

# BlueCare- HMO Grandfathered Plan

## Schedule of Copayments Plan 15

All Copayments are subject to the maximum Copayment limitations described in the Benefit Booklet. The following description of Services is not intended to create, and shall not create, any rights or obligations that differ from or are inconsistent with those set forth elsewhere in the Member Handbook.

### Out-of-Pocket

Benefit Description	Cost to Member
<b>Maximum Out-of-Pocket (per Benefit Period)</b>	
Single	\$2,000
Family	\$4,000

### Physician Services

Benefit Description	Cost to Member
<b>Primary Care Physician (PCP)</b>	\$20 Copayment
<b>Specialist</b>	\$35 Copayment
<b>In-office Surgery</b>	Subject to PCP or Specialist Copayment, whichever is applicable
<b>Allergy Injection</b>	\$0 Copayment
<b>Allergy Testing</b>	
<b>Primary Care Physician</b>	\$20 Copayment
<b>Specialist</b>	\$35 Copayment
<b>Annual Contracting Gynecologist</b>	\$35 Copayment
<b>Maternity – initial obstetrician visit only</b>	\$20 Copayment
<b>Well Child Care Services</b>	\$0 Copayment

## Inpatient Services

Benefit Description	Cost to Member
<b>Inpatient Hospital</b>	\$200 Copayment/day for day 1-5, \$1,000 maximum/Admission
<b>Inpatient Physician</b>	\$0 Copayment
<b>Inpatient Rehabilitation Services</b> (e.g., Physical, Speech, Cardiac, or Occupational)	\$0 Copayment

## Outpatient Services

Benefit Description	Cost to Member
<b>Surgical - Outpatient Hospital Surgical</b>	\$200 Copayment
<b>Surgical - Ambulatory Surgical Center</b>	\$200 Copayment
<b>Dialysis</b>	\$0 Copayment
<b>Diagnostic Lab and X-ray</b> at Hospital or a Free Standing Facility	\$15 Copayment
<b>Diagnostic Testing</b> at Hospital or a Free Standing Facility including MRI,CT Scans, Endoscopy and Stress Tests	\$200 Copayment
<b>X-Ray/Imaging</b> at Hospital or a Free Standing Facility	\$15 Copayment
<b>Birthing Center</b>	\$0 Copayment

## Emergency Services and Care (\*Copayment waived if admitted)

Benefit Description	Cost to Member
<b>Emergency Room</b> in a Contracting Hospital	\$100 Copayment
<b>Emergency Room</b> in a Non-Contracting Hospital	\$100 Copayment
<b>Urgent Care</b> in a Contracting Urgent Care Center	\$30 Copayment
<b>Ambulance</b> (Medically Necessary)	\$0 Copayment

## Behavioral Health Services

Benefit Description	Cost to Member
<p><b>Mental Health Services</b></p> <p>Outpatient Facility Services rendered at:</p> <ul style="list-style-type: none"> <li>Emergency Room (*Copayment waived if admitted)</li> <li>Hospital</li> </ul>	<p>\$100 Copayment*</p> <p>\$200 Copayment</p>
<p>Physician Services at a Hospital and ER</p>	<p>\$0 Copayment</p>
<p>Physician and other health care professionals licensed to perform such Services rendered at:</p> <ul style="list-style-type: none"> <li>PCP Office</li> <li>Contracting Specialist Office</li> <li>All other locations</li> <li>PCP</li> <li>Contracting Specialist</li> </ul>	<p>\$20 Copayment</p> <p>\$35 Copayment</p> <p>\$0 Copayment</p> <p>\$0 Copayment</p>
<p>Inpatient</p> <ul style="list-style-type: none"> <li>Facility Services</li> <li>Physician and other health care professional Services</li> </ul>	<p>\$200 Copayment per day up to \$1,000 per Admission</p> <p>\$0 Copayment</p>
<p><b>Substance Dependency Treatment</b></p> <p>Outpatient Facility Services rendered at:</p> <ul style="list-style-type: none"> <li>Emergency Room (*Copayment waived if admitted)</li> <li>Hospital</li> </ul>	<p>\$100 Copayment*</p> <p>\$200 Copayment</p>
<p>Physician Services at a Hospital and ER</p>	<p>\$0 Copayment</p>
<p>Physician and other health care professionals licensed to perform such Services rendered at:</p> <ul style="list-style-type: none"> <li>PCP Office</li> <li>Contracting Specialist Office</li> <li>All other locations</li> <li>PCP</li> <li>Contracting Specialist</li> </ul>	<p>\$20 Copayment</p> <p>\$35 Copayment</p> <p>\$0 Copayment</p> <p>\$0 Copayment</p>

Benefit Description	Cost to Member
Inpatient (Detoxification Only)  Facility Services  Physician and other health care professional Services	\$200 Copayment per day up to \$1,000 per Admission  \$0 Copayment

