


Blue Medicare RxSM

Standard Plan

2009 Medicare Prescription Drug Formulary

(Comprehensive list of
covered drugs)



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

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

What is the Blue Medicare Rx Formulary?

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

Can the Formulary change?

Generally, if you are taking a drug on our 2009 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2009 coverage year except when a new, less expensive generic drug becomes available or when new adverse information about the safety or effectiveness of a drug is released. Other types of formulary changes, such as removing a drug from our formulary, will not affect members who are currently taking the drug. It will remain available at the same cost-sharing for those members taking it for the remainder of the coverage year. We feel it is important that you have continued access for the remainder of the coverage year to the formulary drugs that were available when you chose our plan, except for cases in which you can save additional money or we can ensure your safety.

If we remove drugs from our formulary, add prior authorization, quantity limit restrictions on a drug, or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 60 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 60-day supply of the drug. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug. The enclosed formulary is current as of March 2009. To get updated information about the drugs covered by Blue Medicare Rx, please visit our Web site at www.bcbsnc.com/member/medicare or call Customer Services at 1-888-247-4142, 7 days a week, 8:00 am to 8:00 pm. TTY/TDD users should call 1-888-247-4145.

How do I use the Formulary?

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

Medical Condition

The formulary begins on page 1. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, “Cardiovascular, Hypertension & Lipids”. If you know what your drug is used for, look for the category name in the list that begins on page number 1. Then look under the category name for your drug.

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page 38. The Index provides an alphabetical list of all of the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

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

Are there any restrictions on my coverage?

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

- **Prior Authorization:** Blue Medicare Rx requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from Blue Medicare Rx before you fill your prescriptions. If you don't get approval, Blue Medicare Rx may not cover the drug.
- **Quantity Limits:** For certain drugs, Blue Medicare Rx limits the amount of the drug that Blue Medicare Rx will cover. For example, Blue Medicare Rx provides 9 tablets per prescription for Imitrex 100 mg. This may be in addition to a standard one month or three month supply.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 1.

You can ask Blue Medicare Rx to make an exception to these restrictions or limits. See the section, “How do I request an exception to the Blue Medicare Rx’s formulary?” on page III for information about how to request an exception.

What if my drug is not on the Formulary?

If your drug is not included in this formulary, you should first contact Customer Services and confirm that your drug is not covered. If you learn that Blue Medicare Rx does not cover your drug, you have two options:

- You can ask Customer Services for a list of similar drugs that are covered by Blue Medicare Rx. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by Blue Medicare Rx.
- You can ask Blue Medicare Rx to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the Blue Medicare Rx’s Formulary?

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

- You can ask us to cover your drug even if it is not on our formulary.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, Blue Medicare Rx limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.
- You can ask us to provide a higher level of coverage for your drug. If your drug is contained in our non-preferred tier, you can ask us to cover it at the cost-sharing amount that applies to drugs in the preferred tier instead. This would lower the amount you must pay for your drug. Please note, if we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug. Also, you may not ask us to provide a higher level of coverage for drugs that are in the tier designated as the high-cost/unique drug tier.

Generally, Blue Medicare Rx will only approve your request for an exception if the alternative drugs included on the plan’s formulary, the lower-tiered drug or

additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

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

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

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

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

If you are a resident of a long-term care facility, we will cover a temporary 31-day transition supply (unless you have a prescription written for fewer days). We will cover more than one refill of these drugs for the first 90 days you are a member of our plan. If you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug (unless you have a prescription for fewer days) while you pursue a formulary exception.

Transition medications will be provided to enrollees who change treatment settings due to changes in level of care (e.g. individuals who enter long term care facilities from hospitals or enter an ambulatory setting from a hospital).

For more information

For more detailed information about your Blue Medicare Rx prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about Blue Medicare Rx, please call Customer Services at 1-888-247-4142, 7 days a week, 8:00 am to 8:00 pm. TTY/TDD users should call 1-888-247-4145. Or visit www.bcbsnc.com/member/medicare.

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

Blue Medicare Rx's Formulary

The formulary below provides coverage information about some of the drugs covered by Blue Medicare Rx. If you have trouble finding your drug in the list, turn to the Index that begins on page 38.

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

The information in the Notes column tells you if Blue Medicare Rx has any special requirements for coverage of your drug. Specific information regarding drugs that may require prior authorization, quantity limitation or limited access are noted in the Requirements / Limits (Req./Limits) column. The following is a key to abbreviations you will find in this column.

LA: Limited Availability. This prescription may be available only at certain pharmacies. For more information call Customer Service.

PA: Prior Authorization. The Plan requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval before you fill your prescriptions. If you don't get approval, we may not cover the drug.

QL: Quantity Limit. For certain drugs, the Plan limits the amount of the drug that we will cover. For example, the Plan provides 9 tablets per prescription for Imitrex 100 mg.

The Drug Table includes a column titled, "Drug Tier." This column indicates what tier each drug is listed under. The following copayments are associated with the corresponding tiers if you receive the drugs at an in-network pharmacy. These copayments apply during the initial coverage phase. Refer to your Evidence of

Coverage for details about your benefits during the coverage gap and catastrophic coverage:

Tier 1 Generic = \$8 for up to and including a 30 day supply, except 31 day supply for long term care pharmacies;

Tier 2 Preferred Brand = \$35 for up to and including a 30 day supply, except 31 day supply for long term care pharmacies;

Tier 3 Non-Preferred Brand = \$75 for up to and including a 30 day supply, except 31 day supply for long term care pharmacies;

Tier 4 Specialty = 33% for up to and including a 30 day supply, except 31 day supply for long term care pharmacies.



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