Click on the Specialty tab<br>• Select Clinics, Limited Services or Urgent Care Center<br>• Outside of Massachusetts: Members can either:<br>» Type the name of the urgent care center or limited clinic in the global search box<br>» Click the Urgent Care Centers tile for a guided search option.<br>Results will be based on the location searched and present providers that participate with the member's plan. |
| **Urgent Care Centers**[2] | Local clinics that treat conditions that aren't life-threatening but require immediate treatment. | • Broken bones<br>• Digital X-rays<br>• Drug tests<br>• EKG test<br>• Lab tests<br>• Minor burns or injuries<br>• PPD/TB skin tests<br>• Pregnancy test<br>• Short-term (acute) illness<br>• Splints<br>• Stitches<br>• Sports & school physicals<br>• Shots & vaccines<br>Plus, symptoms treated at limited services clinics | Days, evenings, weekends | $$$ | |

*continued*

| | | | | | |
|---|---|---|---|---|---|
| **Emergency Room** | Full hospital service for severe symptoms that could seriously jeopardize your health or the health of another (including an unborn child). | • Possible heart attack<br>• Stroke<br>• Poisoning<br>• Loss of consciousness | 24/7 | $$$$$$ | • Call **911** or go to your nearest hospital |

1. Example: CVS Minute Clinic®˜

2. Examples: CareWell®˜' Urgent Care, Doctors Express,®˜ and Health Express

## Notes About Limited Services Clinics and Urgent Care Centers:

- If your doctor's office does not offer urgent care as part of their practice, make sure to check Find a Doctor regularly, as new limited services clinics and urgent care centers are always being added. If you're logged into MyBlue, your network will display automatically. If you're using our public Find a Doctor site, be sure to verify the name of your plan, found on your Blue Cross ID card, and click the Which Network Should I Choose? link for additional help.
- Verify that your health plan covers care at the location you choose.
- If you're outside of Massachusetts, use our Find a Doctor and Estimate Costs tool, or call Member Service at the number on the front of your Blue Cross ID card to confirm if the clinic is in our network or if you need a referral.

## Telehealth: A Convenient New Benefit

Using your computer, smartphone, or tablet, you can access Telehealth video visits to speak with a doctor anytime you need care, including after business hours and on weekends.

- Your Telehealth doctor can review your medical and behavioral health history, answer questions, and diagnose, treat, and prescribe medication.
- Check our Find a Doctor and Estimate Costs tool to find a doctor who offers Telehealth services or visit **bluecrossma.com/telehealth** to learn more about this benefit.
- To see if you have Telehealth coverage, log into MyBlue or call Member Service at the number on your ID card for more information.

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID Card (TTY: **711**).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: **711**).

ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: **711**).