### Special Services

Benefit Description	Cost to Member
<b>Bereavement Counseling</b> \$250 or 6 visits Per Member Per Lifetime	\$0 Copayment
<b>Biofeedback</b>	\$0 Copayment
<b>Durable Medical Equipment</b>	\$0 Copayment
<b>Home Health Care</b> 40 Days Per Member Per Benefit Period	\$0 Copayment
<b>Hospice Care</b>	\$0 Copayment
Outpatient Private Duty Nursing 40 Visits Per Member Per Benefit Period	\$0 Copayment
<b>Prosthetic &amp; Orthotic Devices</b>	\$0 Copayment
<b>Rehabilitation Services</b> (e.g., Outpatient Physical, Speech, Cardiac, or Occupational)	\$20 Copayment/visit

Benefit Description	Cost to Member
<b>Skilled Nursing Facility</b> 90 Days/Benefit Period	\$0 Copayment per day
<b>Second Medical Opinion</b> Services rendered by a Contracting Provider Services rendered by a Non-Contracting Provider	\$35 Copayment 40% of Allowance
<b>Spinal manipulations</b> 26 Visits Per Member Per Benefit Period	\$35 Copayment
<b>TMJ Services</b> 18 visits Per Member per Benefit Period	\$0 Copayment
<b>Transplant – Lodging, Meals and Transportation</b> Per Member Per Lifetime	\$10,000
<b>Wig</b> (after chemotherapy)	\$0 Copayment
<b>Autism Spectrum Disorder Services</b> All Other Services	Unlimited Applicable Provider Copayment

# BlueCare Rx<sup>®</sup> Pharmacy Program

## Schedule of Benefits

This Pharmacy Program Schedule of Benefits is part of the BlueCare Rx Pharmacy Program Endorsement, both of which should be reviewed carefully. To find a Participating Pharmacy, access the Pharmacy Program Provider Directory website at [www.bcbsfl.com](http://www.bcbsfl.com) or call the customer service phone number included on the your Identification Card.

**Pharmacy per Deductible (DED)**..... \$0

Place of Purchase	Cost to You
<b>Participating Retail Pharmacy</b>	
Copayments or Coinsurance percentages that apply to each <b>One-Month Supply</b>	
.....	.....
Covered OTC Drugs	\$15
Preferred Generic Prescription Drugs and Supplies	\$15
Preferred Brand Name Prescription Drugs and Supplies	\$25
Non-Preferred Prescription Drugs and Supplies	\$40
<b>Mail Order Pharmacy</b>	
Copayments or Coinsurance percentages that apply to each <b>Three-Month Supply</b> unless indicated otherwise	
.....	.....
Covered OTC Drugs	\$30
Preferred Generic Prescription Drugs and Supplies	\$30
Preferred Brand Name Prescription Drugs and Supplies	\$50
Non-Preferred Prescription Drugs and Supplies	\$80
<b>Specialty Pharmacy</b>	
Copayments or Coinsurance percentages that apply to each <b>One-Month Supply</b>	
.....	.....
Covered OTC Drugs	\$15
Preferred Generic Prescription Drugs and Supplies	\$15
Preferred Brand Name Prescription Drugs and Supplies	\$25
Non-Preferred Prescription Drugs and Supplies	\$40

## Other Important Information affecting what you will pay:

- If the you or your Provider requests a Brand Name Prescription Drug when there is a Generic Prescription Drug available; you will be responsible for:
  1. the cost share amount that applies to the Brand Name Prescription Drug you received, or in the case of a Non-Preferred Prescription Drug, the cost share amount that applies to Non-Preferred Prescription Drugs, as indicated in this Schedule of Benefits; **and**
  2. the difference in cost between the Generic Prescription Drug and the Brand Name Prescription Drug or Non-Preferred Prescription Drug you received, unless the Provider has indicated on the Prescription that the Brand Name Prescription Drug or Non-Preferred Drug is Medically Necessary.
- Some Specialty medications may be dispensed in lesser quantities due to manufacturer package size or course of therapy and certain Specialty Pharmacy products may have additional quantity limits.
- You can also get up to a Three-Month Supply of a Covered Prescription Drug or Covered Prescription Supply (except Specialty Drugs) purchased at a retail Participating Pharmacy. Specialty Drugs are covered only up to a One-Month Supply.
- Specialty Drugs, as designated in the Medication Guide, are not covered when purchased through the Mail Order Pharmacy.

# BlueCare Rx Pharmacy Program Endorsement

This endorsement is to be attached to and made a part of the BlueCare Benefit Booklet. The Benefit Booklet is hereby amended by adding the following BlueCare Rx Pharmacy Program provisions.

## Introduction

BlueCare Rx provides coverage to you for Covered Prescription Drugs and Supplies and select Over-the-Counter (“OTC”) Drugs purchased at a Pharmacy. In order to obtain benefits under this endorsement, you must pay, at the time of purchase, the Pharmacy Deductible, if any, and the applicable Copayment or Coinsurance indicated on the BlueCare Rx Pharmacy Program Schedule of Benefits.

