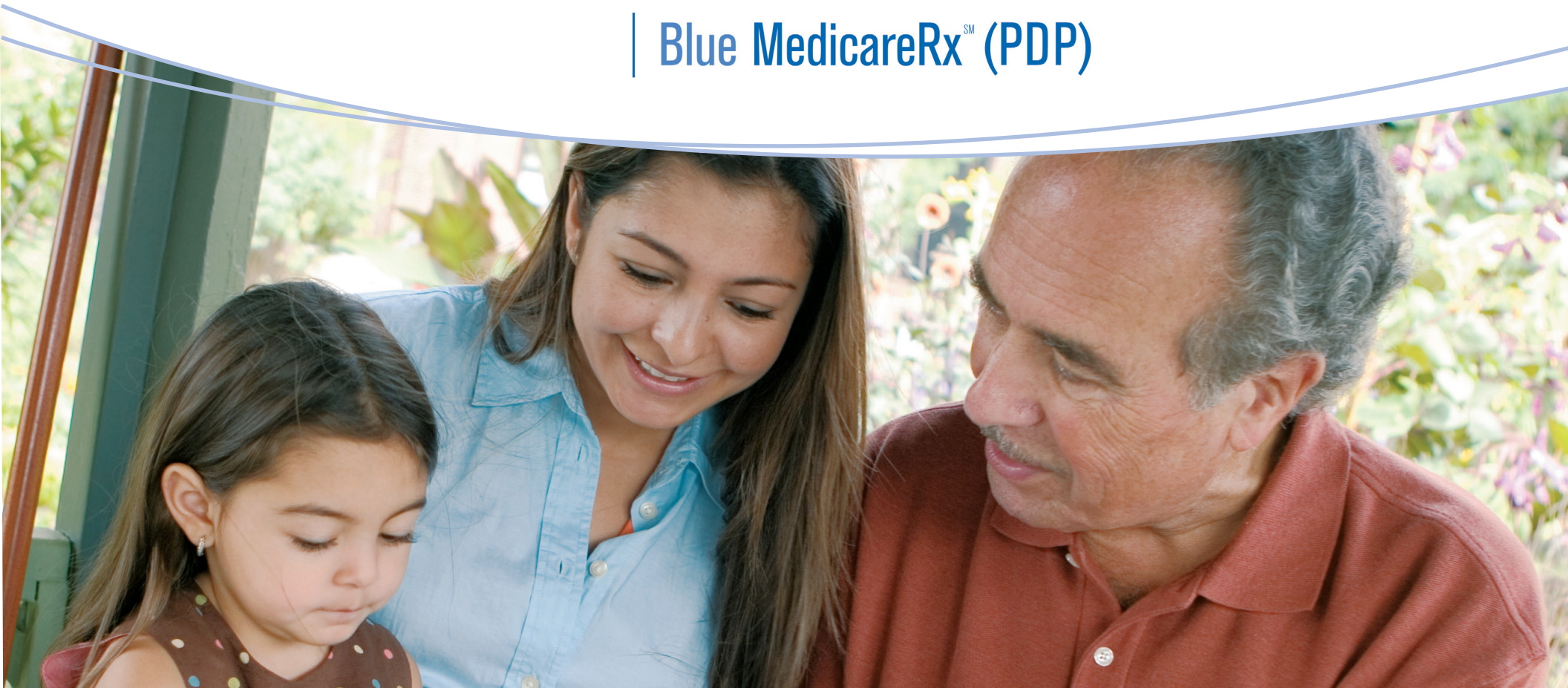




| Blue MedicareRxSM (PDP)



2017 Summary of Benefits Blue MedicareRxSM (PDP)

S2893

Blue MedicareRxSM Value Plus (PDP)

Blue MedicareRxSM Premier (PDP)

Blue MedicareRxSM (PDP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue MedicareRx does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue MedicareRx:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Customer Care at 1-888-620-1747, 24 hours a day, 7 days a week. TTY/TDD users should call 711.

