

PHARMACY PROGRAM ENDORSEMENT

\$15 Preferred Generic Prescription Drugs
\$25 Preferred Brand Name Prescription Drugs
\$40 Non-Preferred Prescription Drugs

Mail Service

\$30 Preferred Generic Prescription Drugs
\$50 Preferred Brand Name Prescription Drugs
\$80 Non-Preferred Prescription Drugs

BlueCare Rx Program Endorsement

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

The What is Not Covered? section of the Benefit Booklet is amended by deleting the applicable exclusion for Prescription Drugs.

BlueCare Rx

Under this BlueCare Rx Program, coverage is provided for Covered Prescription Drugs and Supplies. In order to obtain benefits under this Endorsement, you must pay, at the time of purchase, the applicable Pharmacy Copayment for Covered Prescription Drugs and/or Supplies. Each Covered Prescription Drug and/or Supply when purchased from the Mail Service

Pharmacy will be subject to a Mail Service Copayment. The applicable Pharmacy Copayment or Mail Service Copayment amount is determined by the type of Prescription Drug dispensed (i.e., Preferred Generic Drug, Preferred Brand Name Drug, or any Prescription Drug not on the Preferred Medication List) and whether obtained from a Participating Pharmacy or the Mail Service Pharmacy. Covered Supplies are subject to the appropriate Pharmacy Copayment.

Covered Prescription Drugs and Supplies must be prescribed by a Physician, acting within the scope of his or her license, dispensed by a Pharmacist, and be Medically Necessary to be covered.

Your Copayment responsibility for Covered Prescription Drugs and/or Covered Syringes and Needles:		
Type of Prescription Drug or Syringes and Needles:	Participating Pharmacy for up to a One-Month Supply	Mail Order Pharmacy for up to a 90-Day Supply
Preferred Generic Prescription Drug	\$15	\$30
Preferred Brand Name Prescription Drug	\$25	\$50
All Covered Syringes and Needles	\$25	\$50
Non-Preferred Prescription Drug	\$40	\$80

Covered Items

Unless otherwise excluded, all Prescription Drugs and diabetic supplies are covered under this program.

Insulin is covered if prescribed by a Physician. Insulin needles and syringes will be covered only when prescribed in conjunction with insulin. The Pharmacy Copayment or the Mail Service Copayment amount applies to syringes and needles.

The only self-administered injectable Prescription Drugs prescribed by a Physician and covered under this Endorsement are Insulin, Imitrex, a Prescription Drug for which coverage authorization is given by HOI through the Prior Coverage Authorization Program, and Prescription Drugs contained in Anaphylactic kits (i.e., Epi-Pen, Epi-Pen Jr., Ana-Kit).

All Prescription diaphragms, oral contraceptive Prescription Drugs, and contraceptive patches when prescribed by a Contracting Provider and dispensed by a Pharmacy that is a Contracting Provider will be covered subject to the limitations and exclusions listed in this Endorsement. Prescription diaphragms are subject to the Copayment applicable to Brand Name Prescription Drugs.

Limitations and Exclusions

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

Limitations

1. A maximum quantity of a One-Month Supply per Prescription when obtained from either a Participating Pharmacy or a Non-Participating Pharmacy.
2. A maximum quantity of a 90-day Supply per Prescription when obtained from the Mail Service Pharmacy.
3. Refills that are authorized by the prescribing Physician must be filled within six months or one year from the original Prescription date depending on federal law designations.
4. Syringes and needles will only be covered when prescribed and obtained with a covered injectable Prescription Drug.
5. Certain Prescription Drugs require prior coverage authorization. These Prescription Drugs are listed on the Prescription Drug Prior Coverage Authorization List which is attached hereto.

Exclusions

1. Prescription Drugs which 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 or Physician);
2. Drugs which can be purchased over the counter without a Prescription even though a Prescription was provided by a Physician.
3. Drugs which are dispensed and billed by the Hospital or Physician.
4. Contraceptive injectable Prescription Drugs and implants (e.g., IUD, etc.) inserted for purposes of contraception are excluded from coverage under this Endorsement.
5. All syringes and needles except as otherwise covered under this Endorsement.
6. Prescriptions refilled in excess of the amount specified by the Physician.
7. Drugs in excess of the limitations specified in this Endorsement.
8. Drugs which are obtained by you without charge.
9. Drugs which are Experimental or Investigational.

