What is the EmblemHealth Medicare HMO, EmblemHealth Medicare PPO and EmblemHealth Medicare Prescription Drug Plan (PDP) Formulary?

A formulary is a list of covered drugs chosen by your EmblemHealth plan along with a team of health care providers. Your EmblemHealth plan will generally cover the drugs listed in our formulary as long as:

- The drug is medically needed
- The prescription is filled at an EmblemHealth plan network pharmacy
- Other plan rules are followed

For more information on how to fill your prescriptions, please review your Evidence of Coverage.

How do I search for drugs in the 2014 EmblemHealth Medicare HMO, EmblemHealth Medicare PPO and EmblemHealth Medicare PDP Formulary on the Web site?

For the most up-to-date listing of the formulary information follow these steps:

- Highlight “Explore Plans” and click “Pharmacy Information”
- Click on “Search for Medications”
- Click on EmblemHealth Medicare HMO, EmblemHealth Medicare PPO or EmblemHealth Medicare Prescription Drug Plan (PDP) Formulary
- You can search for a drug by looking at the Table of Contents or referring to the Index found at the end of Formulary.

To view the most recent updates to the formulary, click on Recent changes to EmblemHealth's Formulary 2014.

What are generic drugs?

Your EmblemHealth plan covers both brand name drugs and generic drugs. A generic drug is approved by the Food and Drug Administration (FDA) as having the same ingredients as the brand name drug. Generally, generic drugs cost less than brand name drugs.

Can the formulary change?

Generally, if you are taking a drug on our 2014 formulary that was covered at the beginning of the year, we will not remove or reduce coverage of the drug during the 2014 coverage year. The exception is when a new, less costly 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. For those members, the drug will remain available at the same cost-sharing amount for the rest of the coverage year.

If we remove drugs from our formulary, or add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must tell 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 up to a 60-day supply of the drug. If the FDA says a drug on our formulary is unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and tell members who take the drug.

Are there any restrictions on my coverage?

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

- **Prior Authorization:** Your plan requires you or your doctor to get prior authorization for certain drugs. This means that you will need to get approval from your plan before you fill your prescriptions. If you don't get approval, your plan may not cover the drug.
- **Quantity Limits:** For certain drugs, your plan limits the amount of the drug your plan will cover. For example, we give 30 tablets per 30 days per prescription for Januvia 50 mg tablets. This may be in addition to a standard one-month or three-month supply.
- **Step Therapy:** In some cases, your plan requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, your plan may not cover Drug B unless you try Drug A first. If Drug A does not work for you, your plan will then cover Drug B.

You can find out if your drug has extra requirements or limits by looking in the formulary. You can ask for an exception to these restrictions or limits. See our **Grievance and Appeals Information** page for more information.

What if my drug is not on the formulary?

If your drug is not included in this formulary, you should call Customer Service and confirm that your drug is not covered. If your plan does not cover your drug, you have two choices:

- You can ask Customer Service for a list of similar drugs that are covered by us. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered.
- You can ask your plan to make an exception and cover your drug. See our **Grievance and Appeals Information** page for more information about how to request an exception.

For more information:

For more information about your Medicare prescription drug coverage, please check your Evidence of Coverage and other plan materials. Please visit our Web site at **www.emblemhealth/medicare**.

EmblemHealth Medicare HMO: **1-877-344-7364**, Monday through Sunday, 8 am to 8 pm.

EmblemHealth Medicare PPO: **1-866-557-7300**, Monday through Sunday, 8 am to 8 pm.

EmblemHealth Medicare PDP: **1-877-444-7241**, Monday through Sunday, 8 am to 8 pm.

TTY/TDD users should call **711.**

HIP Health Plan of New York (HIP) is an HMO plan with a Medicare contract. Group Health Incorporated (GHI) is a PPO plan and a standalone PDP with a Medicare contract. Enrollment in HIP and GHI depends on contract renewal. HIP and GHI are EmblemHealth companies.

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