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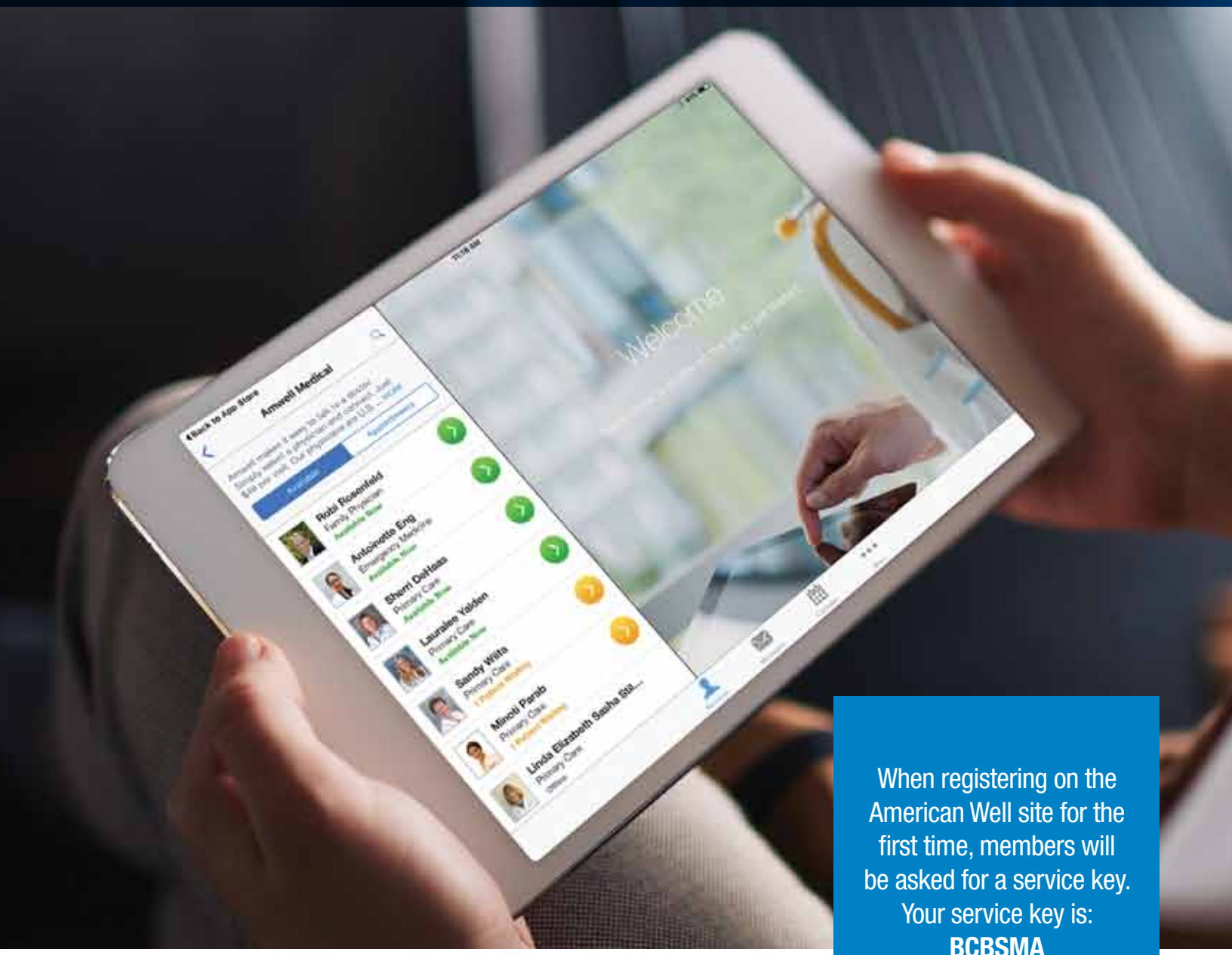
# Telehealth

## Home is where Telehealth is…
## In fact, Telehealth is wherever you need to be.




When registering on the American Well site for the first time, members will be asked for a service key. Your service key is:
**BCBSMA**


# Good news!

Your Telehealth network is now more convenient than ever.

Visit **www.bluecrossma.com/telehealth** to learn more about Telehealth.

# Quick access to see a doctor

You know how quick and easy a Telehealth video visit is. Using your smartphone, computer, or tablet, you can access Telehealth services to speak with a doctor or therapist anytime you need care including after business hours and on weekends.

Telehealth covers both medical and behavioral health care for conditions that can be treated through video visits. With Telehealth, you can see a doctor or therapist anywhere you have online access, including your home, workplace, or wherever else you may be.

# What's new is two easy ways to access Telehealth



Check with your local doctor or use our Find a Doctor tool on Member Central to identify doctors in the network who offer Telehealth services.



Visit **bluecrossma.com/telehealth** to connect to our national network of online doctors and therapists who offer Telehealth services powered by American Well, an independent company.

Since a video visit typically takes about 10 minutes, you'll have more time to spend doing the things that matter most to you!


Telehealth is: **Convenient | Secure | Easy to use**

## How to begin a Telehealth video visit

Local network doctors who offer Telehealth services will have their own way to begin a video visit. Usually, this is as simple as going to the doctor's website or using an app on your mobile device. To get started, ask your local doctor how to access his or her Telehealth service.

To access our national Telehealth service provided by American Well, visit **bluecrossma.com/telehealth** using your smart phone, computer, or any mobile device.

# What to expect from your Telehealth visit

Your doctor can review your medical and behavioral health history, answer questions, and diagnose, treat, and prescribe medication.

Telehealth medical appointments usually take about 10 minutes, while behavioral health appointments can be 30 minutes.