10. Appetite suppressants and/or other Prescription Drugs indicated for weight reduction or control.
11. Mineral supplements, or vitamins, except Prescription prenatal vitamins, oral single product fluoride (non-vitamin supplementation), Prescription sustained release niacin, Prescription folic acid, Prescription oral hematinic agents, dihydrotachysterol and calcitriol.
12. Immunization agents, biological sera, blood and blood plasma and injectable Drugs other than Insulin, Imitrex, a Prescription Drug for which coverage authorization is given by HOI through the Prior Coverage Authorization Program and Prescription Drugs contained in Anaphylactic kits (i.e., Epi-Pen, Epi-Pen Jr, Ana-Kit).
13. Fertility Drugs.
14. Drugs used for cosmetic purposes such as Minoxidil, Rogaine, Renova. Retin-A is excluded after age 26.
15. Drugs prescribed by a Pharmacist.
16. Smoking cessation Drugs (e.g., Zyban).
17. Drugs listed in the Homeopathic Pharmacopeia.
18. Drugs prescribed for uses other than the FDA-approved label indications. This exclusion 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 excluded.
19. Drugs which are not approved by the FDA.
20. Drugs and supplies which are not Medically Necessary.
21. Drugs purchased from a Non-Participating Pharmacy, except as a result of an Emergency Medical Condition or when authorized by HOI.
22. Prescription Drugs approved for sexual dysfunction (e.g., Viagra, Cialis, Levitra, Muse, Edex, Caverject, papaverine, Yocon, and phentolamine) prescribed for any Covered Plan Participant.
23. Prescription Drugs that do not have a valid National Drug Code.
24. All Prescription Drugs for which coverage authorization is required by this Endorsement and for which coverage authorization is not obtained before the Prescription is filled.
25. Any Drug administered by intravenous infusion or injection regardless of the setting in which it is administered or type of provider administering such Drug, except as specified in the Covered Items section of this Endorsement or on the Prescription Drug Prior Coverage Authorization List.
26. Any Prescription 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 Prescription Drug. This exclusion does not apply if:
 - a. the dosages, frequency of use, or duration of administration of a Prescription 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 Prescription Drug is part of an established nationally recognized therapeutic clinical guideline such as those published in the United States by 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. HOI, in its sole discretion, waives this exclusion with respect to a particular Prescription Drug or therapeutic classes of Prescription Drugs.

27. Any Prescription Drug prescribed in excess of the dosages, frequency of use, or duration of administration shown to be safe and effective for such Prescription 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 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 unless HOI, in its sole discretion, decides to waive this exclusion with respect to a particular Prescription Drug or therapeutic classes of Prescription Drugs.

Drugs Purchased From a Participating Pharmacy

You must present your Membership Card to the Participating Pharmacy to be identified as a Covered Plan Participant who is participating in this program.

The Participating Pharmacy will dispense Covered Prescription Drugs and Supplies to you. You will be responsible at the time of purchase for an amount up to the Pharmacy Copayment for each Covered Prescription Drug and/or Supply. If the cost of the Covered Prescription Drug and/or Supply is less than the required Pharmacy Copayment, you will pay the

full cost of the Covered Prescription Drug and/or Supply.

The Participating Pharmacy will not make any charge to, or collect from you, any amount over the Pharmacy Copayment amount referenced in this Endorsement for each Covered Prescription Drug and/or Supply. The Participating Pharmacy will obtain the necessary information from you (e.g., name, contract number, and date of birth) and file the claim. Payment for the Covered Prescription Drugs and/or Supplies will be made directly to the Participating Pharmacy.

Drugs Purchased From the Mail Service Pharmacy

The Mail Service Pharmacy will dispense the Covered Prescription Drug and/or Supply to you. You will be responsible at the time of purchase for the Mail Service Copayment for each Covered Prescription Drug and/or Supply.

The Mail Service Pharmacy will not make any charge to, or collect from you, any amount over the Mail Service Copayment amount referenced in this Endorsement for each Covered Prescription Drug and/or Supply. The Mail Service Pharmacy will obtain the necessary information from you (e.g., name, contract number, and date of birth) and file the claim. Payment for the Covered Prescription Drugs and Supplies will be made directly to the Mail Service Pharmacy.