If you believe that Blue MedicareRx has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Blue MedicareRx (PDP)
Grievance Department Coordinator
P.O. Box 53991
Phoenix, AZ 85072-3991

Phone: 1-866-884-9478

Fax: 1-866-217-3353

You can file a grievance in person, by mail, or fax. If you need help filing a grievance, Blue MedicareRx Grievance Department 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, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.



Blue MedicareRx Value Plus (PDP) / Blue MedicareRx Premier (PDP)
(a Medicare Prescription Drug Plan (PDP) offered by ANTHEM INSURANCE CO. & BCBSMA & BCBSRI & BCBSVT with a Medicare contract)

SUMMARY OF BENEFITS

January 1, 2017 - December 31, 2017

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

For More Information

Hours of Operation

You can call us 24 hours a day, 7 days a week.

Blue MedicareRx Value Plus and Blue MedicareRx Premier Phone Numbers and Website

- If you are a member of our plans, call toll-free 1-888-620-1747 (TTY/TDD: 711)
- If you are not a member of our plans, call toll-free 1-866-832-9702 (TTY/TDD: 711)
- Our website: <http://www.rxmedicareplans.com>

If you want to know more about the coverage and costs of Original Medicare, look in your current "**Medicare & You**" handbook. View it online at <http://www.medicare.gov> or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

This document is available in other formats such as Braille and large print. For additional information, call us at 1-888-620-1747.



Who can join?

To join **Blue MedicareRx Value Plus** or **Blue MedicareRx Premier**, you must be entitled to Medicare Part A, and/or be enrolled in Medicare Part B, be a U.S. citizen or be lawfully present in the United States and live in our service area.

Our service area includes the following: Central New England (Connecticut, Massachusetts, Rhode Island, and Vermont).

Which drugs are covered?

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website (<http://www.rxmedicareplans.com>). Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plans group each medication into one of five “tiers.” You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug’s tier and what stage of the benefit you have reached. There are four benefit stages in your Medicare prescription drug coverage: Deductible Stage, Initial Coverage Stage, Coverage Gap Stage, and Catastrophic Coverage Stage. For more information about formulary tiers and stages of the benefit, please see the plan’s formulary and the *Evidence of Coverage* on our website at www.rxmedicareplans.com, or contact Customer Care.

Which pharmacies can I use?

We have a network of pharmacies and you must generally use these pharmacies to fill your prescriptions for covered Part D drugs.

Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies.

You can see our plans’ pharmacy directories at our website (<http://www.rxmedicareplans.com>). Or, call us and we will send you a copy of the pharmacy directory.

Summary of Benefits

January 1, 2017 – December 31, 2017

Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services

Stage 1: Annual Deductible

| | Blue MedicareRx Value Plus (PDP) | Blue MedicareRx Premier (PDP) |
|----------------------------------|--|---------------------------------------|
| How much is the monthly premium? | \$43.10 per month | \$127.70 per month |
| How much is the deductible? | \$280.00 per year for Part D prescription drugs except for drugs listed on Tier 1 and Tier 2 which are excluded from the deductible. | This plan does not have a deductible. |

Stage 2: Initial Coverage Stage

| | Blue MedicareRx Value Plus (PDP) | Blue MedicareRx Premier (PDP) |
|------------------|--|--|
| Initial Coverage | <p>After you pay your yearly deductible, you pay the following until your total yearly drug costs reach \$3,700. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.</p> <p>You may get your drugs at network retail pharmacies and mail order pharmacies.</p> <p>If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.</p> <p>You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.</p> | <p>You pay the following until your total yearly drug costs reach \$3,700. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.</p> <p>You may get your drugs at network retail pharmacies and mail order pharmacies.</p> <p>If you reside in a long-term care facility, you pay the same as at a standard retail pharmacy.</p> <p>You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.</p> |

Stage 2: Initial Coverage Stage (cont.)