## The benefits of Telehealth include:

| ✔ | ✔ | ✔ | ✔ |
|---|---|---|---|
| Coverage for brief medical and behavioral health video visits (Please refer to your plan's Summary of Benefits for specific coverage details.) | Real-time interactive access totalk with a doctor or therapist through our local or national provider networks | On-demand medical professional consultations, available 24/7/365, and convenient scheduling of behavioral health visits | Quality health care experience—featuring the expansive provider network, exemplary customer service, and dedication to excellence that Blue Cross is known for |

| ✔ | ✔ | ✔ | ✔ |
|---|---|---|---|
| Eliminate exposure to others' illnesses in waiting rooms | More time to spend with family or friends | Avoid costly emergency room visits for simple conditions | Web and mobile visits supported |

## Covered Services

| Medical Convenience Care | Behavioral Health |
|---|---|
| **When to Use** | |
| Patients see a doctor online for a range of issues, including minor illnesses and injuries, symptoms from chronic conditions, and even general health and wellness concerns.<br><br>**Often reasons include:**<br>• Time savings<br>• Alternative to ER<br>• Doctor's office is closed<br>• Follow up with existing doctor | Telehealth provides reliable and convenient therapy visits with trained and certified professionals. Patients see therapists online for a variety of reasons.<br><br>**Often reasons include:**<br>• Not wanting to be seen waiting outside a therapist's office<br>• Experiencing depression or anxiety due to grief, divorce, parenthood, or other major life changes |
| **Examples of Treatable Conditions** | |
| • Bronchitis<br>• Cough<br>• Sinus infection<br>• Sore throat<br>• Urinary tract infection<br>• Fever<br>• Pinkeye<br>• Cold and flu | • Depression<br>• Anxiety<br>• Stress management<br>• Sleep difficulties<br>• Relationship challenges<br>• Child behavior difficulties<br>• Coping with chronic health problems<br>• Smoking cessation |

Telehealth delivers quality health care,
at your convenience, at any time.

Visit **www.bluecrossma.com/telehealth**
to learn more about Telehealth.

Visit **www.bluecrossma.com/telehealth** to learn more about Telehealth.

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# Blue Care line℠

We're here for you 24/7

Call **1-888-247-BLUE (2583)** for the Blue Care Line.


## We're here for you 24/7

Have a question about your health? You can talk to a professionally trained, registered nurse 24 hours a day, seven days a week. They're ready when you are—even at 4 a.m.

## Know your options

Calling the Blue Care Line is a quick way to find out if you need to see a doctor, go to an emergency room, or if you're able to treat it yourself at home.

## We'll call you

Depending on your type of illness or injury, the registered nurse will call and follow up to see how you're responding to the self-treatment.

## Confidentiality

Your information is kept in accordance with our policy on confidentiality.


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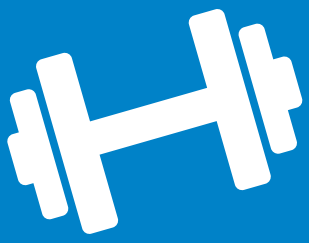
# Fitness Reimbursement

## 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.

# 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 Reimbursement

## Wellness Participation Program

Your Blue Cross Blue Shield of Massachusetts health plan can save you up to $150[1] annually in qualified Weight Watchers®′ and hospital-based weight-loss programs.

## 3 Easy Steps to Getting Reimbursed[2]

**1.** 

### Choose

Start by picking a qualified weight-loss program.

**2.** 

### Complete

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

**3.** 

### Mail

Send the completed form and proof of payment 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:
  - Paid receipts from qualified program
  - Weight Watchers Membership Book
- Receipts, statement, or Weight Watchers Membership Book should include the name of the family member enrolled in the program, the amount paid per session(s), and the date(s) paid.
- The dollar amount you receive may be considered taxable income. Consult your tax advisor about how to treat this reimbursement on your taxes.