Procedure for Ordering Mail Service Prescriptions

1. For the first Mail Service Pharmacy order, you will need to complete the Patient Profile/Registration Form.
2. Original and refill Prescriptions can be ordered from the Mail Service Pharmacy by completing the Mail Service Pharmacy Prescription Order Form.
3. You will need to obtain a new, original Prescription to send with the order form if the original Prescription was filled at a

Pharmacy other than the Mail Service Pharmacy.

4. Once a Prescription has been filled through the Mail Service Pharmacy, you can call the Pharmacy Customer Service to order refills.
5. Additional details for filing Mail Service Pharmacy claims are described in the Mail Service Pharmacy brochure included in the enrollment package.

Drugs Purchased From a Non-Participating Pharmacy

When Covered Prescription Drugs and Supplies are purchased from a Non-Participating Pharmacy, as a result of an Emergency Medical Condition, or when authorized by HOI, you will be required to pay the full cost of the Drug at the point of service. In order to obtain reimbursement, you are required to submit an itemized paid receipt to HOI for each Covered Prescription Drug and/or Supply purchased from a Non-Participating Pharmacy.

The itemized paid receipt is required to be submitted to the address on the Membership Card.

Procedure For Obtaining Prescription Drugs That Require Prior Authorization

You are required to obtain prior coverage authorization from HOI for any of the Prescription Drugs listed on the [Prescription Drug Prior Coverage Authorization List](#) which is attached hereto in order for there to be coverage under this Endorsement. **Failure to obtain authorization will result in denial of coverage.**

NOTE: This does not mean that you cannot obtain the Prescription Drug from the Pharmacy. It only means that there will not be coverage or payment for the Prescription Drug. You are always free to purchase the Prescription Drug at your sole expense.

If your Physician prescribes a Prescription Drug that is on the list referenced above, or if the Pharmacist notifies you that the Prescription Drug is on the list, prior authorization for coverage is required. You may call the number on your Membership Card if a list is needed or to determine if a Drug is on the list.

To obtain prior coverage authorization:

1. You or your Physician must call the Customer Service Number on the Membership Card and provide the information requested by the Customer Service Representative. This information may include, but is not limited to, your name, date of birth, Physician's name and Physician's telephone number.
2. If you call, HOI will contact your Physician regarding the Drug being prescribed in terms of your diagnosis. If the Physician calls, specific medical documentation may be required.
3. Once a decision is made regarding coverage, you and your Physician will be informed.
4. If the decision is made to allow coverage, you will then be able to have the Prescription Drug filled at a Participating Pharmacy for the required Pharmacy Copayment or, in the case of a Mail Service Pharmacy, the applicable Mail Service Copayment set forth in the Prescription Drug Endorsement.
5. If the decision is made to not allow coverage, you will be able to have the Prescription filled, but you will have to pay the full cost of the medication.

To appeal a denial of authorization, please refer to the Complaint & Grievance Process Section of your Benefit Booklet.

Ultimate Responsibility for Medical Decisions

The Prescription Drug Prior Coverage Authorization Program has been established solely to determine whether coverage or benefits for Prescription Drugs will be provided under the terms of the Group Plan. Ultimately the final decision whether the Prescription Drug should be prescribed must be made by you and the prescribing Physician. **Decisions made in administering the Prescription Drug Prior Coverage Authorization Program are made only to determine whether coverage or benefits are available under the Group Plan.**

Any and all decisions that require or pertain to independent professional medical judgments or training, or the need for a Prescription 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 is needed, appropriate, or desirable, even though such Prescription Drug may not be authorized for coverage under the Prescription Drug Prior Coverage Authorization Program. In such cases, it is your right and responsibility to decide whether the Prescription Drug should be purchased even if coverage and payment will not be made under the Group Plan.

Definitions

Brand Name Prescription Drug

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.

Copayment

The amount you must pay to the Participating Pharmacy for each Covered Prescription Drug and/or Supply, at the time of service, as specifically set forth in this Endorsement.

Covered Prescription Drugs and Supplies

All Prescription Drugs and/or Supplies that, under federal or state law, require a Prescription and which are covered by this Endorsement. Sometimes Covered Prescription Drugs and Supplies will be referred to in the singular as Covered Prescription Drug and/or Supply.

Day Supply

A maximum quantity per Prescription as defined by the Drug manufacturer's daily dosing recommendations for a 24-hour period.