Preferred Retail Cost-Sharing

| | Blue MedicareRx Value Plus (PDP) | | Blue MedicareRx Premier (PDP) | |
|--------------------------------|----------------------------------|--------------------|-------------------------------|--------------------|
| Tier | One-month supply | Three-month supply | One-month supply | Three-month supply |
| Tier 1 (Preferred Generic) | \$3 copay | \$9 copay | \$4 copay | \$12 copay |
| Tier 2 (Generic) | \$8 copay | \$24 copay | \$9 copay | \$27 copay |
| Tier 3 (Preferred Brand) | \$35 copay | \$105 copay | \$30 copay | \$90 copay |
| Tier 4 (Non-Preferred Drug) | 40% of the cost | 40% of the cost | \$70 copay | \$210 copay |
| Tier 5 (Specialty Tier) | 27% of the cost | N/A | 33% of the cost | N/A |

Stage 2: Initial Coverage Stage (cont.)

Standard Retail Cost-Sharing

| | Blue MedicareRx Value Plus (PDP) | | Blue MedicareRx Premier (PDP) | |
|--------------------------------|----------------------------------|--------------------|-------------------------------|--------------------|
| Tier | One-month supply | Three-month supply | One-month supply | Three-month supply |
| Tier 1 (Preferred Generic) | \$8 copay | \$24 copay | \$9 copay | \$27 copay |
| Tier 2 (Generic) | \$20 copay | \$60 copay | \$14 copay | \$42 copay |
| Tier 3 (Preferred Brand) | \$45 copay | \$135 copay | \$40 copay | \$120 copay |
| Tier 4 (Non-Preferred Drug) | 50% of the cost | 50% of the cost | \$80 copay | \$240 copay |
| Tier 5 (Specialty Tier) | 27% of the cost | N/A | 33% of the cost | N/A |

Stage 2: Initial Coverage Stage (cont.)

Mail Order Cost-Sharing

| | Blue MedicareRx Value Plus (PDP) | | Blue MedicareRx Premier (PDP) | |
|--------------------------------|----------------------------------|--------------------|-------------------------------|--------------------|
| Tier | One-month supply | Three-month supply | One-month supply | Three-month supply |
| Tier 1 (Preferred Generic) | \$3 copay | \$3 copay | \$4 copay | \$4 copay |
| Tier 2 (Generic) | \$8 copay | \$16 copay | \$9 copay | \$18 copay |
| Tier 3 (Preferred Brand) | \$35 copay | \$70 copay | \$30 copay | \$60 copay |
| Tier 4 (Non-Preferred Drug) | 40% of the cost | 40% of the cost | \$70 copay | \$140 copay |
| Tier 5 (Specialty Tier) | 27% of the cost | N/A | 33% of the cost | N/A |

Stage 3: Coverage Gap Stage

| | Blue MedicareRx Value Plus (PDP) | Blue MedicareRx Premier (PDP) |
|--------------|---|---|
| Coverage Gap | <p>Most Medicare drug plans have a coverage gap (also called the “donut hole”). This means that there’s a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$3,700.</p> <p>After you enter the coverage gap, you pay 40% of the plan’s cost for covered brand name drugs and 51% of the plan’s cost for covered generic drugs until your costs total \$4,950, which is the end of the coverage gap. Not everyone will enter the coverage gap.</p> | <p>Most Medicare drug plans have a coverage gap (also called the “donut hole”). This means that there’s a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$3,700.</p> <p>After you enter the coverage gap, you pay 40% of the plan’s cost for covered brand name drugs and 51% of the plan’s cost for covered generic drugs until your costs total \$4,950, which is the end of the coverage gap. Not everyone will enter the coverage gap.</p> <p>Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug’s tier. See the chart that follows to find out how much it will cost you.</p> |

Preferred Retail Cost-Sharing

| | Blue MedicareRx Value Plus (PDP) | | Blue MedicareRx Premier (PDP) | |
|-------------------------------|--|--------------------|-------------------------------|--------------------|
| Tier | One-month supply | Three-month supply | One-month supply | Three-month supply |
| Tier 1 (Preferred Generic) | After you enter the coverage gap, you pay 40% of the plan’s cost for covered brand name drugs and 51% of the plan’s cost for covered generic drugs until your costs total \$4,950, which is the end of the coverage gap. Not everyone will enter the coverage gap. | | \$4 copay | \$12 copay |
| Tier 2 (Generic) | | | \$9 copay | \$27 copay |

Stage 3: Coverage Gap Stage (cont.)