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

## A qualified weight-loss program is:

- Weight Watchers meetings
- Weight Watchers At Work
- A hospital-based weight-loss program

## What doesn't qualify?

- Weight Watchers Online
- Weight Watchers At Home
- Fees paid for individual nutrition-counseling sessions, food, books, videos, or scales

1. Most plans offer a $150 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.

# Weight-Loss 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 when you have paid receipts from a qualified weight-loss program, 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) _____

Class or 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 or 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 or Program

Health Plan Year

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 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 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 (including copies of paid receipts) 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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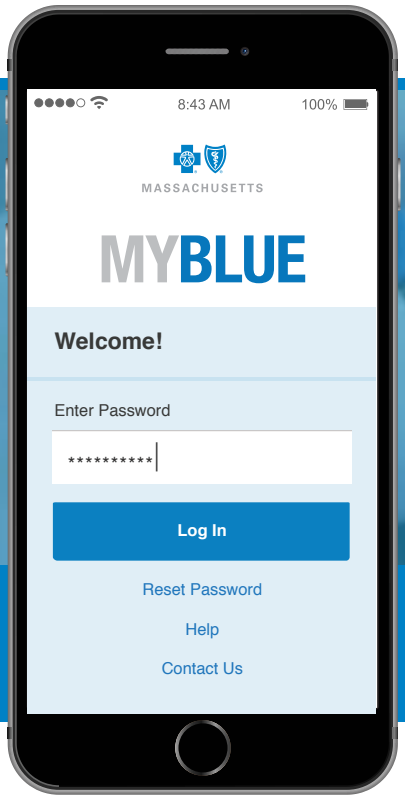


# Meet the MYBLUE Member App

## Simple, Secure, Convenient

## Get Health Care Information Quickly and Easily

The MyBlue Member App gives members instant access to their personal health care information anytime they need it. A simple tap connects them to their doctor, recent prescriptions, and past claims history.

## Personalized health care, right at their fingertips:

Use the interactive ID card to direct-dial important numbers, or email a PDF version to a doctor.

Get access to recent claims history and see copayment amounts.

Review recent doctor visits, including date, specialty, and contact information.

See prescriptions history, including dosage and who prescribed it.

Look up and get directions to nearby doctors, dentists, and hospitals.

View dependents under age 18, and keep track of their information.

Available On Download on the App Store GET IT ON Google Play

*The MyBlue Member App is not available for members with Federal Employee Program (FEP), Blue Benefit Administrators (BBA), Ancillary (Indigo®), Medicare Advantage or stand alone Part D plans, or those with standalone dental, vision, or wellness coverage cannot use the app.*


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# Member Identity Protection Services

The identity protection of our members' private information is our top priority. To provide you with optimal protection, we offer you identity protection services through Experian®, an industry leader in providing credit monitoring and identity theft protection services. This service is being provided to you, free of charge, for as long as you are a Blue Cross member.

## Experian Identity Protection Services Include:

- Credit monitoring—an ongoing review of activity that may affect credit
- Fraud detection—the identification of potentially fraudulent use of your identity or credit
- Credit and identity repair—assistance in resolving issues of fraud that negatively impact your credit or identity

## Your Options and How to Enroll

As a Blue Cross member, you and your family can enroll in two of Experian's identity protection products:

| Experian product | What does it provide? | Who is it for? | How to enroll |
|---|---|---|---|
| ProtectMyID® | • Daily credit monitoring services<br>• Alerts<br>• Credit report checks in Experian's consumer credit database<br>• Identity theft insurance<br>• U.S.-based fraud resolution team support | You and dependents over 18 | Visit the Experian ProtectMyID website at **www.protectmyid.com/bcbsma** and follow the enrollment steps for each person you wish to sign up. You will need engagement code: PC97753. |
| FamilySecure℠ | • Monthly credit monitoring<br>• Credit file misuse alerts<br>• Comprehensive fraud resolution support | Dependents under 18 | Visit the Experian FamilySecure website at **www.familysecure.com/bcbsma** and follow the enrollment steps for each dependent you wish to sign up. You will need engagement code: PC97754. |
| Note: To complete the enrollment process, you'll need your Blue Cross member ID card and the social security number for each individual you want to sign up. | | | |

Members in the following plans are not eligible for this service:

- FEP
- Medicare Advantage and BlueMedicare RX (PDP)

## Questions for Experian?

If you have question about the Experian products or the enrollment process, please contact Experian directly. Depending on your selected product, visit the ProtectMyID website at **www.protectmyid.com/bcbsma** or the FamilySecure website at **www.familysecure.com/bcbsma**. Or, you can call Experian at **1-866-926-9803**.