In the Medication Guide, are lists of Preferred Generic Prescription Drugs, Preferred Brand Name Prescription Drugs, Non-Preferred Prescription Drugs and Covered OTC Drugs. you may be able to reduce your out-of-pocket expenses by: 1) choosing Preferred Prescription Drugs rather than Non-Preferred Prescription Drugs; 2) choosing Generic Prescription Drugs rather than Brand Name Prescription Drugs; and 3) choosing Preferred Generic Prescription Drugs or Covered OTC Drugs.

## Covered Prescription Drugs and Supplies and Covered OTC Drugs

A Prescription Drug, Covered OTC Drug or Self-Administered Injectable Prescription Drug is covered under this endorsement **only** if it is:

1. prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license;
2. dispensed by a Pharmacist;
3. Medically Necessary;

4. in the case of a Self-Administered Injectable Prescription Drug, listed in the Medication Guide with a special symbol designating it as a Covered Self-Administered Injectable Prescription Drug;
5. in the case of a Specialty Drug, Prescription Drugs that are identified as Specialty Drugs in the Medication Guide;
6. a Prescription Drug contained in an anaphylactic kit (e.g., Epi-Pen, Epi-Pen Jr., Ana-Kit);
7. authorized for coverage by us, if prior coverage authorization is required as indicated with a unique identifier in the Medication Guide, then in effect;
8. not specifically or generally limited or excluded herein or by the Benefit Booklet; and
9. Approved by the FDA and assigned a National Drug Code.

A Supply is covered under this endorsement **only** if it is:

1. a Covered Prescription Supply;
2. prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license;
3. Medically Necessary; and
4. not specifically or generally limited or excluded herein or by the Benefit Booklet.

## Coverage and Benefit Guidelines for Covered Prescription Drugs and Supplies and Covered OTC Drugs

In providing benefits under this endorsement, We may apply the benefit guidelines set forth below, as well as any other applicable payment rules specific to particular Covered Services listed in the Benefit Booklet:

## Contraceptive Coverage

All Prescription diaphragms, oral contraceptives and contraceptive patches, will be covered unless listed as not covered on the BlueCare Rx Pharmacy Program Schedule of Benefits and subject to the limitations and exclusions listed in this endorsement.

### Exclusion:

Contraceptive injectable Prescription Drugs and implants (e.g., Norplant, IUD) inserted for any purpose, are excluded from coverage under this endorsement.

## Covered Over-the-Counter (OTC) Drugs

Select OTC Drugs, listed in the Medication Guide, may be covered when you obtain a Prescription for the OTC Drug from their Physician. Only those OTC Drugs listed in the Medication Guide are covered.

A list of Covered OTC Drugs is published in the most current Medication Guide and can be viewed at [www.bcbsfl.com](http://www.bcbsfl.com), or you may call the customer service phone number on your Membership Card and one will be mailed upon request.

## Diabetic Coverage

All Prescription Drugs and Supplies used in the treatment of diabetes are covered subject to the limitations and exclusions listed in this Endorsement.

Insulin is **only** covered if prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license. Syringes and needles for injecting insulin are covered only when prescribed in conjunction with insulin.

The following Supplies and equipment used in the treatment of diabetes are covered under this endorsement: blood glucose testing strips and tablets, lancets, blood glucose meters, and acetone test tablets and syringes and needles.

## Mineral Supplements, Fluoride or Vitamins

The following Drugs are covered **only** when state or federal law requires a Prescription and when prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license:

1. prenatal vitamins;
2. oral single-product fluoride (non-vitamin supplementation);
3. sustained release niacin;
4. folic acid;
5. oral hematinic agents;
6. dihydrotachysterol; or
7. calcitriol.

### Exclusion:

Prescription vitamin or mineral supplements not listed above, non-prescription mineral supplements and non-prescription vitamins are excluded from coverage.

## Limitations and Exclusions

The benefits for Covered Prescription Drugs and Supplies and Covered OTC Drugs are subject to the following limitations and exclusions, in addition to all other provisions and exclusions of the Benefit Booklet:

### Limitations

1. More than the Maximum supply will not be covered, as set forth in the BlueCare Rx Pharmacy Program Schedule of Benefits, per Prescription for Covered Prescription Drugs and Supplies or Covered OTC Drugs.
2. Prescription refills beyond the time limit specified by state and/or federal law are not covered.
3. Certain Prescription Drugs and Supplies and Covered OTC Drugs require prior coverage authorization in order to be covered.

4. Specialty Drugs (self-administered and Provider-administered), as designated in the Medication Guide, are not covered when purchased through the Mail Order Pharmacy.
5. Retin-A or it's generic or therapeutic equivalent is excluded after age 26.