Standard Retail Cost-Sharing

| | Blue MedicareRx Value Plus (PDP) | | Blue MedicareRx Premier (PDP) | |
|-------------------------------|--|--------------------|-------------------------------|--------------------|
| Tier | One-month supply | Three-month supply | One-month supply | Three-month supply |
| Tier 1 (Preferred Generic) | After you enter the coverage gap, you pay 40% of the plan's cost for covered brand name drugs and 51% of the plan's cost for covered generic drugs until your costs total \$4,950, which is the end of the coverage gap. Not everyone will enter the coverage gap. | | \$9 copay | \$27 copay |
| Tier 2 (Generic) | | | \$14 copay | \$42 copay |

Mail Order Cost-Sharing

| | Blue MedicareRx Value Plus (PDP) | | Blue MedicareRx Premier (PDP) | |
|-------------------------------|--|--------------------|-------------------------------|--------------------|
| Tier | One-month supply | Three-month supply | One-month supply | Three-month supply |
| Tier 1 (Preferred Generic) | After you enter the coverage gap, you pay 40% of the plan's cost for covered brand name drugs and 51% of the plan's cost for covered generic drugs until your costs total \$4,950, which is the end of the coverage gap. Not everyone will enter the coverage gap. | | \$4 copay | \$4 copay |
| Tier 2 (Generic) | | | \$9 copay | \$18 copay |



Stage 4: Catastrophic Coverage Stage

| | Blue MedicareRx Value Plus (PDP) | Blue MedicareRx Premier (PDP) |
|-----------------------|---|-------------------------------|
| Catastrophic Coverage | <p>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$4,950, you pay the greater of:</p> <ul style="list-style-type: none">• 5% of the cost,• or \$3.30 copay for generic (including brand drugs treated as generic) and a \$8.25 copay for all other drugs. | |

ENGLISH

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-888-620-1747 (TTY: 711).

ALBANIAN

VËREJTJE: Nëse flisni shqip, shërbimet e asistencës gjuhësore, pa pagesë, janë në dispozicion për ju. Thirrni në 1-888-620-1747 (TTY: 711).

ARABIC

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل بالرقم 1-888-620-1747 (للصم والبكم: 711).

CHINESE

小贴士：如果您说中文，欢迎使用免费语言协助服务。请致电 1-888-620-1747（TTY：711）。

CUSHITE (OROMO)

HUBACHISA: Afaan Oromoo, dubbata yoo ta’e, gargaarsi tajaajilawwan afaanii kanfaltii malee ni jira. 1-888-620-1747 bilbili (TTY: 711).

FRENCH

ATTENTION : Si vous parlez français, des services gratuits d’interprétation sont à votre disposition. Veuillez appeler le 1-888-620-1747 (TTY: 711).

FRENCH CREOLE

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-888-620-1747 (TTY: 711).

GERMAN

BITTE BEACHTEN: Wenn Sie Deutsch sprechen, stehen Ihnen unsere Dolmetscher unter der Nummer 1-888-620-1747 (TTY: 711) kostenlos zur Verfügung.

GREEK

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, υπάρχει διαθέσιμη υπηρεσία γλωσσικής υποστήριξης, οι οποία παρέχεται δωρεάν. Καλέστε στο 1-888-620-1747 (Αριθμός για άτομα με προβλήματα ακοής/ομιλίας: 711).

GUJARATI

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો, ભાષાકીય સહાય સેવા, વિનામુલ્યે, તમારા માટે ઉપલબ્ધ છે. કોલ કરો 1-888-620-1747 (TTY: 711)

HINDI

ध्यान दीजिए: अगर आप हिंदी बोलते हैं, तो आपके लिए भाषा सहायक सेवाएं मुफ्त उपलब्ध हैं। 1-888-620-1747 (TTY: 711) पर कॉल करें।

IBO

Nti: Ọ bụrụ na asụ Ibo, asụsụ aka ọasụ n’efu, defu, aka. Kpoo 1-888-620-1747 (TTY: 711).