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Be smart. Shop smart.

# Welcome to SmartShopper®

Earn cash rewards on select medical procedures when you choose quality care at a lower cost.

MASSACHUSETTS | smartshopper®

# Shop smart. Get rewarded. Receive cash. *Repeat.*

Prices for identical medical procedures, like MRIs and CT scans, vary from hundreds to thousands of dollars depending on where you choose to go for your procedure.

With SmartShopper from Vitals®, an independent company, you can comparison shop for eligible, competitively priced care, have your procedure, and then sit back and wait for your reward check to arrive in the mail!

## Shop smart

### 1. Log In or Register (if you haven't already)

Create a MyBlue account at **bluecrossma.com/myblue** by selecting Register Now.

### 2. Shop—online or by phone

Online:

- Select the Find a Doctor & Estimate Costs box
- On the Find a Doctor & Estimate Costs home page, select the Go to Find a Doctor & Estimate Costs button
- Next, select the SmartShopper incentive button

Phone:

Have a member of the Personal Assistant Team find the best care options that return the biggest reward—simply call **1-877-281-3722**, Monday-Thursday, 8:00 a.m.-8:00 p.m., or Friday, 8:00 a.m.-6:00 p.m.

### 3. Have the Procedure

Have your procedure at the eligible location of your choice, and earn cash rewards!

### 4. Receive Your Cash Reward

Once the claim for your procedure is processed, Vitals will mail your reward check to you within 6 to 8 weeks.

# Get rewarded

## Get cash rewards when you choose to save with SmartShopper on select medical procedures

| List of Sample Procedures | SmartShopper Reward |
|---|---|
| Gall Bladder Surgery | up to $250 |
| Shoulder Surgery | up to $250 |
| Colonoscopy | up to $250 |
| MRIs | up to $100 |
| CT Scans | up to $75 |
| Mammograms | up to $50 |

# Receive cash

## Expect payment in 6 to 8 weeks

Once you've earned your cash reward, and your claim has been paid, you'll receive a check from Vitals®′ in the mail.

## Questions?

For any questions regarding the use of SmartShopper, you can contact the Personal Assistant Team at **1-877-281-3722**.
Mon. – Thurs., 8:00 a.m. – 8:00 p.m., or Fri., 8:00 a.m. – 6:00 p.m.

SmartShopper is managed by Vitals,®′ an independent company.

The money you receive may be considered taxable income. Consult your tax advisor.

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MASSACHUSETTS | smartshopper™



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MASSACHUSETTS

# Nondiscrimination Notice

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. It does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

Blue Cross Blue Shield of Massachusetts provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print or other formats).
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, call Member Service at the number on your ID card.

If you believe that Blue Cross Blue Shield of Massachusetts has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with the Civil Rights Coordinator by mail at Civil Rights Coordinator, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126; phone at **1-800-472-2689 (TTY: 711)**; fax at **1-617-246-3616**; or email at **civilrightscoordinator@bcbsma.com**.

If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, online at **ocrportal.hhs.gov**; by mail at U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, DC 20201; by phone at **1-800-368-1019** or **1-800-537-7697 (TDD)**.

Complaint forms are available at **hhs.gov**.


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MASSACHUSETTS

# Translation Resources
## Proficiency of Language Assistance Services

**Spanish/Español:** ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: **711**).

**Portuguese/Português:** ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: **711**).

**Chinese/简体中文:** 注意：如果您讲中文，我们可向您免费提供语言协助服务。请拨打您 ID 卡上的号码联系会员服务部（TTY 号码：**711**）。

**Haitian Creole/Kreyòl Ayisyen:** ATANSYON: Si ou pale kreyòl ayisyen, sèvis asistans nan lang disponib pou ou gratis. Rele nimewo Sèvis Manm nan ki sou kat Idantitifkasyon w lan (Sèvis pou Malantandan TTY: **711**).

**Vietnamese/Tiếng Việt:** LƯU Ý: Nếu quý vị nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ được cung cấp cho quý vị miễn phí. Gọi cho Dịch vụ Hội viên theo số trên thẻ ID của quý vị (TTY: **711**).