**Exclusions**

Expenses for the following are excluded:

1. Prescription Drugs and OTC Drugs that are covered and payable under a specific section of the Benefit Booklet which this endorsement amends (e.g., Prescription Drugs which are dispensed and billed by a Hospital).
2. Except as covered in the Covered Prescription Drugs and Supplies and Covered OTC Drugs subsection, any Prescription Drug obtained from a Pharmacy which is dispensed for administration by intravenous infusion or injection, regardless of the setting in which such Prescription Drug is administered or type of Provider administering such Prescription Drug.
3. Any Drug or Supply which can be purchased over-the-counter without a Prescription even though a written Prescription is provided (e.g., Drugs which do not require a Prescription), except for insulin and Covered OTC Drugs listed in the Medication Guide.
4. All Supplies other than Covered Prescription Supplies.
5. Any Drugs or Supplies dispensed prior to the Effective Date or after the termination date of coverage for this endorsement.
6. Therapeutic devices, appliances, medical or other Supplies and equipment (e.g., air and water purifiers, support garments, creams, gels, oils and waxes) regardless of the intended use (except for Covered Prescription Supplies).

7. Prescription Drugs and Supplies and OTC Drugs that are:
  - a. in excess of the limitations specified in this endorsement or on the BlueCare Rx Pharmacy Program Schedule of Benefits;
  - b. furnished to you without cost;
  - c. Experimental or Investigational;
  - d. indicated or used for the treatment of infertility;
  - e. used for cosmetic purposes including but not limited to Minoxidil, Rogaine, Renova;
  - f. prescribed by a Pharmacist;
  - g. used for smoking cessation (e.g., Chantix, Nicorette, Zyban);
  - h. listed in the Homeopathic Pharmacopoeia;
  - i. not Medically Necessary;
  - j. indicated or used for sexual dysfunction (e.g., Cialis, Levitra, Viagra, Caverject). The exception described in exclusion number 11 does not apply to sexual dysfunction Drugs excluded under this paragraph;
  - k. purchased from any source (including a pharmacy) outside of the United States;
  - l. prescribed by any health care professional not licensed in any state or territory (e.g., Puerto Rico, U.S. Virgin Islands or Guam) of the United States of America;
  - m. OTC Drugs not listed in the Medication Guide; and
  - n. Self-Administered Injectable Prescription Drugs used to increase height or bone growth (e.g., growth hormone) except for Conditions of growth hormone deficiency documented with two abnormally low stimulation

tests of less than 10 ng/ml and one abnormally low growth hormone dependent peptide or for Conditions of growth hormone deficiency associated with loss of pituitary function due to trauma, surgery, tumors, radiation or disease, or for state mandated use as in patients with AIDS.

Continuation of growth hormone therapy will not be covered except for Conditions associated with significant growth hormone deficiency when there is evidence of continued responsiveness to treatment. Treatment is considered responsive in children less than 21 years of age, when the growth hormone dependant peptide (IGF-1) is in the normal range for age and Tanner development stage; the growth velocity is at least 2 cm per year, and studies demonstrate open epiphyses.

Treatment is considered responsive in both adolescents with closed epiphyses and for adults, who continue to evidence growth hormone deficiency and the IGF-1 remains in the normal range for age and gender.

8. Mineral supplements, fluoride or vitamins except for those items listed in the Coverage and Benefit Guidelines for Prescription Drugs and Supplies and OTC Drugs subsection.
9. Any appetite suppressant and/or other Drug indicated, or used, for purposes of weight reduction or control.
10. Immunization agents, biological sera, blood and blood plasma.
11. Drugs prescribed for uses other than the FDA-approved label indications. This exclusion does not apply to any Drug that has been proven safe, effective and accepted for the treatment of the specific medical Condition for which the Drug has been prescribed, as evidenced by the

results of good quality controlled clinical studies published in at least two or more peer reviewed full length articles in respected national professional medical journals. This exclusion also does not apply to any Drug prescribed for the treatment of cancer that has been approved by the FDA for at least one indication, provided the Drug is recognized for treatment of cancer in a Standard Reference Compendium or recommended for such treatment in Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are also excluded.

12. Drugs that have not been approved by the FDA, as required by federal law, for distribution or delivery into interstate commerce.
13. Drugs that are compounded except those that have at least one active ingredient that is an FDA-approved Prescription Drug with a valid National Drug Code.
14. Prescription Drugs, OTC Drugs and Supplies purchased from a Non-Participating Pharmacy, except as a result of an Emergency Medical Condition or when authorized by us.
15. Any Drug prescribed in excess of the manufacturer's recommended specifications for dosages, frequency of use, or duration of administration as set forth in the manufacturer's insert for such Drug. This exclusion does not apply if:
  - a. the dosages, frequency of use, or duration of administration of a Drug has been shown to be safe and effective as evidenced in published peer-reviewed medical or pharmacy literature;
  - b. the dosages, frequency of use, or duration of administration of a Drug is part of an established nationally recognized therapeutic clinical guideline

such as those published in the United States by the American Medical Association, National Heart Lung and Blood Institute, American Cancer Society, American Heart Association, National Institutes of Health, American Gastroenterological Association, Agency for Health Care Policy and Research; or