ITALIAN

ATTENZIONE: Se lei parla italiano, sono disponibili servizi gratuiti di assistenza linguistica nella sua lingua. Chiami 1-888-620-1747 (TTY: 711).

JAPANESE

お知らせ: 日本語での対応を望まれる方には、無料で通訳サービスをご利用になれます。電話番号 1-888-620-1747 (TTY: 711)までお問い合わせ下さい。

KOREAN

알림: 한국어를 하시는 경우 무료 통역 서비스가 준비되어 있습니다. 1-888-620-1747 (TTY: 711) 로 연락주시기 바랍니다.

KRU

YI LE: I balè u mpot Kru Basa’a, bot ba la hola wè i nyuu mahop, u saa bé to yom, ba yé ha i nyuu yon. Sebél i nsinga ini 1-888-620-1747 (TTY: 711).

LAOTIAN

ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-888-620-1747 (TTY: 711).

MON-KHMER, CAMBODIAN

ប្រយ័ត្ន៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ សេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃ គឺអាចរកបានសំរាប់អ្នក។ ចូរទូរស័ព្ទទៅ 1-888-620-1747 (TTY: 711)។

NEPALI

ध्यान दिनुहोस्: यदि तपाईं नेपाली बोल्नुहुन्छ भने भाषा सहायता सेवाहरू तपाईंको लागि निःशुल्कमा उपलब्ध छन्। 1-888-620-1747 (TTY: 711) मा फोन गर्नुहोस्।

POLISH

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer 1-888-620-1747 (TTY: 711).

PORTUGUESE

ATENÇÃO: Se fala português, estão disponíveis serviços gratuitos de assistência linguística na sua língua. Telefone para 1-888-620-1747 (TTY: 711).

RUSSIAN

ВНИМАНИЕ: Если вы говорите на русском языке, вам будут бесплатно предоставлены услуги переводчика. Звоните по телефону: 1-888-620-1747 (телетайп: 711).

SERBO-CROATIAN

UPOZORENJE: Ukoliko govorite srpsko-hrvatski jezik, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-620-1747 (TTY- *Telefon za osobe sa oštećenim govorom ili sluhom*: 711).

SPANISH

ATENCIÓN: Si usted habla español, tenemos servicios de asistencia lingüística disponibles para usted sin costo alguno. Llame al 1-888-620-1747 (TTY: 711).

TAGALOG

Pansinin: Kung nagsasalita ka ng Tagalog, mga serbisyo ng tulong sa wika, nang walang bayad, ay magagamit sa iyo. Tawagan ang 1-888-620-1747 (TTY: 711).

THAI

หมายเหตุ: หากคุณพูดภาษาไทย เรามีบริการให้ความช่วยเหลือด้านทางภาษาให้คุณฟรี โทร 1-888-620-1747 (TTY: 711).

VIETNAMESE

LƯU Ý: Nếu quý vị nói tiếng Việt, thì có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Hãy gọi số 1-888-620-1747 (TTY: 711).

YORUBA

AKIYESI: Bi o ba nsọ èdè Yorùbá, ọfé ni iranlọwọ lori èdè wa fun yin o. Ẹ pe ẹrọ-ibanisọrọ yi 1-888-620-1747 (TTY: 711).

This information is not a complete description of benefits. Contact the plan for more information.

Limitations, copay, and restrictions may apply.

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1 of each year.

The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

You must continue to pay your Medicare Part B premium.

Anthem Insurance Companies, Inc., Blue Cross and Blue Shield of Massachusetts, Inc., Blue Cross & Blue Shield of Rhode Island, and Blue Cross and Blue Shield of Vermont are the legal entities which have contracted as a joint enterprise with the Centers for Medicare & Medicaid Services (CMS) and are the risk-bearing entities for Blue MedicareRx (PDP) plans. The joint enterprise is a Medicare-approved Part D Sponsor. Enrollment in Blue MedicareRx (PDP) depends on contract renewal.

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