**Russian/Русский:** ВНИМАНИЕ: если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Позвоните в отдел обслуживания клиентов по номеру, указанному в Вашей идентификационной карте (телетайп: **711**).

**Arabic/ةيبر:**

انتباه: إذا كنت تتحدث اللغة العربية، فتتوفر خدمات المساعدة اللغوية مجانًا بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هُويتك (جهاز الهاتف النصي للصم والبكم "TTY": **711**).

**Mon-Khmer, Cambodian/ខ្មែរ:** ការជូនដំណឹង៖ ប្រសិនបើអ្នកនិយាយភាសា ខ្មែរ សេវាជំនួយភាសាឥតគិតថ្លៃ គឺអាចរកបានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅផ្នែកសេវាសមាជិកតាមលេខ នៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់អ្នក (TTY: **711**)។

**French/Français:** ATTENTION : si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le Service adhérents au numéro indiqué sur votre carte d'assuré (TTY : **711**).

**Italian/Italiano:** ATTENZIONE: se parlate italiano, sono disponibili per voi servizi gratuiti di assistenza linguistica. Chiamate il Servizio per i membri al numero riportato sulla vostra scheda identificativa (TTY: **711**).

**Korean/한국어:** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드에 있는 전화번호(TTY: **711**)를 사용하여 회원 서비스에 전화하십시오.

**Greek/Ελληνικά:** ΠΡΟΣΟΧΗ: Εάν μιλάτε Ελληνικά, διατίθενται για σας υπηρεσίες γλωσσικής βοήθειας, δωρεάν. Καλέστε την Υπηρεσία Εξυπηρέτησης Μελών στον αριθμό της κάρτας μέλους σας (ID Card) (TTY: **711**).

**Polish/Polski:** UWAGA: Osoby posługujące się językiem polskim mogą bezpłatnie skorzystać z pomocy językowej. Należy zadzwonić do Działu obsługi ubezpieczonych pod numer podany na identyfikatorze (TTY: **711**).

**Hindi/हिंदी:** ध्यान दें: यदि आप हिन्दी बोलते हैं, तो भाषा सहायता सेवाएँ, आप के लिए नि:शुल्क उपलब्ध हैं। सदस्य सेवाओं को आपके आई.डी. कार्ड पर दिए गए नंबर पर कॉल करें (टी.टी.वाई.: **711**).

**Gujarati/ગુજરાતી:** ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો, તો તમને ભાષાકીય સહાયતા સેવાઓ વિના મૂલ્યે ઉપલબ્ધ છે. તમારા આઈડી કાર્ડ પર આપેલા નંબર પર Member Service ને કૉલ કરો (TTY: **711**).

**Tagalog/Tagalog:** PAUNAWA: Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyo para sa tulong sa wika. Tawagan ang Mga Serbisyo sa Miyembro sa numerong nasa iyong ID Card (TTY: **711**).

**Japanese/日本語:** お知らせ：日本語をお話しになる方は無料の言語アシスタンスサービスをご利用いただけます。IDカードに記載の電話番号を使用してメンバーサービスまでお電話ください（TTY: **711**）。

**German/Deutsch:** ACHTUNG: Wenn Sie Deutsche sprechen, steht Ihnen kostenlos fremdsprachliche Unterstützung zur Verfügung. Rufen Sie den Mitgliederdienst unter der Nummer auf Ihrer ID-Karte an (TTY: **711**).

**Persian/پارسیان:**
توج: اگر زبان شما فارسی است، خدمات کمک زبانی ب صورت رایگان در اختیار شما قرار می گیرد. با شمار تلفن مندرج بر روی کارت شناسایی خود با بخش «خدمات اعضا» تماس بگیرید (TTY: **711**).

**Lao/ພາສາລາວ:** ຂໍ້ຄວນໃສ່ໃຈ: ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍເສຍຄ່າ. ໂທຫາຝ່າຍບໍລິການສະມາຊິກທີ່ໝາຍເລກໂທລະສັບຢູ່ໃນບັດຂອງທ່ານ (TTY: **711**).

**Navajo/Diné Bizaad:** BAA ÁKOHWIINDZIN DOOÍGÍ: Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Díí bee anítahígí ninaaltsoos bine'déé' nóomba biká'ígíiji' béésh bee hodíílnih (TTY: **711**).


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