- c. We, in our sole discretion, waives this exclusion with respect to a particular Drug or therapeutic classes of Drugs.
16. Any Drug prescribed in excess of the dosages, frequency of use, or duration of administration shown to be safe and effective for such Drug as evidenced in published peer-reviewed medical or pharmacy literature or nationally recognized therapeutic clinical guidelines such as those published in the United States by the:
- a. American Medical Association;
  - b. National Heart Lung and Blood Institute;
  - c. American Cancer Society;
  - d. American Heart Association;
  - e. National Institutes of Health;
  - f. American Gastroenterological Association; or
  - g. Agency for Health Care Policy and Research.

Unless We, in our sole discretion, decides to waive this exclusion with respect to a particular Drug or therapeutic classes of Drugs.

- 17. Any amount you are required to pay under this endorsement as indicated on the BlueCare Rx Pharmacy Program Schedule of Benefits.
- 18. Any benefit penalty reductions.
- 19. Self-prescribed Drugs or Supplies and Drugs or Supplies prescribed by any person related to you by blood or marriage.

- 20. Food or medical food products, whether prescribed or not.
- 21. Prescription Drugs designated in the Medication Guide as not covered based on (but not limited to) the following criteria:
  - a. the Drug is no longer marketed;
  - b. the Drug has been shown to have excessive adverse effects and/or safer alternatives;
  - c. the Drug is available Over-the-Counter (OTC);
  - d. the Drug has a preferred formulary alternative;
  - e. the Drug has a widely available/ distributed AB rated generic equivalent formulation;
  - f. the Drug has shown limited effectiveness in relation to alternative Drugs on the formulary; or
  - g. the number of members affected by the change.

Refer to the Medication Guide to determine if a particular Prescription Drug is excluded under this endorsement.

### **Pharmacy Alternatives**

For purposes of this endorsement, there are two types of Pharmacies: Participating Pharmacies and Non-Participating Pharmacies.

#### **Participating Pharmacies**

Participating Pharmacies are Pharmacies participating in our BlueCare Rx Pharmacy Program, or a National Network Pharmacy belonging to our Pharmacy Benefit Manager, at the time Covered Prescription Drugs and Supplies and/or Covered OTC Drugs are purchased by you. Participating Pharmacies have agreed not to charge, or collect from, you, for each Covered Prescription Drug, Covered Prescription Supply and/or Covered OTC Drug,

more than the amount set forth in the BlueCare Rx Pharmacy Program Schedule of Benefits.

With BlueCare Rx, there are four types of Participating Pharmacies:

1. Pharmacies in Florida that have signed a BlueCare Rx Participating Pharmacy Provider Agreement with us;
2. National Network Pharmacies;
3. Specialty Pharmacies; and
4. the Mail Order Pharmacy.

To verify if a Pharmacy is a Participating Pharmacy, you may refer to the Pharmacy Program Provider Directory then in effect at [www.bcbsfl.com](http://www.bcbsfl.com), or you may call the customer service phone number on your Membership Card.

Prior to purchase, you must present your Membership Card to the Participating Pharmacy. The Participating Pharmacy must be able to verify that you are, in fact, covered by us.

When charges for Covered Prescription Drugs, and Supplies or Covered OTC Drugs by a Participating Pharmacy is less than the required Copayment, the amount you will be required to pay, depends on the agreement then in effect between the Pharmacy and us, and will be one of the following:

1. The usual and customary charge of such Pharmacy as if it were not a Participating Pharmacy;
2. The charge under the Pharmacy's agreement with us; or
3. The Copayment, if less than the usual and customary charge of such Pharmacy.

### **Specialty Pharmacy**

Certain medications, such as injectable, oral, inhaled and infused therapies used to treat complex medical Conditions are typically more difficult to maintain, administer and monitor when compared to traditional Drugs. Specialty

Drugs may require frequent dosage adjustments, special storage and handling and may not be readily available at local pharmacies or routinely stocked by Physicians' offices, mostly due to the high cost and complex handling they require.

Using a Specialty Pharmacy to provide these Specialty Drugs should lower the amount you have to pay for these medications.

The Specialty Pharmacies designated, solely by us, are the only Participating suppliers for Specialty Drugs. Any Pharmacy not designated by us as a Specialty Pharmacy is considered Non-Participating for payment purposes, even if such Pharmacy is a Participating Pharmacy for other Covered Prescription Drugs under this BlueCare Rx Pharmacy Program.

For additional details on how to obtain Covered Prescription Specialty Drugs from a Specialty Pharmacy, refer to the Medication Guide.

### **Mail Order Pharmacy**

For details on how to order Covered Prescription Drugs and Supplies and Covered OTC Drugs from the Mail Order Pharmacy, refer to the Mail Order Pharmacy Brochure or the Medication Guide.