Drug

Any medicinal substance, remedy, vaccine, biological product, drug, pharmaceutical or chemical compound.

FDA

United States Food and Drug Administration.

Generic Prescription Drug

A Prescription Drug containing the same active ingredients as a Brand Name Drug that either (i) has been approved by the United States Food and Drug Administration (FDA) for sale or distribution as the bioequivalent of a Brand Name Drug through an abbreviated new drug application under 21 U.S.C. 355 (j); or (ii) is a Prescription Drug that is not a Brand Name Drug, is legally marketed in the United States and, in the judgment of HOI, is marketed and sold as a generic competitor to its Brand Name 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 Drug.

Mail Service Copayment

The amount payable to the Mail Service Pharmacy for each Covered Prescription Drug and/or Supply as set forth in this Endorsement.

Mail Service Pharmacy

A licensed establishment where Prescription Drugs and/or Supplies are dispensed by a Pharmacist licensed by the state where the Pharmacist practices and delivered to you by mail. The Mail Service Pharmacy has signed an agreement with HOI to dispense Covered Prescription Drugs and/or Covered Supplies to you, as set forth in this Endorsement.

National Drug Code (NDC)

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).

Non-Participating Pharmacy

A retail Pharmacy that has not signed an agreement with HOI to render services to Covered Plan Participants.

Non-Preferred Prescription Drug

A Generic Prescription Drug or Brand Name Prescription Drug that is not included on the Preferred Medication List then in effect.

One-Month Supply

A maximum quantity per Prescription up to a 31-day supply as defined by the Drug manufacturer's daily dosing recommendations.

Participating Pharmacy

A retail Pharmacy that has signed an agreement with HOI to dispense Covered Prescription Drugs and/or Covered Supplies to Covered Plan Participants, as set forth in this Endorsement. A Participating Pharmacy may also be a retail Pharmacy that is part of a national network of retail Pharmacies. These retail Pharmacies outside of Florida are under contract with a vendor to provide Covered Prescription Drugs and Supplies to HOI Covered Plan Participants.

Participating Pharmacy Allowance

The pre-negotiated amount agreed upon between Participating Pharmacies and HOI.

Pharmacist

A person properly licensed to practice the profession of Pharmacy pursuant to Chapter 465 of the *Florida Statutes*, or other states' applicable laws.

Pharmacy

An establishment licensed as a Pharmacy pursuant to Chapter 465 of the *Florida Statutes*, or other states' applicable laws.

Preferred Brand Name Prescription Drug

A Brand Name Prescription Drug that is included on the Preferred Medication List then in effect.

Preferred Generic Prescription Drug

A Generic Prescription Drug on the Preferred Medication List then in effect.

Preferred Medication List

A list of preferred Drugs for which coverage and benefits are provided.

Prescription

An order for medications or medicinal supplies by a Physician authorized by the laws of the state to prescribe such Drugs or supplies.

Prescription Drug

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."

90-Day Supply

A maximum quantity per Prescription up to a 90-Day Supply, as defined by the Drug manufacturer's daily dosing recommendations.

All other provisions of the Group Plan 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 Group Plan, 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 Group Plan, the provisions contained in this Endorsement shall control to the extent necessary to effectuate the intent of Health Options, Inc. as expressed herein.

Serviced by:
Health Options, Inc.

Prescription Drug Prior Coverage Authorization List

Prescription Drugs Requiring Prior Authorization

In accordance with the terms of the BlueScript® Pharmacy Program Endorsement or BlueCare Rx Pharmacy Program Endorsement, coverage authorization for certain Prescription Drugs is required. If the Physician prescribes any of the Prescription Drugs on the following list, the person covered by the BlueScript® Pharmacy Program Endorsement or BlueCare Rx Pharmacy Program Endorsement will need to call the Customer Service Number on the identification card to obtain prior coverage authorization.

1. Procrit, Epogen (erythropoietin)
 2. Genotropin, Humatrope, Norditropin, Nutropin, Saizen (somatropin)
 3. Protropin (somatrem)
 4. Serostim (somatropin)
 5. Leukine (GM-CSF)
 6. Neupogen (G-CSF)
 7. Neumega (interleukin-11)
 8. Avonex
 9. Betaseron
 10. Copaxone
 11. Rebif
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