**Note:** Specialty Drugs are not available through the Mail Order Pharmacy.

### **Non-Participating Pharmacies**

A Prescription Drug, OTC Drug or Self-Administered Injectable Prescription Drug purchased from a Non-Participating Pharmacy is covered under this endorsement **only** if it is prescribed as a result of an Emergency Medical Condition or authorized by us.

A Non-Participating Pharmacy is a Pharmacy that has not agreed to participate in our BlueCare Rx Participating Pharmacy Program and is not a National Network Pharmacy, Specialty Pharmacy or the Mail Order Pharmacy.

When Covered Prescription Drugs and Supplies or Covered OTC Drugs are purchased from a Non-Participating Pharmacy, as a result of an Emergency Medical Condition, or when authorized by us, you may be required to pay the full cost of the Drug at the time of purchase.

In order to be reimbursed for Covered Prescription Drugs and Supplies or Covered OTC Drugs purchased from a Non-Participating Pharmacy, you must submit an itemized paid receipt to us at the address on your Membership Card.

## **Pharmacy Utilization Review Programs**

Our pharmacy utilization review programs are intended to encourage the responsible use of Prescription Drugs and Supplies and OTC Drugs.

We may, at our sole discretion, require that Prescriptions for select Prescription Drugs and Supplies or OTC Drugs be reviewed, under our pharmacy utilization review programs then in effect, in order for there to be coverage for them. Under these programs, there may be limitations or conditions on coverage for select Prescription Drugs and Supplies and OTC Drugs, depending on the quantity, frequency, or type of Prescription Drug, Supply or OTC Drug prescribed.

**Note:** If coverage is not available, or is limited, this does not mean that you cannot obtain the Prescription Drug, Supply or OTC Drug from the Pharmacy. It only means that there is no coverage and payment will not be made for the Prescription Drug, Supply or OTC Drug. You are always free to purchase the Prescription Drug, Supply or OTC Drug at their sole expense.

Our pharmacy utilization review programs include the following:

### **Responsible Steps**

Under this program, We may exclude from coverage certain Prescription Drugs and OTC

Drugs unless you have first tried designated Drug(s) identified in the Medication Guide in the order indicated. In order for there to be coverage for such Prescription Drugs and OTC Drugs prescribed by your Physician, we must receive written documentation from you and your Physician that the designated Drugs in the Medication Guide are not appropriate for you because of a documented allergy, ineffectiveness or side effects.

Prior to filling a Prescription, your Physician may contact us to request coverage for a Prescription Drug or OTC Drug subject to the Responsible Steps program by following the procedures for prior coverage authorization outlined in the Medication Guide.

### **Dose Optimization Program**

Under this program, we may exclude from coverage any Prescription Drug or OTC Drug prescribed in excess of the Maximum specified in the Medication Guide.

### **Prior Coverage Authorization Program**

You are required to obtain prior coverage authorization from us in order for certain Prescription Drugs and Supplies and OTC Drugs to be covered. **Failure to obtain authorization will result in denial of coverage.** Prescription Drugs and Supplies and OTC Drugs requiring prior coverage authorization are designated in the Medication Guide.

For additional details on how to obtain prior coverage authorization, refer to the Medication Guide.

Information on our pharmacy utilization review programs is published in the Medication Guide at [www.bcbsfl.com](http://www.bcbsfl.com), or you may call the customer service phone number on your Membership Card. Your Pharmacist may also advise you if a Prescription Drug or OTC Drug requires prior coverage authorization.

## Ultimate Responsibility for Medical Decisions

The pharmacy utilization review programs have been established solely to determine whether coverage or benefits for Prescription Drugs, Supplies and OTC Drugs will be provided under the applicable terms of the Benefit Booklet.

Ultimately the final decision whether the Prescription Drug, Supply or OTC Drug should be prescribed must be made by you and the prescribing Physician. Decisions made by us in authorizing coverage are made only to determine whether coverage or benefits are available under the Benefit Booklet and not for the purpose of providing or recommending care or treatment. We reserve the right to modify or terminate these programs at any time.

Any and all decisions that require or pertain to independent professional medical judgment or training, or the need for a Prescription Drug, Supply or OTC Drug, must be made solely by you and your treating Physician in accordance with the patient/Physician relationship. It is possible that you or your treating Physician may conclude that a particular Prescription Drug, Supply or OTC Drug is needed, appropriate, or desirable, even though such Prescription Drug, Supply or OTC Drug may not be authorized for coverage by us. In such cases, it is your right and responsibility to decide whether the Prescription Drug, Supply or OTC Drug should be purchased even if we have indicated that coverage and payment will not be made for such Prescription Drug, Supply or OTC Drug.

## Definitions

Certain important terms applicable to this endorsement are set forth below. For additional applicable definitions, please refer to the "Definitions" section in the Benefit Booklet, which this endorsement amends.

**Brand Name Prescription Drug** means a Prescription Drug that is marketed or sold by a manufacturer using a trademark or proprietary

name, an original or pioneer Drug, or a Drug that is licensed to another company by the Brand Name Drug manufacturer for distribution or sale, whether or not the other company markets the Drug under a generic or other non-proprietary name.

**Coinsurance** means, when applicable, the sharing of health care expenses for each Covered Prescription Drug and Supply and/or Covered OTC Drug between us and you. After any applicable Pharmacy Deductible requirement is met, we will pay, if applicable, a percentage of the Participating Pharmacy Allowance for each Covered Prescription Drug and Supply and/or Covered OTC Drug, as set forth in the BlueCare Rx Pharmacy Program Schedule of Benefits. The percentage you are responsible for is your Coinsurance.

**Copayment** means, when applicable, the amount you must pay to the Participating Pharmacy for each Covered Prescription Drug and Supply and/or Covered OTC Drug, at the time of purchase, as set forth in the BlueCare Rx Pharmacy Program Schedule of Benefits.

**Covered OTC Drug** means an Over-the-Counter Drug that is designated in the Medication Guide as a Covered OTC Drug.

**Covered Prescription Drug** means a Drug, which, under federal or state law, requires a Prescription and which is covered by this endorsement.

**Covered Prescription Drug(s) and Supply(ies)** means Covered Prescription Drugs and Covered Prescription Supplies.

**Covered Prescription Supply(ies)** means only the following Supplies:

1. Prescription diaphragms;
2. syringes and needles prescribed in conjunction with insulin, or a covered Self-Administered Injectable Prescription Drug which is authorized for coverage by us;

3. syringes and needles prescribed in conjunction with a Prescription Drug authorized for coverage by us;
4. syringes and needles which are contained in anaphylactic kits (e.g., Epi-Pen, Epi-Pen, Jr., Ana Kit); and
5. Prescription Supplies used in the treatment of diabetes limited to only blood glucose testing strips and tablets, lancets, blood glucose meters, and acetone test tablets.

**Day Supply** means a Maximum quantity per Prescription as defined by the Drug manufacturer's daily dosing recommendations for a 24-hour period.

**Dispensing Fee** means the fee a Pharmacy is paid for filling a Prescription in addition to payment for the Drug.

**Drug** means any medicinal substance, remedy, vaccine, biological product, drug, pharmaceutical or chemical compound that has at least one active ingredient that is FDA-approved and has a valid National Drug Code.

**FDA** means the United States Food and Drug Administration.

**Generic Prescription Drug** means a Prescription Drug containing the same active ingredients as a Brand Name Prescription Drug that either 1) has been approved by the United States Food and Drug Administration (FDA) for sale or distribution as the bioequivalent of a Brand Name Prescription Drug through an abbreviated new drug application under 21 U.S.C. 355 (j); or 2) is a Prescription Drug that is not a Brand Name Prescription Drug, is legally marketed in the United States and, in the judgment of BCBSF, is marketed and sold as a generic competitor to its Brand Name Prescription Drug equivalent. All Generic Prescription Drugs are identified by an "established name" under 21 U.S.C. 352 (e), by a generic name assigned by the United States Adopted Names Council, or by an official or non-proprietary name, and may not necessarily have

the same inactive ingredients or appearance as the Brand Name Prescription Drug.

**Mail Service Copayment** means, when applicable, the amount payable to the Mail Order Pharmacy for each Covered Prescription Drug, Covered Prescription Supply and/or Covered OTC Drug as set forth in the BlueCare Rx Pharmacy Program Schedule of Benefits.

**Mail Order Pharmacy** means the Pharmacy that has signed a Mail Services Prescription Drug Agreement with us.

**Maximum** means the amount designated in the Medication Guide as the Maximum, including, but not limited to, frequency, dosage and duration of therapy.

**Medication Guide** means the guide then in effect issued by us that may designate the following categories of Prescription Drugs: Preferred Generic Prescription Drugs; Covered OTC Drugs, Preferred Brand Name Prescription Drugs; and Non-Preferred Prescription Drugs. The Medication Guide does not list all Non-Preferred Prescription Drugs due to space limitations, but some Non-Preferred Prescription Drugs and potential alternatives are provided for your information. **Note:** The Medication Guide is subject to change at any time. You may go to [www.bcbsfl.com](http://www.bcbsfl.com) for the most current guide or call the customer service phone number on their Membership Card for current information.

**National Drug Code (NDC)** means the universal code that identifies the Drug dispensed. There are three parts of the NDC, which are as follows: the labeler code (first five digits), product code (middle four digits), and the package code (last two digits).

**National Network Pharmacy** means a Pharmacy located outside of Florida that is part of the national network of Pharmacies established by our contracting Pharmacy Benefit Manager.

**Non-Participating Pharmacy** means a Pharmacy that has not agreed to participate in our BlueCare Rx Pharmacy Program and is not a National Network Pharmacy, Specialty Pharmacy or the Mail Order Pharmacy.

**Non-Preferred Prescription Drug** means a Generic Prescription Drug or Brand Name Prescription Drug that is not included on the Preferred Medication List then in effect.

**One-Month Supply** means a Maximum quantity per Prescription up to a 30-Day Supply as defined by the Drug manufacturer's daily dosing recommendations. Certain Drugs, e.g. Specialty Drugs, may be dispensed in lesser quantities due to manufacturer package size or course of therapy.

**Over-the-Counter (OTC) Drug** means a Drug that is safe and effective for use by the general public, as determined by the FDA, and can be obtained without a Prescription.

**Participating Pharmacy** means a Pharmacy that has signed an agreement with us to participate in the BlueCare Rx Pharmacy Program. National Network Pharmacies, Specialty Pharmacies and the Mail Order Pharmacy are also Participating Pharmacies.

**Participating Pharmacy Allowance** means the pre-negotiated amount agreed upon between Participating Pharmacies and us.

**Pharmacist** means a person properly licensed to practice the profession of Pharmacy pursuant to Chapter 465 of the Florida Statutes, or a similar law of another state that regulates the profession of Pharmacy.

**Pharmacy** means an establishment licensed as a Pharmacy pursuant to Chapter 465 of the Florida Statutes, or a similar law of another state, where a Pharmacist dispenses Prescription Drugs.

**Pharmacy Benefit Manager** means an organization that has established, and manages, a Pharmacy network and other Pharmacy

management programs for third party payers and employers, which has entered into an arrangement with us to make such network and/or programs available to our Members.

**Pharmacy Deductible** means, when applicable, the amount of charges up to the Participating Pharmacy Allowance, for Covered Prescription Drugs and Supplies and Covered OTC Drugs that each Member must actually pay per Calendar Year, in addition to any applicable Copayment or Coinsurance, to a Pharmacy who is recognized for payment under this endorsement, before payment is made for Covered Prescription Drugs and Supplies and Covered OTC Drugs.

**Preferred Brand Name Prescription Drug** means a Brand Name Prescription Drug that is included on the Preferred Medication List then in effect. The Preferred Medication List is contained within the Medication Guide. A Preferred Brand Name Prescription Drug on the Preferred Medication List then in effect will be reclassified as a Non-Preferred Prescription Drug on the date the FDA approves a bioequivalent Generic Prescription Drug.

**Preferred Generic Prescription Drug** means a Generic Prescription Drug on the Preferred Medication List then in effect. The Preferred Medication List is contained within the Medication Guide.

**Preferred Medication List** means a list of Preferred Prescription Drugs then in effect, which have been designated by us as preferred and for which we provide coverage and benefits, subject to the exclusions of this endorsement. The Preferred Medication List is contained within the Medication Guide.

**Prescription** means an order for medications or Supplies by a Physician or other health care professional authorized by law to prescribe such Drugs or Supplies.

**Preferred Prescription Drug** means a Prescription Drug that appears on the Preferred Medication List then in effect. A Preferred Prescription Drug may be a Brand Name Prescription Drug or a Generic Prescription Drug. The Preferred Medication List is contained within the Medication Guide.

**Prescription Drug** means any medicinal substance, remedy, vaccine, biological product, Drug, pharmaceutical or chemical compound which can only be dispensed pursuant to a Prescription and/or which is required by state law to bear the following statement or similar statement on the label: "Caution: Federal law prohibits dispensing without a Prescription".

**Self-Administered Injectable Prescription Drug** means an FDA-approved injectable Prescription Drug that you may administer to yourself, as recommended by a Physician, by means of injection, excluding insulin. Covered Self-Administered Injectable Prescription Drugs are denoted with a symbol in the Medication Guide.

**Specialty Drug** means an FDA-approved Prescription Drug that has been designated by us as a Specialty Drug due to requirements such as special handling, storage, training, distribution, and management of the therapy. Specialty Drugs are identified with a special symbol in the Medication Guide.

**Specialty Pharmacy** means a Pharmacy that has signed a Participating Pharmacy Provider Agreement with us to participate in the BlueCare Rx Pharmacy Program, to provide specific Prescription Drug products, as determined by us. The fact that a Pharmacy is a Participating Pharmacy does not mean that it is a Specialty Pharmacy.

**Supply(ies)** means any Prescription or non-Prescription device, appliance or equipment including, but not limited to, syringes, needles, test strips, lancets, monitors, bandages, cotton swabs, and similar items and any birth control device.

**Three-Month Supply** means a Maximum quantity per Prescription up to a 90-Day Supply as defined by the Drug manufacturer's dosing recommendations.

All other provisions of the Benefit Booklet shall remain unchanged.

This endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Benefit Booklet, other than as specifically stated in this endorsement. In the event of any inconsistencies between the provisions contained in this endorsement and the provisions contained in the Benefit Booklet, the provisions contained in this endorsement shall control to the extent necessary to effectuate the intent as expressed herein.

Serviced by:

Health Options, Inc.